Western Industrial Xray
W. I. X.
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May 20, 1994

DMBCIE-07)

Docket: 030-32190
License: 49-27356-01

In response to March 12,1994
Letter and Response To
Conference April 1,1994

APPENDIX A

Pertaining to Inspector Richard Leaorardi's investigation of:

#3 Control of Licensed Material (83822)

The statement is some "individual" observed an unattended exposure device with a survey instrument sitting next to it "with-in" a roped off area. My first question is who was this individual? What qualifications did the individual have as to determining what an exposure device was,description of exposure device,or D.O.T. canister with radioactive yellow II labels on it. Was the radiographer on the other side of the truck, in the darkroom, where was the radiographer and where was the individual making these statements.

Gentleman with all due respect this investigation and accusation are at least vague. The individual didn't notice if the exposure device was locked. Was it "broke down" with dust covers on,or was it in a secured D.O.T. canister with the lid on and bolt securing the lid with Radioactive Yellow II labels on it?

Part 4 INTERNAL INSPECTION PROGRAM (87100)

On the subject of inhouse internal inspection program for quarterly inspection.Larry Wicks R.S.O. had audited the two radiographers in the given quarters because he had worked right along side them all day. Larry Wicks had failed to fill out inspection report for these days but had done a physical inspection as their work companion on the given quarters with both radiographers. Daily work sheets will verify this.

APPENDIX B

Addressing the following investigation of Mark R. Shaffer & Mr.Dennis Boal of O.I.

Part 4 Facilities,Equipment,and Independent Measurement

Pertaining to section 34.25(b) The two sources that were not leak tested and were never used after the 6 month interval were in fact in storage in W.I.X. vault and never used after this interval and the cameras were never returned to mfg. The source changer and new sources put in these cameras were all surveyed properly and the old sources was sent back in source changer to mfg. There was absolutely no danger to anyone in this situation. A written addition to W.I.X. procedures has been written to perform leak test on cameras regardless to time in

Part 5 Radiation Protection and Radiation surveys (83822,87100)

Concerning the dosimeter #9032091 and alarm rate meter of radiographer.

These were personal items of the radiographer on both investigations on July 26-31,1993. The RA had her own personal rate alarm on Jan.5 the inspector discussed this with Larry Wicks. I immediately ordered new dosimeters and rate alarms. No W.I.X. employee will have there own personal equipment any more . I'm responsible for a calibrations. The RA was fully trained written,orally and practically. She failed to turn on her rate meter, failed to survey properly, lock the camera. As of Jan 1993 The radiographers and asst. radiographers assume liability for their actions and violations,is that not correct? We as licensees can do every thing possible but how do you eliminate the human element in radiation safety to themselves and public.

The radiographer in this incident has read the W.I.X. O&E manual which states that all asst. must be under constant surveillance during radiographic exposures. He was in direct violation of W.I.X. procedures.

Then the RA & Radiographer turned in false statements to the R.S.O. Larry Wicks as to what actually happened. All the included information the R.S.O. Larry Wicks got was during the Jan investigation. The RA stated that she was in direct violation operating device without supervision, but she went ahead because of her desire to learn. The licensee at no time and never will condone this practice.

On July 31, 1993 the RA and the RA's husband arrived at the R.S.O.'s house with written statements, and RA's T.L.D. The individuals never told the R.S.O. any of the statements were false and never verbally told him any of the details found out through Mark Shaffer's investigation. Calculations were done on RA's verbal amount of time, which was minuscule in accordance with her later statement of 10 to 15 minutes. Her T.L.D. was sent in, as July 31 was last day of the month of the dosimetry period, with the rest of the companies T.L.D.s. We started a shutdown with Amoco with 12 hours on and 12 hours off. The RA was assigned a new T.L.D. and was working with her husband and was never, never in a restricted area. The restricted area that her husband was performing radiographic exposures was at least 500 yards from the truck where she was doing absolutely no radiographic exposures but only developing film. We worked a lot of hours during this shutdown and I did not follow up on her badge. I looked at Quarterly Reports and nothing was out of the ordinary.

Her T.L.D. was shipped to Vendor, Landauer, after further investigation, they responded that it must have been lost in the mail.

The inspector did a dose assessment and arrived at 49 Rem. I was informed by telephone by Mr. Cain that I had to do a dose assessment. Without the badge for actual dosimetry I could only justify 200 mr. and I don't know if it happened on the first exposure or the second or the fifth exposure since the RA was violating every known safety procedure of W.I.X. O & E manual. Since Mr. Cain was adamant in his demands for a dose assessment I re-enacted the situation to the best of my knowledge. Pure and simple this was a guess because which lie do you believe, the first written statement by my RA & R or the second to Mark Shaffer and Dennis Boal. I re-enacted this situation at several speeds and took an average and came up with 6 rem. The blood tests proved that she never picked up a severe dose of any kind. I personally don't think she picked up 6 rem but in all fairness I should have assigned her the 1.25 for a lost badge. All this re-enactment was a guess which Mr. Cain now informs me is a violation. How do you get a violation for a hypothetical scenario.

7. Receipt, Transfer, & Transportation (86740, 87100)

I have secured an NRC approved Q.A.P. for Radioactive materials packages as required by 10 CFR.71.12(b) as of (April 12, 1994). I had sent my program in many previous times but it was presented to the right persons and is now approved.

8. Incident Involving A Possible Overexposure

On July 31, 1993 the RA proceeded to violate just about every known safety precaution provided in her written, oral, and practical training. She was not an inexperienced assistant. She didn't properly survey the guide tube, camera or lock the camera. She moved the camera without the survey meter. She stated that she took approximately 10-15 minutes to cover 60 to 70 feet. This is highly unbelievable and she had not turned her rate meter on before radiographic procedures. Gentlemen what can I possibly do, when the personnel in this incident were fully trained and completely neglect all aspects of radiation safety, your asking for trouble.

Part 10 CFR 20.101.(b) allows a licensee to permit an individual to receive a whole body dose of 3 rems per calendar quota which would be 12 rems per year. Yet you cannot have over 5 rems in any given year! Where does specifics enter in to violations Mr. Cain this is not a double standard, I talk a lot of care in radiation safety, I give many seminars in radiation safety to area plants. Until this incident I have never had an employee go "offscale" since 1991. As for all of my equipment in W.I.X. Inspections property, it is all calibrated, every RA & R has an alarm rate meter and a W.I.X. dosimeter. I want to and shall continue to adhere to all N.R.C. rules and regulations and all W.I.X. personnel will also.

Thanks,

Larry Wicks

Larry Wicks
President W.I.X. Inspection