UNITED STATES
NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	Docket No. 030-32190
Western Industrial X-Ray	)	License No. 49-27356-01
Inspection Company, Inc.	)	EA 93-238
Evanston, Wyoming	)	

ORDER SUSPENDING LICENSE
(EFFECTIVE IMMEDIATELY)
AND DEMAND FOR INFORMATION

I

Western Industrial X-Ray Inspection Company, Inc. (Licensee or WIX) is the holder of Byproduct Material License No. 49-27356-01 issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR Parts 30 and 34. The license authorizes the Licensee to possess sealed sources of iridium-192 in various radiography devices for use in performing industrial radiography activities. The license, originally issued on August 12, 1991, is due to expire on August 31, 1996.

II

In April 1993 and in January and March 1994, the NRC conducted inspections and investigations of Western Industrial X-Ray Inspection Company, Inc., at the company's offices in Evanston, Wyoming, and at temporary job sites near Granger, Wyoming. These inspections and investigations identified numerous violations of NRC's radiation safety requirements, including some violations which were found to have recurred after being found in previous inspections. These violations were described in inspection reports 030-32190/93-01 and 030-32190/94-01 issued on May 12, 1994. In addition, based on the investigations conducted by the Office of Investigations (OI), several of the violations have

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been determined by the NRC to have been committed deliberately by Licensee employees.

In a March 2, 1994, letter to the Licensee, the NRC described the apparent violations that had been identified as of that date and confirmed the arrangements for the Licensee to attend an enforcement conference in the NRC's Arlington, Texas office. The enforcement conference, which was transcribed, occurred on April 1, 1994. The Licensee was represented by Mr. Larry D. Wicks, who is the president and owner of WIX as well as the company's designated radiation safety officer (RSO).

The most significant of the NRC's concerns, and many of the violations, are related to a July 31, 1993, incident involving a WIX radiographer and radiographer's assistant who were performing radiography on a pipeline near LaBarge, Wyoming. The incident involved a radiographic device containing a 37-curie, sealed iridium-192 source and resulted in a potentially significant radiation exposure to the radiographer's assistant.

This incident was reviewed during the inspection and investigation that began in January 1994. The following information regarding this incident is based on joint interviews conducted by the inspector and investigator; on signed, sworn statements taken by the investigator during these interviews; and on statements made by Mr. Wicks at the April 1 enforcement conference. With the exception of certain statements made by Mr. Wicks at the enforcement conference, which are noted below, all other statements were made to the inspector and investigator during their joint interviews of WIX personnel.

The radiographer admitted that he violated NRC requirements by not observing the assistant as she radiographed welds and moved equipment from one location to another (in a later statement, the radiographer said he was aware he was responsible for the assistant but not aware that he had to observe her performing radiographic operations 100% of the time). The assistant admitted that she violated NRC requirements by not performing a radiation survey after each radiographic exposure and by not locking the sealed radioactive source in the radiography device prior to moving equipment to another weld. The assistant stated further that after moving the equipment to another weld she noticed her survey instrument was "pegged," and that her self-reading pocket dosimeter was off-scale, both indications that the device's radioactive source had not been returned to its fully shielded position or had been jostled from its shielded position when the device was moved. The assistant stated that her alarm ratemeter, a protective device which is set to alarm in a radiation field of 500 millirem/hour, did not alarm but added that it was probably turned off. Both she and the radiographer stated that she immediately brought this incident to the radiographer's attention and that he "cranked" the source into the device and locked it, and that they stopped work for the day.

Both the assistant and the radiographer stated that they prepared incident reports for their employer, Larry Wicks, the company president and RSO, and that the incident reports were false in that they falsely stated that the radiographer and the assistant were working together at the time of the incident and falsely stated that they had surveyed the device and locked the source in the device prior to its being moved. The assistant claimed that she told Mr. Wicks at the time the reports were turned in that the incident

reports were false, but Mr. Wicks denied this claim during interviews with the inspector and investigator and at the enforcement conference, stating that he did not know the incident reports were false until brought to his attention by the NRC.

Mr. Wicks stated during the investigation and at the enforcement conference that after learning of the incident he sent the assistant's thermoluminescent dosimeter (TLD) in for immediate processing along with other TLDs worn by company personnel during the month of July 1993. Mr. Wicks also stated that all of the TLDs were sent in the same package. However, the company that processes TLDs for WIX, Landauer, Inc., stated, through its representative, to NRC personnel that while it had received TLDs from WIX for other employees for the month of July 1993, it had no record of receiving a TLD for the assistant for the month of July 1993 and no record of receiving a request from Mr. Wicks for immediate processing of any TLDs sent in for that month. Exposure records mailed by Landauer to WIX and retained by WIX contain no information regarding the assistant's exposure for the month of July 1993 (her exposure records for all other months are available). The assistant, whom Mr. Wicks placed on restricted duty pending a determination of her exposure, also told NRC personnel that she persisted in trying to obtain from Mr. Wicks her exposure record for the month of July and that Mr. Wicks eventually -- about three weeks after the incident -- told her that she had received 350 millirem.

Mr. Wicks stated during the investigation, however, that he never provided the assistant an exposure estimate based on Landauer's processing of the TLD because he did not have such a number to give her. The only explanation he

has offered for not pursuing the question of her July 1993 exposure is that he was very busy. Despite the occurrence of the following events, Mr. Wicks has stated that he was not reminded of the need to evaluate the assistant's exposure from the incident or for the month of July 1993: 1) placing the assistant on restricted duty from the date of the incident (July 31, 1993) until she left his employ in September 1993; 2) receiving Landauer reports for July 1993 which contained no exposure records for the assistant even though, according to Mr. Wicks' statement, he had sent in her TLD for immediate emergency processing; 3) preparing a summary of the assistant's radiation exposure history for her new employer, which included the period in question (July 1993); and 4) responding in the fall of 1993 to a request from the NRC for the radiation exposure reports of terminated employees. In responding to the latter request, Mr. Wicks did not provide a report for the radiographer's assistant despite having provided one for her husband, whose termination date occurred five days after hers. As of the time of the inspection and investigation in January 1994, Mr. Wicks had not performed an adequate evaluation to determine the assistant's exposure resulting from the July 31, 1993 incident. After further requests from the NRC, Mr. Wicks submitted on March 8, 1994, an estimate of 6 rems for the assistant's whole body exposure and at the enforcement conference characterized that estimate as "pure and simply a guess," noting that "I had to have something to send you."

Based on its inspection and investigation of the July 31, 1993 incident, as well as the information obtained during the enforcement conference, the NRC has concluded that the Licensee and its employees violated NRC requirements by failing to: 1) perform an evaluation of the assistant's radiation exposure to

ensure compliance with NRC limits, as required by 10 CFR 20.201, and send the assistant's TLD in for immediate processing when her pocket dosimeter had gone off-scale, as required by 10 CFR 34.33(d); 2) check the alarm function on alarm ratemeters prior to the start of each shift, as required by 10 CFR 34.33(f)(1); 3) perform a radiation survey of a radiography device following each exposure, as required by 10 CFR 34.43(b); 4) lock the sealed radioactive source in the device after each exposure, as required by 10 CFR 34.22(a); 5) ensure that radiographers supervise assistant radiographers who are performing radiographic operations, as required by 10 CFR 34.44, a repeat violation in that it occurred in July 1993, was discussed during the inspection in January 1994, and was found again in March 1994; 6) provide NRC a report of an individual's radiation exposure following the individual's termination of employment, as required by 10 CFR 20.408(b); and 7) ensure that alarm ratemeters worn by radiography personnel were calibrated at a one-year frequency, as required by 34.33(f)(4), a repeat violation in that it was found and discussed with Mr. Wicks following the inspection and investigation in April 1993, recurred in July 1993 and was found again in January 1994.

Other violations found during the NRC's inspections and investigations, but unrelated to the July 1993 incident, include the Licensee's failure to: 1) ensure that pocket dosimeters worn by radiography personnel were checked for correct response to radiation at 12-month intervals, as required by 10 CFR 34.33(c), a violation that occurred on January 18, 1994, 13 days after the inspector had informed the RSO that he should remove uncalibrated dosimeters from service; 2) perform and record quarterly audits of radiography personnel for all calendar quarters in 1992, as required by license condition;

3) maintain constant surveillance and immediate control of licensed material in March 1993, as required by 10 CFR 20.207; 4) submit to the NRC a quality assurance program for use of shipping containers, as required by 10 CFR 71.12(b), a repeat violation in that it was cited in 1992 and had not been corrected by January 1994; and 5) leak test sealed sources prior to removing them from storage and transferring them to the manufacturer in April 1993 and December 1993, as required by license condition.

The NRC has also concluded from its inspections and investigations that Mr. Wicks and employees of WIX violated the provisions of 10 CFR 30.10, "Deliberate Misconduct," a regulation which prohibits individuals from deliberately causing a licensee to be in noncompliance with NRC requirements and prohibits individuals from deliberately providing materially false information to the NRC or a licensee. Specifically, based on its review of the July 31, 1993 incident, its review of the OI findings, and its review of the enforcement conference transcript, the NRC has concluded that Mr. Wicks deliberately failed to perform an evaluation of the assistant's radiation exposure; that Mr. Wicks deliberately failed to send the assistant's TLD in for immediate processing; that the radiographer deliberately failed to watch an assistant perform radiography operations; and that the radiographer and assistant deliberately provided materially false information to the Licensee about the incident.

Based on its review of violations that were unrelated to the July 1993 incident, the NRC has concluded that Mr. Wicks deliberately failed to perform and record quarterly audits of radiography personnel in 1992, because Mr.

Wicks stated that he was aware of these requirements and his responsibility to comply with them but failed to do so. The NRC also has concluded that Mr. Wicks deliberately failed to ensure that alarm ratemeters used by radiography personnel in March, April and July 1993 and January 1994 were calibrated at a one-year frequency, again because Mr. Wicks stated that he was aware of these requirements and his responsibility to comply with them but repeatedly failed to do so.

III

Based on the above, it appears that Licensee employees, including the president and radiation safety officer, have engaged in deliberate misconduct by deliberately violating NRC requirements that are important to the protection of radiography personnel and the public and have failed to ensure compliance with numerous requirements that are important to the safe use of radiographic sources. Deliberate violations of the nature described above cannot and will not be tolerated by the NRC. Further, the history of numerous violations, including repetitive violations, and the failure to follow through on important safety issues, indicate that Mr. Wicks, who is the president and radiation safety officer, is either incapable or unwilling to ensure that the Licensee's radiography program is conducted in accordance with all NRC requirements.

Consequently, I lack the requisite reasonable assurance that the Licensee's current operations can be conducted under License No. 49-27356-01 in compliance with the Commission's requirements and that the health and safety

of the public, including the Licensee's employees, will be protected. Therefore, the public health, safety, and interest require that License No. 49-27356-01 be suspended. Furthermore, pursuant to 10 CFR 2.202, I find that the significance of the violations and deliberate misconduct described above are such that the public health, safety, and interest require that this Order be immediately effective.

IV

Accordingly, pursuant to sections 81, 161b, 161i, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR Parts 30 and 34, IT IS HEREBY ORDERED, EFFECTIVE IMMEDIATELY, THAT LICENSE NO. 49-27356-01 IS SUSPENDED PENDING FURTHER ORDER.

The Regional Administrator, Region IV, may, in writing, relax or rescind this order upon demonstration by the Licensee of good cause.

V

In accordance with 10 CFR 2.202, the Licensee must, and any other person adversely affected by this Order may, submit an answer to this Order, and may request a hearing on this Order, within 20 days of the date of this Order. The answer may consent to this Order. Unless the answer consents to this Order, the answer shall, in writing and under oath or affirmation, specifically admit or deny each allegation or charge made in this order and set forth the matters of fact and law on which the Licensee or other person

adversely affected relies and the reasons as to why the Order should not have been issued. Any answer or request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Chief, Docketing and Service Section, Washington, D.C. 20555. Copies of the hearing request also should be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, to the Assistant General Counsel for Hearings and Enforcement at the same address, to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and to the Licensee if the hearing request is by a person other than the Licensee. If a person other than the Licensee requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.714(d).

If a hearing is requested by the Licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Order should be sustained.

Pursuant to 10 CFR 2.202(c)(2)(i), the Licensee, or any other person adversely affected by this Order, may, in addition to demanding a hearing, at the time the answer is filed or sooner, move the presiding officer to set aside the immediate effectiveness of the Order on the ground that the Order, including the need for immediate effectiveness, is not based on adequate evidence but on mere suspicion, unfounded allegations, or error.

In the absence of any request for hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. AN ANSWER OR A REQUEST FOR HEARING SHALL NOT STAY THE IMMEDIATE EFFECTIVENESS OF THIS ORDER.

VI

In addition to issuance of this Order Suspending License No. 49-27356-01, the Commission requires further information from the Licensee in order to determine whether the Commission can have reasonable assurance that in the future the Licensee will conduct its activities in accordance with the Commission's requirements or, lacking such assurance, whether the Commission should proceed to revoke the license.

Accordingly, pursuant to sections 161c, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's requirements in 10 CFR 2.204 and 10 CFR 30.32(b), in order for the Commission to determine whether License No. 49-27356-01 should be revoked, or other enforcement action taken to ensure compliance with NRC regulatory requirements, the Licensee is required to submit to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, within 20 days of the date of this Order and Demand for Information, the following information, in writing and under oath or affirmation:

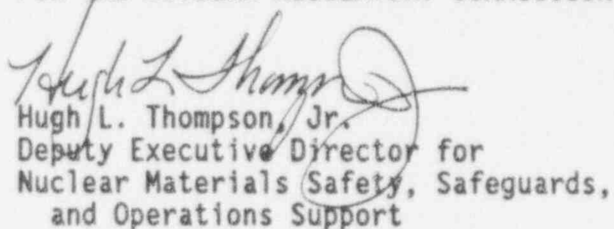
A. State why, in light of the violations and managerial failures discussed in II and III above, NRC License No. 49-27356-01 should not be revoked.

B. State why, in light of the facts described above, an order should not be issued to Mr. Wicks as an individual prohibiting Mr. Wicks from performing NRC-licensed activities. In addition, if an order is not issued to prohibit Mr. Wicks from performing NRC-licensed activities, then why should the NRC have confidence Mr. Wicks will comply with Commission requirements.

Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address, and to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011-8064.

After reviewing your response, the NRC will determine whether further action is necessary to ensure compliance with regulatory requirements.

FOR THE NUCLEAR REGULATORY COMMISSION



Hugh L. Thompson, Jr.
Deputy Executive Director for
Nuclear Materials Safety, Safeguards,
and Operations Support

Dated at Rockville, Maryland
this 16 day of June 1994

bcc w/Enclosure:

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