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January 31, 1991

Docket No. 030-07022
License No. 29-13613-02
EA 89-80

Process Technology North Jersey
ATTN: John Scandalios
President and Chief Executive
Officer
108 Lake Denmark Road
Rockaway, New Jersey 07866

Gentlemen:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES - \$13,000
(NRC INSPECTION REPORT NO. 89-001 AND NRC INVESTIGATION REPORT
NOS. 1-89-006 and 1-89-006S)

This letter refers to the NRC safety inspection conducted on March 21 and 23, 1989, of activities authorized by NRC License No. 29-13613-02, and to the subsequent investigations conducted by the NRC Office of Investigations (OI). The report of the inspection was forwarded to you on April 17, 1989. The redacted versions of the OI investigation reports were forwarded to you on July 20, 1990. During the inspection and investigations, violations of NRC requirements were identified. On April 26, 1989 and August 14, 1990, enforcement conferences were held with you and members of your staff during which these violations, their causes and safety significance, and your corrective actions were discussed.

The violations are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice). Violation I of the Notice involves inaccurate and incomplete statements by current and former members of your staff during the April 1989 enforcement conference and during the investigations. This violation contains four examples. Example (A) involves your former Plant Manager/Radiation Safety Officer (RSO) and your Vice President/Quality, both of whom during the April 1989 Enforcement Conference failed to acknowledge any keyless entries (climbing over the door) of the irradiator cell, when in fact, these individuals knew of two such entries. Not to have provided the NRC with this information was very significant because these entries bypassed interlocks designed to control access into an irradiator.

Example (B) involves your former RSO who, during the April 1989 enforcement conference, stated that the irradiator operating system computer records all entries into the cell (an assertion used to support that there were no keyless entries made into the cell) when, in fact, this was not true. Not to have

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provided accurate information was significant because the NRC was seeking information on whether the computer verified whether keyless entries occurred even if the source was in the "down" position.

Example (C) involves the former RSO who willfully misrepresented his prior knowledge of damage to the cell door knob. Example (C) also involves the failure of your former Vice President of Operations and Engineering (VP, Ops/Eng) and RSO to acknowledge during the enforcement conference that they were aware that the door to the irradiator cell had been forced open by a former Shift Supervisor/Irradiator Operator (Operator) prior to an audit conducted on February 13, 1989, without the use of a key. In addition the VP, Ops/Eng initially denied to an OI investigator having had knowledge prior to the enforcement conference that this had occurred, although in fact he had been told by the Operator prior to the enforcement conference that the door was forced open. This was significant because the NRC needed such information to understand the chronology of events involving the malfunctioning of the cell door knob and locking mechanism.

Example (D) involves the former Operator who willfully misinformed the NRC of the manner in which the irradiator cell was improperly accessed by two other Operators. The failure to provide accurate information about how the irradiator was accessed significantly impacted the course of the NRC investigation.

With regard to Example (A) of this violation, your President and Chief Executive Officer (CEO) contends that he did not read the April 24, 1989 memoranda describing the climbing incidents, which he had been sent prior to the enforcement conference until after the enforcement conference and, therefore, was not aware of these occurrences. Your former Vice President of Operations and Engineering (VP, Ops/Eng) also contended he was not aware of these occurrences at the time of the enforcement conference, although your former RSO alleged that the VP, Ops/Eng was told. However, in our view, a CEO and the VP, Ops/Eng of an irradiator should have been aware of this information and the failure to be so informed is significant because of the fact that the failure of the lock mechanism on the Maze Access Door was one of the topics planned to be discussed at the April 26, 1989 enforcement conference, and operators gaining entry into an irradiator cell by climbing over the door is an extraordinary occurrence at an irradiator. Moreover, your Vice President of Quality demonstrated, at a minimum, poor judgment in not being more candid during the enforcement conference.

Violation I raises serious questions regarding the ability and willingness of Process Technology North Jersey to comply with NRC requirements, in particular, the specific NRC requirement that information provided to the NRC be complete and accurate in all material respects. Such concerns were of additional importance since false statements to the NRC, as well as other forms of wrongdoing by senior managers and employees of Radiation Technology, Incorporated (your predecessor company), had previously occurred between 1984 and 1986. Those previous violations resulted in orders suspending your license in March and June 1986, as well as the termination of employment, criminal prosecution and conviction of three former employees, and the incarceration of the former

President, who was also the Radiation Safety Officer in the 1984-1986 time period. While the more recent violations set forth in the enclosed Notice are not considered as egregious as those earlier violations, they are nonetheless disturbing, given the prior operating and enforcement history at this facility, and demonstrate the continuing need to emphasize complete and accurate communications.

A license to use radioactive material is a privilege that confers upon the licensee and its officials and employees the special trust and confidence of the public. When the NRC issues a license, it is expected and required that the licensee, as well as its employees and contractors, be completely candid and honest in all of its dealings with the NRC, and ensure that any submittal of written or oral information to the NRC be complete and accurate. The number and nature of the violations with respect to the former RSO, including the submittal of inaccurate or incomplete information to NRC, is of particular concern to the NRC. If this individual had still been employed at your facility, the NRC would have considered issuance of an Order precluding him from the performance or supervision of licensed activities.

In addition to the violation set forth in Section I of the Notice, involving the submittal of inaccurate and incomplete information to the NRC, several other violations of NRC requirements were identified during the March 1989 inspection, or during the investigations. These violations are described in Section II of the enclosed Notice. These violations include, but are not limited to: (1) the failure by the plant superintendent, RSO, and VP/Quality to assure that the problem with the personnel access door lock was properly corrected when an operator notified the RSO in February 1989 that the lock was malfunctioning; (2) the deliberate bypassing of administrative procedures, safety interlock, and physical barriers by two operators who entered the irradiator cell by climbing over the irradiator cell access door, a method of entry not permitted by regulatory requirements; and (3) modification of the Irradiator Start-Up procedure by replacement of a certain key operated "time delay" safety switch, without first obtaining prior approval of the Commission. These violations are of particular concern as they represent a significant lack of attention to and carelessness for licensed responsibilities by supervisors and managers at your facility.

In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1989), the violation in Section I of the Notice has been classified at Severity Level II because it involves erroneous information on material matters given by supervisors and managers, and at least two examples of a licensee manager or supervisor deliberately providing inaccurate information to the NRC. The violations in Section II of the Notice have been classified in the aggregate at Severity Level III because they represent a significant breakdown in management attention and control of licensed responsibilities.

The NRC recognizes that your CEO had been employed in this capacity for only a short time prior to the March 1989 inspection. The NRC also acknowledges that your subsequent corrective actions, as described in your letter dated August 5, 1990, to the NRC and at the August 1990 enforcement conference, were extensive. These actions included: (1) procedural improvements; (2) increased training of your staff; (3) increased, improved, and expanded audits; and (4) the establishment and active involvement of the Radiation Safety Committee in all matters pertaining to the operations of the irradiator.

Nonetheless, to emphasize the importance of ensuring that (1) licensed activities are conducted safely and in accordance with the conditions of your license; (2) deficiencies, when they exist, are promptly identified and corrected; and (3) all information communicated to the NRC is both complete and accurate, I have been authorized, after consultation with the Commission to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalties in the amount of \$13,000 for the violations set forth in the enclosed Notice.

The base civil penalty amounts for Severity Level II and III matters are \$8,000 and \$5,000 respectively. Although a higher civil penalty is warranted based on the application of the adjustment factors in the Commission's Enforcement Policy for both the Severity Level II and III matters, after consultation with Commission only the base civil penalty provided under the Policy will be proposed for the violation in Section I and the violations in Section II of the Notice. We are exercising discretion in this case because your performance has been good subsequent to these violations, the violations were identified and/or occurred shortly after a new President and CEO had been appointed by the licensee and he had had minimal opportunity to re-orient the licensee's operations, and for the most part the managers involved in these violations have been removed.

You are required to respond to the enclosed Notice and, in preparing your response, you should follow the instructions specified therein. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. This response should also provide your basis for concluding that each person involved in licensed activities understands his or her responsibilities and is committed to assuring that NRC requirements will be followed and communications with the NRC are complete and accurate. After reviewing your response to this Notice, including your proposed corrective actions, and the results of future inspections, the NRC will determine whether further enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosure will be placed in the NRC's Public Document Room.

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The responses directed by this letter and the enclosure are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. 96-511.

Sincerely,

/s/ William F. Kane

Thomas T. Martin
Regional Administrator

Enclosure: Notice of Violation and Proposed
Imposition of Civil Penalties

cc w/encls:
Public Document Room (PDR)
Nuclear Safety Information Center (NSIC)
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