DCD/DCB (RIDS)

December 14, 1990

Docket No. 030-12208
License No. 13-06147-04
EA No. 90-202

Industrial NDT Services Division
ATTN: Brent Junkins
Vice President
2124 Wendell Avenue
P. O. Box 2245
Indianapolis, IN 46202

Gentlemen:

SUBJECT: NOTICE OF VIOLATION (NRC INSPECTION REPORT NO. 030-06147/90001(DRSS))

This refers to the special safety inspection conducted on November 14, 1990, at your Indianapolis, Indiana facility. During this inspection, violations of NRC requirements were identified. On November 29, 1990, an enforcement conference was held in the Region III office between you and Mr. Mike Thompson, your Radiation Safety Officer (RSO), and Dr. C. J. Paperiello, and other members of the NRC staff. A copy of the inspection report was mailed to you on November 26, 1990, and a copy of the enforcement conference report was sent on December 3, 1990.

The violations, which are described in the enclosed Notice of Violation, address three separate issues. The first involves two violations pertaining to an overexposure to the hand of a radiographer on September 12, 1990. On this day, the radiographer failed to perform a survey following a radiographic operation. Had he performed a survey, he would have discovered that the source had not properly retracted and was not in the shielded condition. Instead, as he tried to engage the locking mechanism, he steadied the camera with his hand on the guide tube. This resulted in his receiving a radiation dose of 111.4 rem to his left hand.

The second issue, which also consists of two violations, concerns the errors in calculating the overexposure and in reporting that overexposure to the NRC. During the enforcement conference, you discussed how these violations occurred and your subsequent actions to ensure that the correct dose was calculated.

Finally, the same radiographer was involved in another event which resulted in the source becoming disconnected due to his failure to properly secure the source and insert the safety plug prior to moving the camera, as is

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your standard company practice. It is a measure of the effectiveness of your training program that the radiographer, even though he realized that his job could be jeopardized, promptly notified the RSO of the event and took proper actions.

In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C (1990), the overexposure violations have been classified in the aggregate as a Severity Level II problem. The evaluation and reporting violations have been classified in the aggregate as a Severity Level III problem. The violations resulting from the October 31, 1990 event have been classified as Severity Level IV violations.

The root causes of each of the violations and the subsequent corrective actions were discussed during the November 29, 1990, enforcement conference. The root cause of the first problem and the last violations appeared to be due to carelessness and inattentiveness on the part of the radiographer involved. The root cause of the second problem appeared to stem from inattention to detail in performing and checking the mathematical calculation. During the conference we noted the thoroughness and extent of your corrective actions, and that you took these actions prior to the NRC performing the inspection. The fact that you not only retrained the individuals involved, but also the rest of your staff, is commendable. You also took the additional steps of hiring an outside consultant to prepare a presentation for your annual retraining, having an additional check performed on dose calculations, and appointing an assistant to the RSO to help ensure that all your program requirements would continue to be met. Finally, your RSO met with other senior management to discuss other ways to improve your overall operation to prevent such events from recurring. We also note that your past inspection history has been excellent, with only two minor violations in the past nine and a half years. We consider all of these actions to be those of a good performing licensee.

In accordance with the Enforcement Policy, a civil penalty is considered for both Severity Level II and Severity Level III problems. However, after consultation with the Director, Office of Enforcement, I have decided that a civil penalty will not be proposed in this case because of (a) your identification of the overexposure, (b) your prompt and extensive corrective actions for all of the violations, and (c) your excellent past performance. We also considered your use of NRC guidance documents, such as Office of Nuclear Material Safety and Safeguards newsletters, in your training program to be a positive factor.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your responses to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, P.L. No. 96-511.

Sincerely,

Original signed by
A. Bert Davis

A. Bert Davis
Regional Administrator

Enclosures:
1. Notice of Violation
2. Inspection Report
No. 030-06147/90001(DRSS)

cc w/enclosures:
Public Document Room (PDR)
State of Indiana

OE	D:OE	DEDS
JDelMedico	JLieberman	HThompson
	(Received via fax)	
12/12/90	12/13/90	12/13/90

RIII	RIII	RIII	RIII	RIII
Lougheed/db	Narelius	Pederson	Paperiello	Davis
12/14/90	12/14/90	12/14/90	12/14/90	12/14/90

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