UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BOULEVARD
ARLINGTON, TEXAS 76011-4511

July 3, 2019

EA-19-017

Mr. Russell Allan Phillips
Radiation Safety Officer
Intertek Asset Integrity Management, Inc.
P.O. Box 1536
Morgan City, LA 70381-1536

SUBJECT: NRC INSPECTION REPORT 030-37816/2019-001 AND NOTICE OF VIOLATION

This letter refers to the announced reactive inspection conducted on January 29, 2019, at your facility in Houma, Louisiana. The inspection was conducted in response to an event called into the NRC on January 29, 2019, Event Notification 53850, regarding a radiography source disconnect that had occurred offshore in the Gulf of Mexico on January 26, 2019. The results of the inspection are documented in Enclosures 2 and 3. A final exit briefing was conducted telephonically with Mr. William Johnston, Corporate Radiation Safety Officer, on May 31, 2019, and with you on June 4, 2019.

The objectives of the reactive inspection were to: (1) review the facts and circumstances surrounding the event, (2) evaluate the licensee's response to the event, (3) assess the licensee's compliance with license conditions and other applicable regulatory requirements related to the event and the licensee's response, and (4) evaluate the licensee's immediate and planned long-term corrective actions to prevent recurrence.

Based on the results of this inspection, apparent violations 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 Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. An apparent violation involved the failure to develop and implement written procedures for conducting inspections and maintenance on radiographic equipment at intervals not to exceed 3 months. Further details are documented in the publicly available inspection report in Enclosure 2. In addition, an apparent violation involving security requirements is documented in the non-publicly available inspection report in Enclosure 3. The circumstances surrounding these apparent violations, the significance of the issues, and the need for lasting and effective corrective actions were discussed with Mr. Johnston during the final telephonic exit briefing conducted on May 31, 2019.

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 the inspection report within 30 days of the date of this letter, (2) request a predecisional enforcement conference (PEC), or

Enclosure 3 contains Sensitive Unclassified Non-Safeguards Information. When separated from the Enclosure 3, this cover letter and Enclosures 1 and 2 are decontrolled

(3) request alternative dispute resolution (ADR). If a PEC is held, the PEC will be closed to public observation since Security-Related Information will be discussed. If you decide to participate in a PEC or pursue ADR, please contact Ms. Patricia Silva at 817-200-1455 within 10 days of the date of this letter. A PEC should be held within 30 days and an ADR session within 45 days of the date of this letter.

If you choose to provide a written response, it should be clearly marked as a "Response to Apparent Violation in NRC Inspection Report 030-37816/2019-001; EA-19-017" and should include for each apparent violation: (1) the reason for the apparent violation or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response.

Additionally, your response should be sent to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy mailed to the Director, Division of Reactor Projects, U.S. Nuclear Regulatory Commission, Region IV, 1600 E. Lamar Blvd., Arlington, TX 76011-4511, within 30 days of the date of this letter. 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 these matters and any other information that you believe the NRC should take into consideration before making an enforcement decision. The decision to hold a PEC does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference would be conducted to obtain information to assist the NRC in making an enforcement decision. The topics discussed during the conference may include 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.

In lieu of a PEC, you may also request ADR with the NRC in an attempt to resolve this issue. Alternative dispute resolution is a general term encompassing various techniques for resolving conflicts using a neutral third party. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained neutral 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 as well as NRC brochure NUREG/BR-0317, "Enforcement Alternative Dispute Resolution Program," Revision 2 (Agencywide Documents Access and Management System (ADAMS) Accession ML18122A101). The Institute on Conflict Resolution at Cornell University has agreed to facilitate the NRC's program as a neutral third party. Please contact the Institute on Conflict Resolution at 877-733-9415 within 10 days of the date of this letter if you are interested in pursuing resolution of these issues through ADR.

In addition, please be advised that the number and characterization of apparent violations described in Enclosures 2 and 3 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.

Based on the results of the inspection, one Severity Level IV violation of NRC requirements occurred. The violation involved the failure to provide a timely notification to the NRC following the radiographic source disconnect in the Gulf of Mexico and documented in the Notice of Violation (Notice) contained in Enclosure 1. This violation is being cited because it was identified by the NRC during the inspection.

In accordance with the NRC Enforcement Policy, a materials licensee's failure to make an immediate or 24-hour report or notification when required is normally categorized as a Severity Level III violation. However, in this case, several factors were considered to disposition this violation as a Severity Level IV violation. These factors included: (1) the brief delay of 2 days between the required 24-hour reporting deadline and the actual report; (2) the short lapse in reporting time would not have changed the NRC's decision-making and response to the event; (3) there were no actual consequences in health and safety matters to report from the event; and (4) the licensed activities were performed in offshore waters, thereby limiting security access concerns, as well as potential for exposure and contamination to members of the public. Considering these mitigating factors, the NRC determined this violation is more appropriately categorized as a Severity Level IV violation.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390 of the NRC's "Agency Rules of Practice and Procedure," a copy of this letter, Enclosures 1 and 2, and your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's Agencywide Documents Access and Management System (ADAMS), 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 or proprietary information so that it can be made available to the public without redaction.

However, Enclosure 3 contains Security-Related Information in accordance with 10 CFR 2.390(d)(1) and its disclosure to unauthorized individuals could present a security vulnerability. Therefore, Enclosure 3 will not be made available electronically for public inspection in the NRC Public Document Room or from ADAMS.

If you choose to provide a response to the apparent violation in Enclosure 3 and Security-Related Information is necessary to provide an acceptable response, please mark your entire response "Security-Related Information – Withhold from public disclosure under 10 CFR 2.390" in accordance with 10 CFR 2.390(b)(1) and follow the instructions for withholding in 10 CFR 2.390(b)(1). In accordance with 10 CFR 2.390(b)(1)(ii), the NRC is waiving the affidavit requirements for your response.

If you have any questions concerning this matter, please contact Ms. Patricia Silva of my staff at 817-200-1455.

Sincerely,

/RA/

Linda L. Howell, Acting Director
Division of Nuclear Materials Safety

Docket: 030-37816
License: 17-29308-01

Public Enclosures:
1. Notice of Violation
2. Health and Safety - NRC Inspection Report 030-37816/2019-001

Nonpublic Enclosure:
3. Security - NRC Inspection Report 030-37816/2019-001

cc w/Enclosures:
Jeff Dauzat, Administrator
Louisiana Dept. of Environmental Quality

Charlotte Sullivan, Manager
Texas Department of State Health Services

NRC INSPECTION REPORT 030-37816/2019-001 AND NOTICE OF VIOLATION - DATED JULY 3, 2019

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NOTICE OF VIOLATION

Intertek Asset Integrity Management, Inc.
Morgan City, Louisiana

Docket No.: 030-37816
License No.: 17-29308-01
EA-19-017

During an NRC inspection conducted on January 29, 2019, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

> 10 CFR 30.50(b)(2) requires, in part, that each licensee shall notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or fails to function as designed.
>
> 10 CFR 30.50(c)(1) requires, in part, that licensees shall make reports required by paragraphs (a) and (b) of 10 CFR 30.50 by telephone to the NRC Operations Center.
>
> Contrary to the above, on January 27, 2019, the licensee failed to notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or failed to function as designed. Specifically, the licensee notified the NRC on January 29, 2019, of a source disconnect that occurred on January 26, 2019, a period in excess of 24 hours.

This is a Severity Level IV violation (NRC Enforcement Policy Section 6.9.d).

Pursuant to 10 CFR 2.201, Intertek Asset Integrity Management, Inc. is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, Region IV, 1600 E. Lamar Blvd., Arlington, Texas 76011, within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

This reply should be clearly marked as a "Reply to a Notice of Violation; EA-19-017" and should include: (1) the reason for the violation, or, if contested, the basis for disputing the violation or severity level; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued requiring information as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

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.

Your response will be made available electronically for public inspection in the NRC Public Document Room or in the NRC's Agencywide Documents Access and Management System (ADAMS), 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 or proprietary information so that it can be made available to the public without redaction.

Enclosure 1

If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information).

In accordance with 10 CFR 19.11, you may be required to post this Notice within 2 working days of receipt.

Dated this 3rd day of July 2019

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket:	030-37816
License:	17-29308-01
Report:	2019-001 (Health & Safety)
EA No:	19-017
Licensee:	Intertek Asset Integrity Management, Inc.
Location Inspected:	212 Clendenning Road, Houma Louisiana
Inspection Dates:	Onsite January 29, 2019 In-office review through May 9, 2019
Exit Meeting Date:	May 31, 2019
Inspector:	Jason vonEhr, Health Physicist Materials Licensing and Inspection Branch Division of Nuclear Materials Safety, Region IV
Approved By:	Patricia A. Silva, Chief Materials Licensing and Inspection Branch Division of Nuclear Materials Safety
Attachment:	Supplemental Inspection Information

Enclosure 2

EXECUTIVE SUMMARY

Intertek Asset Integrity Management, Inc.
NRC Reactive Inspection Report 030-37816/2019-001 (Health and Safety)

On January 29, 2019, the U.S. Nuclear Regulatory Commission (NRC) performed an announced reactive inspection at Intertek Asset Integrity Management, Inc., at its facility in Houma, Louisiana, with in-office reviews through May 9, 2019. The scope of the inspection was limited to the review of the radiography source disconnect that occurred offshore in the Gulf of Mexico on January 26, 2019. This report describes the Health and Safety observations and findings of the inspection.

Program Overview

Intertek Asset Integrity Management, Inc. is authorized under NRC Materials License 17-29308-01 to possess and use byproduct materials, including iridium-192, for industrial radiographic operations. Licensed activities, including radiographic source recovery activities, are authorized to be performed at temporary job sites in areas of NRC jurisdiction. (Section 1)

Inspection Findings

During an announced reactive inspection conducted on January 29, 2019, and through in-office reviews with May 9, 2019, an apparent violation of NRC regulatory requirements was identified. The apparent violation involved the licensee's failure to develop written procedures for the inspection and maintenance of radiographic equipment at intervals not to exceed 3 months. In addition, Severity Level IV violation was identified that involved the failure to notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or failed to function as designed. (Section 3)

Corrective Actions

The licensee initiated several corrective actions related to the event. The licensee drafted a new revision to its Operating and Emergency Procedures and is in the process of deploying a new maintenance program to better capture and document maintenance of associated radiographic equipment. The licensee issued a "Safety Alert" to its staff across the organization on January 26, 2019, to communicate the event and stress the importance of daily visual and operability checks. (Section 5)

REPORT DETAILS – Health & Safety

1. Program Overview (87121 & 87103)

1.1. Program Scope

Intertek Asset Integrity Management, Inc. is authorized under U.S. Nuclear Regulatory Commission (NRC) Materials License 17-29308-01 to possess and use byproduct materials, including iridium-192, for industrial radiographic operations. Licensed activities, including radiographic source recovery activities, are authorized at temporary job sites in areas of NRC jurisdiction, such as the Gulf of Mexico.

1.2. Inspection Scope

On January 29, 2019, the NRC performed an announced reactive inspection at Intertek Asset Integrity Management, Inc., at its facility in Houma, Louisiana, with in-office reviews through May 9, 2019. The objectives and scope of the reactive inspection were to: (1) review the facts and circumstances surrounding the event, (2) evaluate the licensee's response to the event, (3) assess the licensee's compliance with license conditions and other applicable regulatory requirements related to the event and the licensee's response, and (4) evaluate the licensee's immediate and planned long-term corrective actions to prevent recurrence.

2. Event Timeline

During a series of radiographic exposures offshore in the Gulf of Mexico in Walker Ridge, approximately 280 miles south of New Orleans (see Figure 1), the licensee experienced a radiography source disconnect on January 26, 2019, at approximately 4:30 p.m. (all times are in Central Time). The radiography was occurring in one of the "legs" (Chiller Room, Northwest Hull) to an offshore production platform in the Jack/St. Malo offshore oil field (see Figure 2).

The crew onboard the semi-submersible production platform determined that the radiography source would not return to the shielded position and removed themselves from the immediate area to place calls to their on-call manager for guidance. The source was left in the collimator to reduce potential exposures.

The licensee arranged for a source-recovery trained individual to fly to the platform on the first available flight on January 27, 2019. The licensee was authorized by NRC License 17 29308-01, Amendment 5, License Condition 13, to conduct source recovery activities involving radiography sources.

The radioactive source (iridium-192) was determined to have been disconnected by a cable break (see Figure 3). The break was caused by corrosion of the cable. The radiography source was transferred to a Source Production and Equipment Company (SPEC) C-1 source exchanger, which was stored in the licensee's mobile darkroom onboard the platform until subsequently being flown back to the onshore licensee facility for evaluation on January 28, 2019. The licensee notified the NRC of the event on January 29, 2019.

Figure 1 - Location of the offshore fields that the single platform services (Chevron website).

Figure 2 - Production platform the radiography was occurring on (Chevron website). Red Circle indicates the approximate location of the radiography at the time of the disconnect.

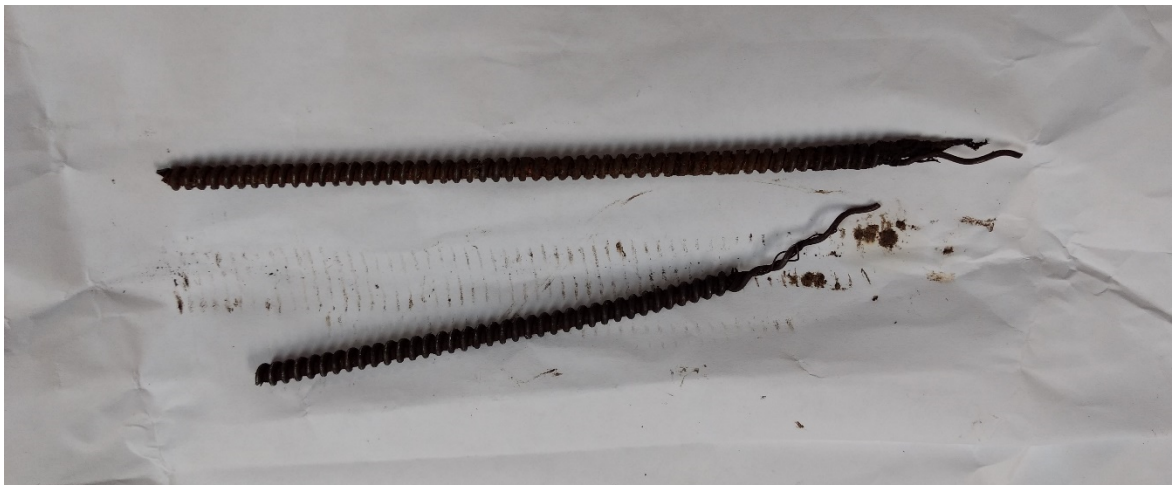

Figure 3 – Broken source cable (Note the advanced state of corrosion).

3. Observations and Findings

During the announced reactive inspection conducted on January 29, 2019, an apparent violation of NRC regulatory requirements was identified. The apparent violation involved the licensee's failure to develop written procedures for and conduct adequate inspection and maintenance of radiographic equipment at intervals not to exceed 3 months.

The licensee's lead radiographer was interviewed following the inspection when he had returned from the offshore facility. The radiographer described how he and the crew had handled the radiography equipment and conducted daily visual and operability checks on the equipment in accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 34.31 and the licensee's Operating and Emergency Procedures, tied down to the license via License Condition 19.N. The inspector also interviewed the corporate radiation safety officer, Mr. William Johnston, to understand the processes for offshore radiography, routine quarterly and daily maintenance, and radiography source recovery in the event of misconnects or disconnects.

The inspector reviewed the records associated with the transport, storage, and use of the radiographic equipment, including the radiography camera and associated radioactive source, for the period that the equipment was offshore through the date of the event. The inspector also reviewed records associated with training for the radiography crew and the source recovery individual, calibration of associated survey meters and dosimetry equipment, maintenance and testing of the radiographic equipment, and the licensee's Operating and Emergency procedures.

During the document review for the event, the inspector identified that the licensee's radiography cable involved in the event was purchased and installed new in June 2018, seven months prior to the event. The inspector also identified that the licensee's recordkeeping system was focused on tracking routine maintenance on the basis of the radiography camera's serial number, and not necessarily any unique identifier of the associated equipment.

The radiography equipment and the radiography camera were not necessarily maintained concurrently, and therefore, the camera maintenance records were not

indicative of associated radiographic equipment maintenance. As a result, the licensee had no records unique to or tied to the associated equipment and could not demonstrate via records that the radiography cable and other associated equipment had undergone the required 3-month routine maintenance since the original installation. In addition, the licensee's maintenance personnel were interviewed, and could not recall the specific equipment having been returned to their shops for routine maintenance.

The licensee's radiography source recovery operation was conducted adequately. Although operational issues associated with the circumstances caused the recovery to take longer than originally envisioned, the radiography source was successfully removed from the guide tube and placed into intermediate storage inside a SPEC C-1 source exchanger. The whole-body radiation exposures recorded for the involved licensee staff were reported at: Lead Radiographer – 40 millirem, Second Radiographer – 21 millirem, and Source Retriever – 275 millirem. In addition, the licensee estimated the additional extremity exposure of the Source Retriever at between 144 millirem to 240 millirem, due to issues experienced in manipulating the disconnected radiography source. The inspector concurred with these estimates as reasonable given the events as provided through interviews and the radiological hazard involved in the event.

The licensee was required by 10 CFR 34.101 to provide a 30-day report regarding the disconnect event to the NRC. On February 19, 2019, the licensee provided this non-publicly available report.

3.1. Apparent Violation - 10 CFR 34.31

The inspector determined that the licensee's procedures were adequately developed to require the radiography crew, in the performance of daily maintenance, to identify issues, such as cable corrosion, worn, damaged, or bent cables, prior to corrosion causing an actual event. The procedures dictated that the cable is to be flexible, not crimped, and free of identifiable damage, bends, or excessive wear. The advanced state of corrosion of the cable, seen in Figure 3, had not been identified by the radiography crew. The crew did not conduct the above described tests and assessment against the full length of the cable, but rather only the first short length, which was not yet in the same state of corrosion.

During the inspection, the licensee's corporate radiation safety officer demonstrated portions of the required operability test, including bending and flexibility, using the actual cable involved in the event. Under normal circumstances, a cable should bend and return to an upright position without issue. However, the cable in question was visibly corroded and when bent remained bent at an angle, and therefore, did not pass the visual and operability check.

The inspector determined that the licensee's procedures, while comprehensive in describing the visual and operability tests required for daily use, failed to address how the radiographic equipment would be routinely maintained and inspected on a quarterly basis, as required by 10 CFR 34.31(b). This failure was coupled with the lack of records to show that the cable had been maintained or inspected between the initial installation in June 2018, and the day of the event in January 2019. As a result of the above, the inspector identified the following apparent violation:

10 CFR 34.31(b) requires, in part, that the licensee have written procedures for inspection and routine maintenance of associated radiographic equipment at intervals not to exceed 3 months to ensure proper functioning of components important to safety.

Contrary to the above, from at least April 12, 2016, to January 26, 2019, the licensee failed to have written procedures for inspection and routine maintenance of associated radiographic equipment at intervals not to exceed 3 months to ensure proper functioning of components important to safety. Specifically, the licensee had written procedures for daily visual and operability checks required by 10 CFR 34.31(a), but failed to develop written procedures for the inspection and maintenance of required equipment at intervals not to exceed 3 months. In addition, the licensee failed to perform inspection and routine maintenance on a set of associated radiographic equipment, which may have contributed to a failure of the equipment and a disconnected radiographic source.

The licensee's failure to written procedures for inspection and routine maintenance of associated radiographic equipment at intervals not to exceed 3 months to ensure proper functioning of components important to safety was identified as an apparent violation of 10 CFR 34.31(b). (030-37816/2019-001-01)

3.2. Violation of 10 CFR 30.50(b)(2)

The licensee's radiography source disconnect involved a failure of equipment (radiography source cable) and licensed material to function as designed. The NRC issued Regulatory Issue Summary 2005-15 "Reporting Requirements for Damaged Industrial Radiographic Equipment" (https://www.nrc.gov/reading-rm/doc-collections/gen-comm/reg-issues/2005/ri200515.pdf) to address this and other similar issues. The Regulatory Issue Summary clarifies that radiography disconnects are dual-reportable under 10 CFR 30.50 and 10 CFR 34.101, and requires a 24-hour notification to be made to the NRC or equivalent Agreement State body.

The licensee's radiography source disconnect occurred at approximately 4:30 p.m. on January 26, 2019, as described in in Section 2. The licensee failed to provide a notification to the NRC until 9:44 a.m. on January 29, 2019. This was a period in excess of 24 hours required by 10 CFR 30.50(b)(2), and was identified as a Severity Level IV violation in accordance with the NRC Enforcement Policy Section 6.9.d. The violation is cited in Enclosure 1 and restated below:

10 CFR 30.50(b)(2) requires, in part, that each licensee shall notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or fails to function as designed.

10 CFR 30.50(c)(1) requires, in part, that licensees shall make reports required by paragraphs (a) and (b) of 10 CFR 30.50 by telephone to the NRC Operations Center.

Contrary to the above, on January 27, 2019, the licensee failed to notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or failed to function as designed. Specifically, the licensee notified the NRC on January 29, 2019 of a source disconnect that occurred on January 26, 2019, a period in excess of 24 hours.

The licensee's failure to provide a timely notification to the NRC following a radiography source disconnect was identified as a Severity Level IV violation of 10 CFR 30.50(b)(2). (030-37816/2019-001-02)

4. Conclusions

During the inspection conducted on January 29, 2019, an apparent violation of NRC regulatory requirements was identified. The apparent violation involved the licensee's failure to develop written procedures for and conduct adequate inspection and maintenance of radiographic equipment at intervals not to exceed 3 months. Finally, the NRC determined that a Severity Level IV violation regarding the failure to make a timely notification following a radiographic source disconnect had occurred.

5. Corrective Actions

In the weeks that followed the NRC's January 2019 inspection the licensee had issued a "Safety Alert" company-wide to communicate the immediate issue of daily visual and operability checks at the radiography crew level and was drafting revisions to the company's Operating and Emergency procedures that would comprehensively address the deficiencies in the maintenance program. This draft revision was in the process of deploying a new maintenance program to better track, capture, and document the required maintenance of associated radiographic equipment.

6. Exit Meeting Summary

At the conclusion of the on-site portion of the inspection on January 29, 2019, the NRC inspector provided the preliminary inspection findings to the corporate radiation safety officer, Mr. William Johnston. On May 31, 2019, the NRC conducted a final telephonic exit briefing with Mr. Johnston and with Mr. Russell Allan Phillips on June 4, 2019. The licensee acknowledged the inspection findings and did not dispute any of the details presented during the call.

Supplemental Inspection Information

PARTIAL LIST OF PERSONS CONTACTED

Mr. William Johnston, Corporate Radiation Safety Officer

INSPECTION PROCEDURES USED

87103 Inspection of Material Licensees Involved in an Incident or Bankruptcy Filing
87121 Industrial Radiography Programs

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

030-37816/2019-001-01	APV	Failure to have written procedures for inspection and routine maintenance of associated radiographic equipment at intervals not to exceed 3 months to ensure proper functioning of components important to safety. (10 CFR 34.31(b))
030-37816/2019-001-02	VIO	Failure to provide a timely notification to the NRC following a radiography source disconnect. (10 CFR 30.50(b)(2))

Closed

None

Discussed

None

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
ADR	Alternative Dispute Resolution
APV	Apparent Violation
CFR	*Code of Federal Regulations*
NRC	Nuclear Regulatory Commission
PEC	Predecisional Enforcement Conference
SPEC	Source Production and Equipment Company

Attachment