UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

OFFICE OF THE
GENERAL COUNSEL

November 30, 2004

Ann M. Young, Chair
Administrative Judge
Atomic Safety and Licensing Board Panel
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Washington, DC 20555

Dr. Peter S. Lam
Administrative Judge
Atomic Safety and Licensing Board Panel
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Alex S. Karlin
Administrative Judge
Atomic Safety and Licensing Board Panel
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U.S. Nuclear Regulatory Commission
Washington, DC 20555

In the Matter of
US INSPECTION SERVICES (USIS)
Dayton, Ohio
(Civil Monetary Penalty)
Docket No. 30-35059-CivP

Dear Administrative Judges:

The purpose of this letter is to provide the Licensing Board with documents related to this proceeding. The Board issued an Order on November 15, 2004, directing the NRC Staff (Staff) to furnish to the Board documents that may assist the Board in preparing for a scheduled telephone prehearing conference on December 2, 2004. Subsequently, on November 16, 2004, a representative of US Inspection Services (USIS) requested by letter to withdraw the licensee's September 24, 2004 hearing request. In light of this letter, and a November 29, 2004 e-mail from the Board, the Staff is providing a list of relevant documents, attached hereto as Attachment A. Copies of these documents also accompany this letter as Attachments B through G.

Sincerely,

Michael A. Woods
Counsel for NRC Staff

cc: Jon E. Silks
Office of the Secretary

Office of Commission Appellate Adjudication

November 30, 2004

Attachment A

Letter from J.E. Dyer, Regional Administrator, to James Bailey, President, Dayton X-Ray Co. (dba USIS) (Nov. 29, 2002) (Notice of Violation) (ML023370691) (Attachment B).

Letter from James L. Caldwell, Regional Administrator, to Jim Bailey, President, USIS (June 15, 2004) (Notice of Violation and Proposed Imposition of Civil Penalty) (ML041680263) (Attachment C).

Letter from Jon E. Silks, Corporate Radiation Safety Officer, to Director, Office of Enforcement (July 12, 2004) (ML042240049) (Attachment D).

Letter from Frank J. Congel, Director, Office of Enforcement, to Jim Bailey, President, USIS (Sept. 1, 2004) (Order Imposing Civil Monetary Penalty) (ML042460026) (Attachment E).

Letter from Jon E. Silks, Corporate Radiation Safety Officer, USIS, to Secretary, NRC (Sept. 24, 2004) (Attachment F).

Letter from Jon E. Silks, Corporate Safety Manager, USIS, to Atomic Safety and Licensing Board Panel (Nov. 16, 2004) (ML043310381) (Attachment G).

Attachment B

November 29, 2002

EA-02-201

James Bailey, President
Dayton X-Ray Company
(dba U. S. Inspection Services)
705 Albany Street
Dayton, OH 45408

SUBJECT: NOTICE OF VIOLATION
(NRC SPECIAL INSPECTION REPORT NO. 03035059/2002-003(DNMS))

Dear Mr. Bailey:

This refers to the inspection conducted September 3-18, 2002, at your permanent radiographic installation and at a temporary job site in Indianapolis, Indiana. The purpose of the inspection was to review the conduct of radiographic operations and compliance with NRC requirements and license conditions. The inspection report was transmitted to you in an October 18, 2002, letter and identified three apparent violations of NRC requirements.

In the letter transmitting the inspection report, we provided you the opportunity to address the apparent violations identified in the report by either attending a predecisional enforcement conference or by providing a written response before we made our final enforcement decision. In a letter, dated November 12, 2002, you provided a response to the apparent violations.

Based on the information developed during the inspection and the information that you provided in your response to the inspection report, dated November 12, 2002, the NRC has determined that violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. During the conduct of radiographic operations at a temporary job site on August 29, 2002, three violations of NRC requirements occurred. The violations involved the failure to: (1) ensure that radiographic operations performed at a temporary job site were observed by two qualified individuals; (2) limit the radiation dose in unrestricted areas to 0.002 rem in an hour; and (3) post the radiation area at a temporary job site.

Violation A of the Notice, involving the failure to have two qualified individuals observe radiographic operations at a temporary job site, is a potentially significant safety issue. The purpose of the second individual is to observe radiographic operations and provide immediate assistance to prevent unauthorized entry into areas where radiography is being conducted and thus prevent unnecessary exposures to members of the public. Therefore, this violation has been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 at Severity Level III.

In accordance with the Enforcement Policy, a base civil penalty in the amount of $6,000 is considered for a Severity Level III violation. Because your facility has not been the subject of escalated enforcement actions within the last two inspections, the NRC considered whether credit was warranted for *Corrective Action* in accordance with the civil penalty assessment process in Section VI.C.2 of the Enforcement Policy. Credit was warranted for corrective actions which included: (1) immediately retraining company personnel on the requirements for conducting radiography at temporary job sites, including that two individuals must observe radiographic operation at all times; (2) requiring additional personnel to be used when all access points are unable to be observed by two qualified individuals; (3) instructing radiographic personnel to use temporary radiation shielding at temporary job sites; and (4) additional training to the field station radiation safety officer involved with the violations on his responsibilities and the proper procedure in performing audits of radiographic operations.

Therefore, to encourage prompt and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, significant violations in the future could result in a civil penalty. In addition, issuance of this Severity Level III violation constitutes escalated enforcement action, that may subject you to increased inspection effort.

Violations B and C of the Notice, which involve the failure to limit the radiation dose in unrestricted areas to 0.002 rem in an hour and the failure to post the radiation area at a temporary job site, have been categorized in accordance with the Enforcement Policy at Severity Level IV.

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance was achieved, is already adequately addressed on the docket in Inspection Report No. 03035059/2002-003(DNMS) and your letter, dated November 12, 2002. Therefore, you are not required to respond to this letter unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if you choose to provide one, will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), which is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made

available to the Public without redaction. The NRC also includes significant enforcement actions on its Web site at www.nrc.gov; select **What We Do, Enforcement**, then **Significant Enforcement Actions.**

Sincerely,

***/RA/*** James L. Caldwell for

J. E. Dyer
Regional Administrator

Docket No. 030-35059
License No. 34-06943-02

Enclosure: Notice of Violation

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NOTICE OF VIOLATION

Dayton X-Ray Company
Dayton, Ohio

Docket No. 030-35059
License No.34-06943-02
EA-02-201

During an NRC inspection conducted September 3-18, 2002, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below:

A. 10 CFR 34.41(a) requires that whenever radiography is performed at a location other than a permanent radiographic installation (i.e., a temporary job site), the radiographer must be accompanied by at least one other qualified radiographer or an individual who met the requirements of 10 CFR 34.43(c). The additional qualified individual must observe the operations and be capable of providing immediate assistance to prevent unauthorized entry. Radiography may not be performed if only one qualified individual is present.

Contrary to the above, on August 29, 2002, radiography was performed at a temporary job site located at 901 E. Beecher Street, Indianapolis, Indiana, a location other than a permanent radiographic installation, with only one qualified individual present. Specifically, the second qualified individual was in an adjacent business rendering him unable to observe the radiographic operations and incapable of providing immediate assistance to prevent unauthorized entry.

This is a Severity Level III violation (Supplement VI).

B. 10 CFR 20.1501 requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazards that could be present.

Pursuant to 10 CFR 20.1003, *survey* means an evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

Contrary to the above, as of August 29, 2002, the licensee did not make surveys to assure compliance with 10 CFR 20.1301, which limits radiation exposure to individual members of the public to 0.1 rem in a year. Specifically, the licensee failed to conduct a radiation survey of a section of a radiation area to determine if radiation levels exceeded 0.002 rem in an hour during radiography at a temporary job site located at 901 E. Beecher Street, Indianapolis, Indiana.

This is a Severity Level IV violation (Supplement IV)

C. 10 CFR 34.53 requires, notwithstanding any provisions in 10 CFR 20.1903, that areas in which radiography is being performed be conspicuously posted as required by 10 CFR 20.1902(a).

10 CFR 20.1902(a) requires that each radiation area be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words "CAUTION, RADIATION AREA."

Contrary to the above, on August 29, 2002, during radiography performed at a temporary job site located at 901 E. Beecher Street, Indianapolis, Indiana, the licensee did not post the radiation area in which industrial radiography was being performed.

This is a Severity Level IV violation (Supplements IV and VI)

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance was achieved, is already adequately addressed on the docket in Inspection Report No. 0303509/2002-003(DNMS) and your November 12, 2002, letter. However, you are required to submit a written statement or explanation pursuant to 10 CFR 2.201 if the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation; EA-02-201," and send it to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, Region III, 801 Warrenville, IL 60532-4351, within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

If you contest this enforcement action, you should also provide a copy of your response, with the basis for your denial, to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

If you choose to respond, your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), which is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. Therefore, to the extent possible, the response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 29th day of November 2002.

Attachment C

June 15, 2004

EA-03-204
NMED No. 030726

Mr. Jim Bailey, President
U.S. Inspection Services
705 Albany Street
Dayton, OH 45408

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - $19,200 (NRC REACTIVE INSPECTION REPORT NO. 03035059/2003(DNMS) AND NRC OFFICE OF INVESTIGATIONS REPORT NO. 3-2004-002)

Dear Mr. Bailey:

This refers to the reactive inspection conducted on September 12, 2003, at your Dunbar, West Virginia field station and a temporary job site in Charleston, West Virginia, and a subsequent follow up inspection at your Dayton, Ohio office on October 29 and 30, 2003. The purpose of the inspections was to obtain information surrounding the circumstances related to a reported overexposure event that occurred on September 9, 2003. The inspection report issued on November 26, 2003, documented seven apparent violations of NRC requirements involving an overexposure to a radiographer. The NRC Office of Investigations (OI) also conducted an investigation to determine whether personnel employed by U.S. Inspection Services willfully violated NRC requirements.

On January 6, 2004, a predecisional enforcement conference was conducted in Region III with you and members of your staff to discuss the significance and root cause(s) of the apparent violations, and corrective actions that you have taken or planned to take to prevent recurrence. During the conference you agreed with the violations presented by the NRC and provided a discussion of corrective actions that had been or would be implemented. Enclosure 2 is a copy of the slides that were presented by you and your staff at the conference.

Based on our evaluation of the information obtained during the inspections and from the letter you provided to the NRC on January 5, 2004, and information that you provided during the conference, the NRC has determined that seven violations of NRC requirements occurred. The violations are cited in the enclosed Notice of Violation (Notice) (Enclosure 1) and the circumstances surrounding them are described in detail in the subject inspection report. The violations involved the failure to: (1) ensure that occupational personnel do not accrue a cumulative radiation dose in excess of the regulatory limits; (2) conduct a radiation survey; (3) calibrate a survey instrument after it was repaired; (4) test an alarming ratemeter for operability before use; (5) follow established procedures to ensure that a sealed source contained in a radiographic device was in the locked, shielded position prior to approaching the device; (6) conduct a daily inspection of a radiographic exposure device and associated safety

equipment; and (7) ensure that equipment modifications did not compromise the design safety features of the cable and drive crank assembly. In addition, results of the OI investigation concluded that none of the violations were willful. The OI report synopsis is provided as Enclosure 3.

During radiographic operations conducted at a temporary jobsite on September 9, 2003, two radiographers employed by U.S. Inspection Services failed to comply with several NRC requirements, associated license conditions and licensee procedures. These failures were directly related to an occupational overexposure to one radiographer. The individual received a deep dose equivalent of approximately 20.5 rem (and a corresponding cumulative annual total effective dose equivalent (TEDE) exceeding 21.5 rem) whole body, a shallow dose equivalent (SDE) of 140 rem to the skin of the whole body, and 235 rem to the skin of an extremity, all of which were well above the allowable annual regulatory limits of 5 rem and 50 rem respectively. No immediate health effects have been observed as a result of the overexposures.

The NRC considers these violations to be a very significant safety concern because an individual received a TEDE and a SDE that were in excess of four times the annual regulatory limit. Furthermore, there was the potential for a more significant radiation exposure if the exposure to radiation had been longer and/or the radiographic device used during the event contained a sealed source with more activity. Additionally, and more important, this event would not have occurred had personnel employed by U.S. Inspection Services complied with the regulatory requirements and the licensee's procedures. Therefore, these violations are categorized collectively in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, as a Severity Level II problem.

In accordance with the Enforcement Policy, a base civil penalty in the amount of $9600 is considered for a Severity Level II problem. Because your facility has been the subject of escalated enforcement actions within the last two years,[1] the NRC considered whether credit was warranted for *Identification* and *Corrective Action* in accordance with the civil penalty assessment process in Section VI.C.2 of the Enforcement Policy. Credit is not warranted for identification because identification of the violations occurred as a result of the overexposure and given the fact that the NRC identified virtually all the violations during the reactive inspection that was conducted subsequent to the event. Credit is warranted for corrective actions based on the licensee's response to correct the violations and to prevent a recurrence, specifically, U.S. Inspection Services: (1) conducted required maintenance on all radiographic exposure devices and associated equipment; (2) verified that all applicable staff possessed current copies of the licensee's operating and emergency manuals; (3) numbered all crank assemblies, guide tubes, and extensions for traceability purposes; (4) removed equipment with damaged or missing hardware from service until items were repaired; (5) instituted corporate radiation safety officer (CRSO) notification of potential equipment condition deficiencies before use; (6) implemented a program for CRSO review of radiation safety related field office documentation; (7) provided comprehensive, mandatory training for all radiographic personnel;

[1]A Severity Level III violation was issued on November 29, 2002, for failure to have two qualified individuals observe radiographic operations (EA-02-201).

(8) replaced the CRSO and added two assistant CRSOs to assist the CRSO in the administration of the radiation protection program; and (9) contracted with an outside contractor to conduct an independent audit of the radiation safety program.

Although the NRC recognizes that application of the civil penalty assessment process described in Section VII.C.2 of the Enforcement Policy would result in a base civil penalty in this case, the NRC is exercising discretion in accordance with Section VI.A.1(c) of the Enforcement Policy and is proposing a civil penalty at twice the base amount for your staff's particularly poor performance that preceded and was directly related to the overexposure event. Specifically, U.S. Inspection Services' management missed numerous opportunities to identify and correct the staff's inadequate understanding and implementation of routine licensed activities including the proper repair, testing, and day-of-use checks of radiographic safety equipment. In addition, management's poor oversight of radiographic equipment maintenance hindered your ability to detect inadequate and inappropriate modifications, repairs, and tests of radiographic safety equipment. The lack of management oversight of the radiation safety program significantly contributed to creating the conditions that led to the overexposure event.

Therefore, to emphasize the importance of complying with the regulatory requirements, ensuring that your personnel adhere to and follow procedures, providing appropriate management oversight of the radiation safety program, identifying violations, and implementing prompt and comprehensive corrective action for violations, and in recognition of your previous escalated enforcement action, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Materials, Research and State Programs, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $19,200, or twice the base amount, for the Severity Level II problem. In addition, issuance of this Notice constitutes escalated enforcement action, that may subject you to increased inspection effort.

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence, and the date when full compliance was achieved, is already adequately addressed on the docket in Inspection Report No. 03035059/2003(DNMS), and U.S. Inspection Services' letter dated January 5, 2004. Therefore, you are not required to respond to the provisions of 10 CFR 2.201 unless the descriptions in our inspection report and your letter do not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response, if any, will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. The NRC also includes

significant enforcement actions on its Web site at www.nrc.gov; select **What We Do, Enforcement**, then **Significant Enforcement Actions.**

Sincerely,

***/RA/***

James L. Caldwell
Regional Administrator

Docket No. 030-35059
License No. 34-06943-02

Enclosure: 1. Notice of Violation and Proposed Imposition of Civil Penalty
2. Enforcement Conference Slides
3. OI Report Synopsis
4. NUREG/BR-0254 Payment Methods (Licensee only)

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NOTICE OF VIOLATION
AND
PROPOSED IMPOSITION OF CIVIL PENALTY

U.S. Inspection Services
Dayton, Ohio

Docket No. 030-35059
License No. 34-06943-02
EA-03-204
NMED No. 030726

During an NRC inspection conducted on September 12 and October 29-30, 2003, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the NRC proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

A. 10 CFR 20.1201 requires, in part, that the licensee control the occupational dose to individual adults to an annual limit of 5 rem total effective dose equivalent; 15 rem to the lens of the eye, and 50 rem to the skin of the whole body or skin of any extremity.

Contrary to the above, on September 9, 2003, the licensee failed to control the annual occupational dose to an adult to 5 rem total effective dose equivalent, 50 rem to the skin of the whole body, and 50 rem to the skin of any extremity. Specifically, a radiographer received a 20.5 rem total effective dose equivalent (a cumulative total effective dose equivalent exceeding 21.5 rem), a 140 rem shallow dose equivalent to the skin of the whole body, and a 235 rem shallow dose equivalent to the skin of an extremity, all in excess of the annual occupational dose.

B. 10 CFR 34.49(b) requires, in part, that the licensee shall, using a survey instrument, conduct a survey of the radiographic exposure device and the guide tube after each exposure when approaching the device or the guide tube to determine that the sealed source has returned to its shielded position before exchanging films, repositioning the exposure head, or dismantling equipment.

Contrary to the above, on September 9, 2003, the licensee failed to conduct a survey of the radiographic exposure device and the guide tube after each exposure when approaching the device or the guide tube. Specifically, a radiographer conducted an inadequate survey of the radiographic exposure device by failing to determine that the sealed source was not in its shielded position prior to exchanging film and repositioning the exposure head.

C. 10 CFR 34.25(b)(1) requires, in part, that each radiation survey instrument be calibrated at intervals not to exceed 6 months and after instrument servicing, except for battery changes.

Contrary to the above, in May of 2003, the licensee serviced a survey instrument and did not have it calibrated. Specifically, the licensee repaired an NDS Model ND-2000 survey instrument, Serial No. 2755, in May 2003 and used this uncalibrated instrument to perform required radiation surveys on several occasions between May 2003 and September 9, 2003.

D. 10 CFR 34.20(b)(3) specifies that modification of radiographic exposure devices, source changers, and source assemblies and associated equipment is prohibited, unless the design of any replacement component, including source holder, source assembly, and controls or guide tubes, would not compromise the design safety features of the system.

Condition 21 of License No. 34-06934-02 requires, in part, that the licensee conduct its radiation safety program in accordance with the statements, representations, and procedures contained in the letter dated June 5, 2001.

Attachment No. 1, "Quarterly Inspection and Maintenance of Iridium/Cobalt/Cesium Exposure Devices," of Procedure RS-GP-9, Revision 2, "Inspection and Maintenance of Radiographic Exposure Devices, Transport/Storage Containers, Associated Equipment, and Survey Instruments," attached to the letter dated June 5, 2001, states that modification of any exposure device and associated equipment is prohibited, unless the design of any replacement component would not compromise the design safety feature of the system.

Contrary to the above, an exposure device component, specifically, the source crank assembly, was modified by the licensee and this modification directly compromised the design safety feature of the system, in that, the licensee used parts from two damaged crank assemblies to assemble one working crank. The modified crank assembly did not contain the wear strip, the brake latch, or two of four required bolts used to hold the crank together, all of which were necessary components critical to safety. The modified crank assembly was subsequently used to conduct radiographic operations on August 12, August 18, and September 9, 2003.

E. 10 CFR 34.20 (c)(2) states, in part, that the radiographic exposure device must automatically secure the source assembly when it is cranked back into the fully shielded position within the device. This securing system may only be released by means of a deliberate operation on the exposure device.

Condition 21 of License No. 34-06934-02 requires, in part, that the licensee conduct its radiation safety program in accordance with the statements, representations, and procedures contained in the facsimile dated October 23, 2002.

Item 2.16.1 of Procedure RS-5-1, "Operating Instructions for Technical Operations Models 660, 680, & 741 Series Exposure Devices (Projectors)," attached to the facsimile dated October 23, 2002, states, in part, that after source retraction, apply a slight amount of forward pressure on the crank handle, as to expose the source, to ensure that the positive locking mechanism has actuated.

Contrary to the above, on September 9, 2003, the licensee failed to ensure that the radiographic exposure device automatically secured the source assembly when it was cranked back into the shielded position after source retraction and failed to apply a slight amount of forward pressure on the crank handle as to expose the source, to ensure that the positive locking mechanism was actuated.

F. 10 CFR 34.31(a) requires, in part, that the licensee perform visual and operability checks on radiographic exposure devices, transport and storage containers, and associated equipment before use on each day the equipment is to be used to ensure that the equipment is in good working condition, the sources are adequately shielded, and that required labeling is present.

Condition 21 of License No. 34-06934-02 requires, in part, that the licensee conduct its radiation safety program in accordance with the statements, representations, and procedures contained in the letter dated June 5, 2001.

Item 3.0 of Procedure RS-GP-9, "Inspection and Maintenance of Radiographic Exposure Devices, Transport/Storage Containers, Associated Equipment, and Survey Instruments," attached to the letter dated June 5, 2001, states, in part, that the radiographer/assistant radiographer check before use on each day the equipment is to be used: (1) the camera for damage to fittings, lock, fasteners and labels; and (2) the crank for damage and loose hardware.

Contrary to the above, on September 9, 2003, radiography personnel failed to check the radiographic exposure device and associated equipment as required. Specifically, radiography personnel did not check: (1) the camera for damage to fittings, lock, fasteners and labels; and (2) the crank for damage and loose hardware.

G. 10 CFR 34.47(g)(1) requires that each alarm ratemeter be checked to ensure that the alarm functions properly (sounds) before using the ratemeter at the start of each shift.

Condition 21 of License No. 34-06934-02 requires, in part, that the licensee conduct its radiation safety program in accordance with the statements, representations, and procedures contained in the letter dated August 10, 2001.

Item 3.3 of Procedure RS-GP-2, Revision 3, "Personnel Monitoring Equipment and Usage," attached to the letter dated August 10, 2001, requires, in part, that each radiographer/assistant radiographer wear an assigned rate alarm meter; check the battery and audio tone by pressing the push button at the arrow and verifying that the LED illuminates and the alarm sounds; and do not use the rate alarm meter if either test fails.

Contrary to the above, on September 9, 2003, a radiographer's assistant failed to perform the required battery and audio tone tests on his assigned rate alarm meter (NDS Products Model RA-500, Serial No. 29895). Specifically, the radiographer's assistant failed to press the button at the arrow and verify that the LED illuminated and the alarm sounded.

This is a Severity Level II problem (Supplements IV and VI).
Civil Penalty - $19,200

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence, and the date when full compliance was achieved, is already adequately addressed on the docket in Inspection Report No. 03035059/2003(DNMS), and U.S. Inspection Services' letter dated January 5, 2004. However, you are required to submit a written statement or explanation pursuant to 10 CFR 2.201 if the descriptions in our report and your letter do not accurately reflect your corrective actions or your position. In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation; EA-03-204" and send it within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

The licensee may pay the civil penalty proposed above in accordance with NUREG/BR-0254 and by submitting to the Director, Office of Enforcement, a statement indicating when and by what method payment was made, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement. Should the licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty, in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.C.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234(c) of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, statement as to payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Frank Congel, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4351.

If you choose to respond, your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. Therefore, to the extent possible, the response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 15th day of June 2004.

Attachment D

US INSPECTION SERVICES

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July 12, 2004

Director, Office of Enforcement
Nuclear Regulatory Commission
Region III
2443 Warrenville Rd, Suite 210
Lisle, Illinois 60532-4352

Subject: Answer to Notice of Violation; EA-03-204

Dear Director, Office of Enforcement,

This is in reference to the notice of violation, EA-03-204, and USNRC letter to US Inspection Services dated June 15, 2004. It is our intent to protest the proposed imposition of civil penalty in the amount of $19,200.00.

As noted on page three, paragraph three of the USNRC's letter to USI dated June 15, 2004, the January 5, 2004 US Inspection Services letter to the USNRC fulfilled the requirements to respond in accordance with the provisions of 10 CFR 2.201.

In the USNRC's letter to US Inspection Services dated June 15, 2004 a severity level III violation issued on November 29, 2002 that occurred at a US Inspection Services temporary job site in Indiana was referred to twice. First, on page 2 of that letter it is stated, "Because your facility has been the subject of escalated enforcement actions within the last two years[1], the NRC..." and then again on page 3 of the same letter, "..., and in recognition of your previous escalated enforcement action..."

NUREG-1600 section VI, Disposition of Violations, subpart C.2, Civil Penalty Assessment, on pages 22 and 23 outlines the basis for the assessment process and the need to consider escalated enforcement action within the past two years. Had the 2002 violation not occurred the process would have taken on a whole new path and most certainly a different outcome would have been realized. With that in mind, US Inspection Services contends that the 2002 violation was assessed in error and gives the following reasons in doing so:

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A. The interpretation of 10 CFR 34.41 as stated in the Notice of Violation concerning the audit of our personnel on August 29, 2002 at a temporary job site located at 901 E. Beecher St, Indianapolis, Indiana was incorrect in the view of US Inspection Services.

B. Conversations with personnel from the Ohio Department of Health and Walter Cofer with the Florida Department of Health, who is also a committee chairperson for the CRCPD, in regard to this issue have confirmed our belief that this interpretation was incorrect. According to their interpretation and the interpretation of US Inspection Services, 10 CFR 34.41 requires there to be two qualified radiographic personnel involved with the operations which does not mean they have to be in direct line of site. Radio contact would allow the entire area to be monitored and allow for immediate assistance to prevent unauthorized entry. In fact, the use of radios allows the two qualified individuals to perform their duties more effectively and in turn protect members of the public from radiation exposure more effectively. Personnel from the organizations mentioned above stated that they believe the interpretation was in error and has served to confuse many in the industry. US Inspection Services met the intent of the regulation and in using radios, actually went beyond the requirements.

C. If the interpretation of 10 CFR 34.41 stands as stated in the NOV mentioned above it is our belief that the entire industry is in confusion about this issue. Performing radiography in refineries, boiler units and many other instances will result in violations on a regular basis. US Inspection Services requests a clarification on the interpretation of 10 CFR 34.41 for the benefit of the entire industrial radiography community.

D. Figure 8.7 on page 8-38 of NUREG 1556 does not indicate that the radiographers in such a situation need to be in line of sight. The diagram is simplistic and does not adequately represent the many obstacles inherent in such facilities and the position of the radiographer in charge is ideal but unlikely. Many times the radiographer is deep within the floor surrounded by a maze of piping and tanks. In these cases radios, and additional personnel, are the most effective way to prevent unauthorized entry.

E. In the "Part 34 - Statements of Consideration" (attachment A) document the official USNRC response is given to over 50 comments submitted on Part 34.41. The USNRC responded, in part, to these comments by stating, "The text of this section has been modified to

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emphasize that the purpose of the second individual is to provide immediate assistance when required and to prevent unauthorized entry into the restricted area." There is no mention of "direct line of sight" in this document and no verbiage that clearly suggests that intent.

It is the belief of US Inspection Services that our escalated enforcement action from 2002, and therefore the basis for the current proposed civil penalty, is in question and should be taken into consideration in regard to our mitigation request.

Furthermore, in the USNRC's letter to US Inspection Services dated June 15th, 2004 it is stated that, "Credit is warranted for corrective actions based on the licensee's response to correct the violations and to prevent a recurrence, specifically..."

Following the flow diagram on page 23 of NUREG-1600 and in light of the civil penalty proposed at twice the base rate, it does not appear that we were given any credit for our corrective actions. Based on that diagram, if credit is given for corrective action the second level of enforcement action is noted. The second level of enforcement action is indicated as, "Notice of Violation & Base Civil Penalty"

The corrective actions of US Inspection Services were comprehensive and prompt as indicated by the USNRC's statement, "Credit is warranted for corrective actions..." in the letter mentioned above. US Inspection Services has estimated that our corrective actions expenditures to date have totaled $73,000.00, not including the proposed $19,200.00 civil penalty. Those costs were incurred from actions outlined in our letter to the USNRC dated January 5, 2004, specifically the six points noted on page one concerning corrective actions that had taken place and points one through three, on pages one and two concerning corrective actions that were to take place in the future. [As noted on page three, paragraph three of the USNRC's letter to USI dated June 15, 2004, the January 5, 2004 US Inspection Services letter to the USNRC fulfilled the requirements to respond in accordance with the provisions of 10 CFR 2.201.] Further actions that have been taken include a telephone interview program in which all radiographers in the company were required to call the CRSO for a knowledge assessment and policy briefing. The main thrust of this program was completed on June 19, 2004. Also, a radiographer's pocket reference guide has been developed and will be distributed to all

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radiographers and radiographer's assistants by July 31, 2004. A one day seminar was held for all US Inspection Services Facility RSOs in which the factors involved in the September 9, 2003 incident were addressed. These actions, all included, indicate a serious commitment to radiation safety and the willingness to "do whatever it takes" to prevent any such incident in the future. One basis given for the proposed penalty was, "...to emphasize the importance of complying with regulatory requirements..." It is the belief of US Inspection Services that we have already demonstrated our position concerning the importance of compliance through an aggressive, extensive and costly corrections program. Our actions have been decisive and comprehensive.

Based on our contention of the 2002 interpretation of 10 CFR 34.41, the remarks above concerning the flow diagram on page 23 of NUREG-1600, and our prompt and thorough corrective actions that were noted as deserving credit, we ask that the civil penalty be waived in this case.

As a secondary note, US Inspection Services agrees with the conclusions drawn by the USNRC's Office of Investigations, Region III as detailed in the synopsis attached to the USNRC's letter to US Inspection Services dated June 15, 2004. The synopsis focused entirely on equipment condition and repair. In regard to the repair and condition of the equipment we believe the actions of the radiographer were unintended and therefore not willful which agrees with the synopsis.

While the disrepair of the equipment was indeed an issue and was in part the reason for the incident, it was not the primary reason. The primary reason for this incident was the failure of the radiographer to perform confirmatory surveys and utilize personal dosimetry properly. In the USNRC's letter referred to above it was stated, "Additionally, and more important, this event would not have occurred had personnel employed by U.S. Inspection Services complied with the regulatory requirements and the licensee's procedures." We believe that the investigation of willful violations should have focused on this issue. The radiographers stated that they were indeed wearing all of the required dosimetry but in an unfortunate turn of events, none of them worked to prevent the incident. Upon sending the equipment out to the respective manufacturers for evaluation it was determined that all of the equipment was in operable condition. It should also be noted here that while the crank in this case was in disrepair it was operational as determined by the reenactment and

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post incident investigations. The equipment was capable of moving the sealed source from the secured to the unsecured position and back again. This is noted, not as a basis for mitigation but for the purpose of clarifying our position on the situation.

If you should have any questions or require any additional information, please contact me at (937) 228-9729 or (937) 603-1481.

Sincerely,

Jon E. Silks
Corporate Radiation Safety Officer
US Inspection Services
705 Albany St
Dayton, Ohio 45408
USNRC License No. 34-06943-02

transportation of radioactive material used in industrial radiography. The proposed rule contained requirements to lock and physically secure transport packages and to store licensed material in a manner that minimizes the danger from explosions or fire. The proposed rule also contained a requirement for a QA program, as described in § 71.105.

Comment

Three comments were received on this section. All requested that the applicable Department of Transportation (DOT) regulations, including the QA requirements on packages, be included in 10 CFR Part 34.

Response

The NRC agrees that certain requirements in 10 CFR Part 71 relating to a QA program should be relocated in 10 CFR Part 34. The Commission has made a determination that inspection programs for industrial radiography containers meeting the requirements of § 34.31(b) will satisfy the requirements in § 71.101. While radiography licensees have always had to comply with the QA requirement for transport packages in 10 CFR Part 71, there have been numerous cases where they were unaware of this requirement and, therefore, failed to comply. The inclusion of this requirement in 10 CFR Part 34 will reduce the burden on radiography licensees to submit a QA program for NRC approval separately. Much of the same information on inspection and maintenance that was required as part of the license application was similar to that information required for a QA program under 10 CFR Part 71. A revision to § 71.101 has been made to state that the inspection and maintenance programs for radiographic exposure devices, source changers, or packages transporting these devices that meet the provision of § 34.31(b) or equivalent Agreement State regulations, need not be submitted separately as a QA program for Commission approval. This change eliminates the potential for duplicate submission of information and reduces the monetary burden on radiography licensees because they will no longer be required to pay the fees associated with the QA program in 10 CFR Part 71. This change, however, does not relieve radiography licensees from complying with the transport requirements in 10 CFR Part 71.

*Section 34.41: Conducting Industrial Radiographic Operations*

This new section specifies certain conditions that must be met before performing radiographic operations in order to ensure that adequate safety measures are in place before conducting radiographic operations. The proposed rule specified that all radiographic operations conducted at locations of use listed on the license must be conducted in a permanent radiographic installation. The NRC has always believed that radiography performed in a fixed facility, meeting the requirements of § 34.33, would provide a safer environment for workers and the public. If licensees need to perform radiography at their place of business outside of a permanent facility due to some unique circumstances, i.e., item to be radiographed is too large for the facility, Commission authorization would be required. The proposed rule included a requirement for two individuals to be present whenever radiographic operations occur outside of a permanent installation. One of these individuals is required to be a fully qualified radiographer and the other individual is required to be a radiographer's assistant meeting the requirements specified in § 34.43(c).

Comment

More than 50 comments were received on this section, 42 in favor and 11 opposed. Those not in favor of adopting the two-person requirement cited the additional cost for the second individual as the major reason. Some suggested modifying the requirement to allow use of less qualified people such as security guards for the second individual. Another suggestion was to allow the RSO to determine when a second individual was required. One comment addressed radiography performed within a factory environment where access could be controlled by one radiographer who could lock access to the site to prevent persons from entering during radiography operations. Those in favor of the requirement cited the increased safety provided by having two individuals present at all times. Several commenters pointed out that the additional cost of this provision would be borne by the users with little impact on the licensees. One commenter was concerned that unless explicitly stated, unqualified individuals could be asked to perform duties that should be performed by qualified individuals, for example, rather than using a 2-person crew comprised of a radiographer and a radiographer's assistant, the customer may propose the use of one of its employees as a method to reduce the nondestructive testing company's fees.

Response

The Commission has decided to adopt the requirement for at least two qualified individuals to be present whenever radiographic operations are performed outside of a permanent radiographic installation. The Commission believes that the safety issues involved mandate the adoption of this requirement, particularly when radiography is performed in high places or in trenches, where problems can most often occur, and where the radiographer alone is not able to control access. It should also be evident that in case of accident or injury, the second person needed at the site must be more than an observer. The person should have sufficient radiography and safety training to allow him/her to take charge and secure the radioactive material, provide aid where necessary, and prevent access to radiation areas by unauthorized persons, whereas an untrained person; such as a security guard or contractor's employee as suggested by one commenter, would be unable to perform these functions in a safe manner. The text of this section has been modified to emphasize that the purpose of the second individual is to provide immediate assistance when required and to prevent unauthorized entry into the restricted area.

Section 34.41(d) was added to include a requirement to have approved procedures before conducting specific types of radiographic operations such as lay-barge, underwater, and off-shore platform radiography to make NRC regulations more compatible with Agreement State requirements.

*Section 34.42: Radiation Safety Officer for Industrial Radiography*

This new section identifies the qualifications and duties of the RSO for industrial radiography. Previously, these requirements were referenced in regulatory guides and included as license conditions on a case-by-case basis, but not spelled out in the regulations. The NRC believes the RSO is the key individual for oversight of the licensee's radiography program and the person responsible for ensuring safe operation of the program.

The proposed rule specified that to be considered eligible for the RSO position, an individual must have a minimum of 2000 hours of documented experience as a qualified radiographer in industrial radiographic operations. Among the responsibilities of the RSO specified in the proposed rule, were the establishment and oversight of all operating, emergency, and ALARA procedures and conduct of the annual review of the radiation protection program required by § 20.1101(c).

Attachment E

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, DC 20555 - 0001

September 1, 2004

EA-03-204

Mr. Jim Bailey, President
U.S. Inspection Services
705 Albany Street
Dayton, OH 45408

SUBJECT: ORDER IMPOSING CIVIL MONETARY PENALTY - $19,200

Dear Mr. Bailey:

This refers to your letter dated July 12, 2004, in response to the Notice of Violation and Proposed Imposition of Civil Penalty - $19,200 (Notice) sent to you by our letter dated June 15, 2004. Our letter and Notice described six violations identified during a reactive inspection conducted on September 12, 2003, at the U.S. Inspection Services facility in Dunbar, West Virginia, and a temporary job site in Charleston, West Virginia. Follow-up inspection activities were conducted on October 29 and October 30, 2003, at the U.S. Inspection Services facility in Dayton, Ohio.

To emphasize the importance of complying with regulatory requirements, ensuring that personnel adhere to and follow procedures, providing appropriate management oversight of the radiation safety program, and promptly identifying violations, a civil penalty of $19,200 was proposed.

In your response you did not deny the violations, in whole or in part, did not dispute the severity level assigned to the violations, and you did not contest the use of enforcement discretion to increase the amount of the civil penalty. The amount of the civil penalty was increased due to a lack of management oversight of the radiation safety program that significantly contributed to the conditions leading to the overexposure event described in the June 12, 2004, letter and Notice. However, you protested the proposed imposition of a civil monetary penalty in the amount of $19,200, indicating that the civil penalty adjustment factor for *Identification* was incorrectly applied and no credit was given for the corrective actions that you have implemented.

With regard to the factor for *identification*, you contended that a prior enforcement action, EA-02-201, issued on November 29, 2002, associated with a failure to have two qualified individuals present during radiographic operations, prevented you from receiving consideration for the civil penalty adjustment factor for *Identification*, and should be withdrawn. In addition, you questioned the staff's interpretation of 10 CFR 34.41, "Conducting Industrial Radiographic Operations."

NRC gave careful consideration to your response, and has addressed your response in an Appendix attached to the enclosed Order. For the reasons given in the Appendix, the NRC is imposing the civil penalty by Order, and hereby serves the enclosed Order on U.S. Inspection

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| J L. Caldwell, Regional Administrator | L. Gersey for C. Miller | H. McGurren for F. Cameron | C. Nolan | F.J. Congel |
| 8/18/04 | 8/27/04 | 08/31/04 | 09/01/04 | 09/01/04 |

[7590-01-P]

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

| | | |
|---|---|---|
| In the Matter of | ) | |
| | ) | |
| U.S. Inspection Services | ) | Docket No. 030-35059 |
| Dayton, OH | ) | License No. 34-06943-02 |
| | ) | EA-03-204 |

ORDER IMPOSING CIVIL MONETARY PENALTY

I

Materials License No. 34-06943-02 was issued by the Nuclear Regulatory Commission (NRC or Commission) to U.S. Inspection Services (Licensee) on August 31, 1999. The license authorizes the Licensee to receive, acquire, possess and transfer iridium-192 and cobalt-60 in sealed sources for use in industrial radiography and depleted uranium for shielding in industrial radiography equipment in accordance with the conditions specified therein. The license was renewed in its entirety on June 22, 2004, with Amendment No. 7 and is to expire on September 30, 2011.

II

An inspection of the Licensee's activities was conducted on September 12, 2003. The results of this inspection indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was served upon the Licensee by letter dated June 15, 2004. The Notice states the nature of the violations, the provisions of the NRC's requirements that the Licensee had violated, and the amount of the civil penalty proposed for the violations.

The Licensee responded to the Notice in a letter dated July 12, 2004. In its response, the Licensee did not deny the violations, in whole or in part, did not dispute the severity level assigned to the violations, and did not contest the application of enforcement discretion to increase the amount of the civil penalty. The amount of the civil penalty was increased because of a lack of management oversight of the radiation safety program that significantly contributed to the conditions leading to the overexposure event described in the June 15, 2004, letter and Notice. However, the Licensee protested the proposed imposition of a civil monetary penalty in the amount of $19,200 indicating that the civil penalty adjustment factor for *Identification* was applied incorrectly. The Licensee also claimed that credit was not given for the corrective actions the Licensee had implemented.

III

After considering the Licensee's response and the statements of fact, explanation, and argument for mitigation contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that the violations occurred as stated and that the civil penalty of $19,200 proposed for the violations designated in the Notice should be imposed.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The Licensee pay a civil penalty in the amount of $19,200 within 30 days of the date of this Order, in accordance with NUREG/BR-0254. In addition, at the time of making the payment, the Licensee shall submit a statement indicating when and by what method payment was made, to

the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738.

V

The Licensee may request a hearing within 30 days of the date of this Order. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, and include a statement of good cause for the extension. A request for a hearing should be clearly marked as a "Request for an Enforcement Hearing, EA-03-204" and shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Rulemakings and Adjudications Staff, Washington, D.C. 20555. Copies also shall be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, to the Assistant General Counsel for Materials Litigation and Enforcement at the same address, and to the Regional Administrator, NRC Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4351, Because of continuing disruptions in delivery of mail to United States Government offices, it is requested that requests for hearing be transmitted to the Secretary of the Commission either by means of facsimile transmission to 301-415-1101 or by e-mail to hearingdocket@nrc.gov and also to the Office of the General Counsel either by means of facsimile transmission to 301-415-3725 or by e-mail to OGCMailCenter@nrc.gov.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order (or if written approval of an extension of time in which to request a hearing has not been granted),

the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be, whether, on the basis of the violations admitted by the Licensee, this Order should be sustained.

FOR THE NUCLEAR REGULATORY COMMISSION

*/RA/*

Frank J. Congel, Director
Director, Office of Enforcement

Dated this 1st day of September 2004

APPENDIX

EVALUATION AND CONCLUSION

A response to the Notice was provided by U.S. Inspection Services (Licensee) in a letter dated July 12, 2004. In its response, the Licensee did not deny the violations, in whole or in part, and the Licensee did not contest the severity level assigned to the violations. The Licensee also did not dispute the use of enforcement discretion to increase the amount of the civil penalty. The amount of the civil penalty was increased due to a lack of management oversight of the radiation safety program which significantly contributed to the conditions leading to the overexposure event. However, the Licensee protested the proposed imposition of a civil monetary penalty in the amount of $19,200 because the Licensee believed that the civil penalty adjustment factor for *Identification* was incorrectly applied and credit was not given for the corrective actions taken by the Licensee.

Licensee's Request for Recission or Mitigation of the Civil Penalty

In the response to the Notice, the Licensee contended that the NRC incorrectly applied the civil penalty assessment process described in Section VI.C.2 of the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. In its presentation, the Licensee indicated that a prior escalated enforcement action, EA-02-201, that occurred within two years or two inspections of the current enforcement actions should be withdrawn. With EA-02-201 withdrawn, the Licensee contended that the Licensee would no longer have an escalated enforcement history within the prior two years or two inspections; therefore, the NRC Staff was not required to assess the civil penalty adjustment factor for *Identification* in accordance with Section VI.C.2.b(1) of the Enforcement Policy. In requesting that EA-02-201 be withdrawn, the Licensee argued that 10 CFR 34.41, the regulation cited in the Notice associated with EA-02-201, does not require that radiographic personnel be in direct line-of-site with each other; rather, the radiographic personnel present on August 29, 2002, maintained contact with each other by radio which is sufficient to meet the requirements of 10 CFR 34.41.

The Licensee also contended that credit was not given for the *Corrective Action* civil penalty adjustment factor.

NRC Evaluation of Licensee's Request for Recission or Mitigation of the Civil Penalty

A. The Licensee is correct that the previous escalated enforcement action, EA-02-201, should not have been considered in determining the application of the civil penalty adjustment factor for *Identification*. Section VI.C.2.b(1) of the Enforcement Policy provides that the NRC will consider the civil penalty adjustment factor for *Identification* for the second non-willful Severity Level III violation within a period of two years or two inspections, whichever is longer. The violations in the current escalated enforcement action, EA-03-204, were categorized as a Severity Level II problem.

   In accordance with Section VI.C.2.b(1) of the Enforcement Policy the NRC Staff is not required to consider a Licensee's enforcement history in assessing the civil penalty adjustment process for a Severity Level II violation. Since the current violations are categorized as a Severity Level II problem, the NRC Staff was not required to consider a previous escalated enforcement action to assess the *Identification* civil penalty adjustment factor. Therefore, the existence of EA-02-201 is not a factor in assessing the civil penalty adjustment factor for *Identification*.

The NRC Staff concludes that the civil penalty adjustment factor for *Identification* was properly assessed in accordance with the Enforcement Policy and consideration of the previous escalated enforcement action, EA-02-201, was not required by the Enforcement Policy to complete that assessment. Since the NRC Staff identified the violation, no credit for the *Identification* factor was warranted.

B. As part of its argument regarding the civil penalty adjustment factor for *Identification*, the Licensee contended that the prior enforcement action, EA-02-201, should be withdrawn. On November 29, 2002, the NRC issued a Severity Level III violation associated with the Licensee's failure to have two qualified individuals present during radiographic operations on August 29, 2002, at a field location in Indianapolis, Indiana, in violation of 10 CFR 34.41(a), "Conducting Industrial Radiographic Operations." The Licensee contends that 10 CFR 34.41(a) does not require radiographic personnel to maintain direct visual line-of-site contact. Rather, the Licensee personnel used radios on August 29, 2002, to maintain communications at the temporary site in Indianapolis, Indiana, and the use of radios improved their ability to provide immediate assistance to prevent unauthorized entry into the radiation field. Therefore, EA-02-201 should be withdrawn.

The Commission's regulations at 10 CFR 34.41 provide that during field radiography, the radiographer must be accompanied by at least one other qualified individual and the other qualified individual must observe operations and be capable of providing immediate assistance to prevent unauthorized entry. Additionally, 10 CFR 20.1902, "Posting Requirements," provides, in part, that the Licensee will post each radiation area with a conspicuous sign or signs marking the radiation hazard.

A "radiation area" is defined in 10 CFR 20.1003 as an area, accessible to individuals, in which radiation levels could result in an individual receiving a dose equivalent in excess of 0.005 rem in 1 hour at 30 centimeters or 30 centimeters from any surface that the radiation penetrates. For the purposes of 10 CFR 20.1003, individual means any human being. Measurements and assessments of the radiation level at the Indianapolis, Indiana, job site indicated a level of 25 milliroentgen per hour, exterior to the building, at 65 feet from the exposure device containing 41 curies of iridium-192, assuming a point source, a gamma constant of 5.2 roentgen per hour per curie at 30 centimeters, and considering shielding inherent to the facility including structures and equipment.

On August 29, 2002, a radiographer and a radiographer's assistant were assigned by the Licensee to conduct field radiographic operations at a temporary job site in Indianapolis, Indiana. The radiography consisted of eight exposures, including uncollimated panoramic exposures, of a heat exchanger inside of a building. The radiographer and the radiographer's assistant did not conspicuously post the radiation area exterior to the building to warn of the radiation area created during the radiographic exposures. While the radiographer remained inside the building to observe the radiographic operation, the radiographer's assistant was to stay outside of the building to warn anyone approaching the area of the radiation hazard.

One section of the radiation area was behind a wooden fence and that area was accessible to the public. That section was not posted as a radiation area and the fence blocked the view of that area for the radiographer's assistant. Therefore, neither the radiographer nor the radiographer's assistant could provide immediate assistance to

prevent unauthorized entry into the radiation area because the radiographer's view of the area was blocked by the building wall.

While controlling access outside of the building to prevent unauthorized entry into another section of the radiation area, the radiographer's assistant was approached by the owner of an adjacent building with questions about potential radiation hazards in that person's building. The radiograph's assistant left the radiation area where he was posted to control access to prevent unauthorized access and went to the near-by building to answer questions about potential radiation hazards. While inside the adjacent building, the radiographer's assistant could not view the radiation area and the radiographer could not maintain visual surveillance of the area because of the intervening building wall. The absence of a qualified individual to maintain surveillance to prevent unauthorized access to a radiation area and the failure to post warnings of the radiation hazard are violations of 10 CFR 34.41(a) and 10 CFR 20.1902.

The NRC Staff concludes that the radiographer's assistant could not observe a section of the radiation area at the temporary job site in Indianapolis, Indiana, and therefore could not observe radiographic operations or provide assistance to prevent unauthorized entry into a radiation area and the area was not marked as a radiation area. The NRC Staff also concluded that the radiographer's assistant left another section of the radiation area unattended and the radiation area was not posted; therefore, no means existed to warn individuals of the presence of a radiation area or to prevent unauthorized entry into that area. The use of radios between Licensee personnel would not have adequately compensated for the absence of the radiographer's assistant or appropriate postings to warn of the radiation hazard.

Since qualified individuals could not observe the radiation area exterior to the building while radiographic operations were taking place, they were not in a position or capable of providing immediate assistance to prevent unauthorized entry into the radiation area exterior to the building, and radio communication would not have provided any assistance to prevent unauthorized entry into the radiation area. Therefore, EA-02-201 remains valid and will not be withdrawn.

C. The Licensee contended that the NRC did not give credit for the civil penalty adjustment factor associated with *Corrective Action*. As explained in the June 15, 2004, letter from the NRC, credit was warranted for the *Corrective Action* adjustment factor and no additional civil penalty was assessed for the *Corrective Action* factor.

The NRC gave appropriate credit to the Licensee for the corrective actions implemented by the Licensee, as described in the June 15, 2004, letter from the NRC to the Licensee.

Section VI.C of the Enforcement Policy, provides, in part, that management involvement, direct or indirect, may lead to an increase in the civil penalty. Section VII.A.1 of the Enforcement Policy provides for escalating the amount of the civil penalty by the base or twice the base civil penalty to ensure that the civil penalty reflects the significance of the circumstances. The NRC escalated the amount of the civil penalty by the base amount due to a lack of management oversight of the radiation safety program which significantly contributed to the conditions leading to the overexposure event described in the June 15, 2004, letter and Notice. The Licensee, however, did not contest this application of enforcement discretion in its July 12, 2004, response to the Notice.

NRC Conclusion

The NRC has concluded that the violations occurred as stated and neither an adequate basis for a reduction of the severity level nor for recission or mitigation of the civil penalty was provided by the Licensee. Consequently, the proposed civil penalty in the amount of $19,200 should be imposed.

Attachment F

US INSPECTION SERVICES

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- Toledo, OH

September 24, 2004

Secretary, U.S. Nuclear Regulatory Commission
Attn: Rulemakings and Adjudications Staff
Washington, D.C. 20555

Subject: Request for Enforcement Hearing; EA-03-204

Dear Rulemaking and Adjudications Staff,

This is in reference to the letter from the U.S. Nuclear Regulatory Commission's Region III Office of Enforcement dated September 1st, 2004 to US Inspection Services with the subject line, "Order Imposing Civil Monetary Penalty – $19,200.00."

We respectfully request a hearing to further discuss the issues surrounding the September 9th, 2003 incident that resulted in the proposed civil penalty noted above and the position taken by the U.S. Nuclear Regulatory Commission.

US Inspection Services has taken drastic and decisive measures to assure that incidents of this nature will not occur in the future. We have added fulltime staff, brought on board a new CRSO, incurred costs to improve our program and equipment that are approaching $100,000.00, and have diligently communicated these efforts to the U.S. Nuclear Regulatory Commission.

As stated in your letter it was your intent to "emphasize the importance of complying with regulatory requirements, ensuring that personnel adhere to and follow procedures, providing appropriate management oversight of the radiation safety program, and promptly identify violations," through the proposed civil penalty. We are chiefly motivated by a sincere concern for the safety of our employees and the general public that we encounter. Our corrective actions in regard to the September, 2003 incident and current safety culture are evidence that this is the case. We also believe that we have proven that the escalated civil penalty is not necessary to "emphasize the importance of complying with regulatory requirements, ensuring that personnel adhere to and follow procedures, providing appropriate management oversight of the radiation safety program, and promptly identify violations". It is already an obvious emphasis.

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It should also be noted that US Inspection Services has been subjected to four separate "follow-up" audits between August 10th and 19th, 2004 by a U.S. Nuclear Regulatory Commission Region III Inspector. All four were noted with, "Based on the inspection findings, no violations were identified."

Again, we request a hearing to discuss these issues and present our ongoing efforts to the U.S. Nuclear Regulatory Commission.

If you should have any questions or require any additional information, please contact me at (937) 228-9729 or (937) 603-1481.

Sincerely,

Jon E. Silks
Corporate Radiation Safety Officer
US Inspection Services
705 Albany St
Dayton, Ohio 45408
USNRC License No. 34-06943-02

Attachment G

US INSPECTION SERVICES
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November 16, 2004

Atomic Safety and Licensing Board Panel
Mail Stop T-3 F23
US Nuclear Regulatory Commission
Washington, DC. 20555-001

Attention: Ann M. Young
Alex S. Karlin
Dr. Peter S. Lam
Office of the Secretary

Reference: Docket No. 30-35059-CivP and ASLBP No. 04-834-01-CivP

Dear Atomic Safety and Licensing Board,

After conversations with Michael Woods, Counsel for NRC Staff, and other United States Nuclear Regulatory Commission staff, US Inspection Services would like to request a withdrawal from the formal hearing process initiated by our letter dated September 24, 2004.

Payment of the civil penalty imposed by the USNRC will be submitted by US Inspection Services at the time that this request is granted.

Thank you for your consideration and the opportunity to enter into this process.

Respectfully,

Jon E. Silks
Corporate Safety Manager
US Inspection Services

cc: Michael A. Woods