UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE RD. SUITE 210
LISLE, IL 60532-4352

January 17, 2017

EA-16-130

Mr. Steven Flickinger
Safety Director
JANX Integrity Group
P.O. Box 190
8550 East Michigan Avenue
Parma, MI 49269

SUBJECT: RESULTS OF NRC INVESTIGATION REPORT NO. 03011772/2016004(DNMS)
JANX INTEGRITY GROUP

Dear Mr. Flickinger:

The U.S. Nuclear Regulatory Commission (NRC) conducted a routine safety and security inspection on January 19-21, 2016, at your facility in Parma, Michigan, and at several temporary jobsites within the State of Michigan. The details of the inspection were documented in the non-public version of NRC Inspection Report No. 03011772/2016002(DNMS), issued on February 25, 2016. During the inspection, the NRC identified unresolved items requiring further agency review. The NRC Office of Investigations began an investigation into these issues on February 1, 2016, and completed the investigation on June 1, 2016. A factual summary of the NRC investigation is enclosed.

Based on the results of the NRC inspection and investigation, apparent violations of NRC requirements were identified and are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's website at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The circumstances surrounding the apparent violations, the significance of the issues, and the need for lasting and effective corrective action were discussed with you during an exit meeting by telephone on January 19, 2017. These apparent violations involve: (1) a deliberate failure to conduct radiography at a temporary job site with at least two qualified individuals, as required by Title 10 of the *Code of Federal Regulations* (CFR) Part 34.41(a); (2) a deliberate failure to conduct a survey of the radiographic exposure device and guide tube after each exposure when approaching the device, as required by 10 CFR 34.49(b); and (3) a deliberate failure to perform visual and operability checks on radiographic exposure devices as required by 10 CFR 34.31(a).

Before the NRC makes its enforcement decision, we are providing you an opportunity to either: (1) respond in writing to the apparent violations addressed in this inspection report within 30 days of the date of this letter; (2) request a Predecisional Enforcement Conference (PEC);

or (3) request Alternate Dispute Resolution (ADR). If a PEC is held, the NRC will issue a press release to announce the time and date of the conference; however the PEC will be closed to public observation since information related to an Office of Investigations report will be discussed and the report has not been made public. However, the NRC will record and transcribe the meeting. **Please contact Aaron T. McCraw at 630-829-9650 or Aaron.McCraw@nrc.gov within ten days of the date of this letter to notify the NRC of your intended response.**

If you choose to provide a written response, it should be clearly marked as "Response to the Apparent Violations; EA-16-130," and should include, for the apparent violations: (1) the reason for the apparent violations, or, if contested, the basis for disputing the apparent violations; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance was or will be achieved. In presenting your corrective actions, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be useful in preparing your response. You can find the information notice on the NRC website at: http://www.nrc.gov/reading-rm/doc-collections/gen-comm/info-notices/1996/in96028.html. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. If an adequate response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision or schedule a PEC.

If you choose to request a PEC, the conference will afford you the opportunity to provide your perspective on the apparent violations and any other information that you believe the NRC should take into consideration before making an enforcement decision. The topics discussed during the conference may include the following: information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned to be taken.

In lieu of a PEC, you may also request Alternative Dispute Resolution (ADR) with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a third party neutral. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained neutral (the "mediator") works with parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC's program can be obtained at http://www.nrc.gov/about-nrc/regulatory/enforcement/adr.html. The Institute on Conflict Resolution (ICR) at Cornell University has agreed to facilitate the NRC's program as a neutral third party. Please contact ICR at 877-733-9415 within ten days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

Because you identified the violation, a civil penalty may not be warranted in accordance with Section 2.3.4 of the Enforcement Policy. In addition, based upon NRC's understanding of the

facts and your corrective actions, it may not be necessary to conduct a PEC in order to enable the NRC to make a final enforcement decision. Our final decision will be based on your confirming on the license docket that the corrective actions previously described to the staff have been or are being taken. In addition, please be advised that the number and characterization of the apparent violations described in the enclosed inspection report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

In accordance with Title 10 CFR 2.390 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 available electronically for public inspection in the NRC's Public Document Room or from the NRC's Agency wide Documents Access Management System (ADAMS), accessible from the NRC's website 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 publicly available without redaction.

Please feel free to contact Ryan Craffey of my staff if you have any questions regarding this inspection. Mr. Craffey can be reached at 630-829-9655.

Sincerely,

/RA/

John B. Giessner, Director
Division of Nuclear Materials Safety

Docket No. 030-11772
License No. 21-16560-01

Enclosure:
Factual Summary of NRC Investigation

cc w/encl: State of Michigan

Letter to Steven Flickinger from Aaron McCraw dated January 17, 2017.

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JANX INTEGRITY GROUP

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FACTUAL SUMMARY OF OFFICE OF INVESTIGATIONS REPORT 3-2016-004

On February 1, 2016, the U.S. Nuclear Regulatory Commission's (NRC) Office of Investigations (OI), Region III Field Office, initiated an investigation to determine whether JANX Integrity Group (JANX) personnel: (1) deliberately failed to have at least one other qualified individual accompany the radiographer during radiographic operations as required in Title 10 of the *Code of Federal Regulations* (CFR) 34.41(a); (2) deliberately failed to survey the radiographic exposure device and the guide tube with a survey instrument after each exposure when approaching the device in violation of 10 CFR 34.49(b); and (3) deliberately failed to conduct operability checks of the radiography exposure device prior to use in violation of 34.31(a). The NRC completed its investigation on June 1, 2016.

On January 19, 2016, during a routine inspection at JANX, the Radiation Safety Officer (RSO) informed the inspector that two individuals, a Radiographer (Radiographer A) and an Assistant Radiographer (Radiographer B), were terminated in September 2015 for not following NRC regulations.

The Region III OI interviewed a number of individuals including a regional compliance manager, the RSO, Radiographer A, Radiographer B and a third radiographer (Radiographer C). Radiographer C had worked with Radiographer A and testified that Radiographer A would remain in the truck developing and reading film while he performed most of the work. Radiographer C raised the issue to management. On August 12, 2015, during an audit the regional compliance manager verbally reminded Radiographer A of the requirement for both qualified individuals to be present during radiographic operations. However, on August 13, 2015, the manager observed Radiographer A violate the requirement despite the verbal reminder the previous day.

During the investigation, the RSO stated that he had observed Radiographer A and Radiographer B perform radiographic operations for approximately 3 hours on September 18, 2015. According to the RSO, when the radiographic operations began, Radiographer A sat in the truck facing forward, used his phone and worked on his computer while the Radiographer B worked in the rear of the truck. The RSO also observed that the survey meter to be used to survey the radiography device after each exposure was left on the truck and not used. Later, during a verbal confrontation with both individuals, the RSO also questioned whether the operational checks were completed before work commenced that day. He asked Radiographer B to demonstrate the misconnect test. The radiography device failed the test indicating that the test was most likely not completed that day.

During the OI interview, Radiographer A did not recall receiving any training from JANX; however, he acknowledged his experience in performing radiographic operations and was able to describe the equipment, its function, and methods in performing radiography. Radiographer A recalled the August 2015 events and not having both qualified individuals present during radiographic operations. He also recalled the September 18, 2015, confrontation with the RSO; however, he did not admit to violating the requirement.

Radiographer B stated that he assumed Radiographer A was watching him perform work. He admitted that he was focused on the work and did not pay attention to Radiographer A. He also stated that he was trained in performing the surveys after each exposure and conducting the misconnect test. Radiographer B admitted that he was responsible for conducting the surveys

and that he, “got lazy,” and did not survey the exposure devices and the guide tube. He also eventually admitted to not performing the misconnect test that morning.

Based on the evidence gathered during the OI investigation, it appears that on September 18, 2015, Radiographer A deliberately failed to accompany the radiographer during radiographic operations as required in 10 CFR 34.41(a). Also, it appears that Radiographer B deliberately failed to survey the radiographic exposure device with a survey instrument after each exposure and perform the required operability check (misconnect test) of the equipment in violation of 10 CFR 34.49 (b) and 10C FR 34.31(a).