



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

October 31, 1996

IA 96-069

Jeffery Brennan
[HOME ADDRESS DELETED]
PURSUANT TO 10 CFR 2.790]

SUBJECT: NRC INSPECTION REPORT NO. 030-17129/96-01

Dear Mr. Brennan:

This letter is being issued to you based on your involvement in committing significant violations of NRC requirements during radiography operations. At the time of these violations, you were employed by CTI Alaska, Inc., and working under the authority of CTI's NRC license.

The NRC conducted a special inspection on January 17 through July 2, 1996, with particular focus on an incident involving an inadvertent radiation exposure, but not an overexposure, that occurred while you were conducting radiography at Endicott Island during the evening of December 23-24, 1995. The inspection report was issued on July 15, 1996. A predecisional enforcement conference was conducted with CTI on August 6, 1996, at our office in Arlington, Texas.

Based on the information developed during the inspection, particularly our inspector's interview of you and the other radiographer on the job, and the information provided by CTI representatives, the NRC has determined that your failure to meet the requirements of 10 CFR 34.43(b) and 10 CFR 34.33(f)(1) directly contributed to your being inadvertently exposed to a radiographic source after a safety latch inside the locking mechanism of an INC Model IR-100 exposure device failed to secure the source assembly in a fully shielded position. Also, instead of stopping the job and notifying appropriate company officials, you continued working and you did not notify your supervisor until the next morning, at the conclusion of the shift.

Specifically, the violations that led to your excessive exposure included your failures to: 1) conduct an adequate survey of the radiography camera after a radiographic exposure to verify return of the sealed source to its shielded position; and 2) ensure the proper operation of an alarm ratemeter before the shift began, which could have given warning that the source had not fully retracted. We understand there were problems with the operation of both the survey meter and the alarm ratemeter. But, you did not perform the survey correctly; instead you stated that you merely looked for a significant deflection of the meter needle. Further, you stated that you checked your alarm ratemeter properly only about half the time. As a result, during the event, you were unaware that the alarm ratemeter was not functioning properly.

Each of these violations was significant in that compliance with any one of these requirements could have prevented or mitigated your exposure. Conducting an adequate survey of the radiography camera after a radiographic exposure, and wearing an alarm ratemeter are each intended to serve as safety barriers designed to prevent incidents of this type from occurring and to protect workers and members of the public from inadvertent and potentially significant radiation exposures. Your failure to assure compliance with these requirements circumvented these separate and distinct safety barriers.

The NRC also found that two other violations of NRC requirements had occurred during the job. The first involved the failure to post the high radiation area and the second involved indicating on the "Daily Radiation Job Sheet" that the area had been posted when it had not. As senior radiographer, you should have ensured that a high radiation area sign was appropriately posted, and you should have ensured the accuracy of the "Daily Radiation Job Sheet," which indicated that the high radiation area had been posted.

You should be aware that NRC regulations (i.e., 10 CFR 30.10, "Deliberate Misconduct," a copy of which is enclosed as Enclosure 1) allow enforcement actions to be issued directly against unlicensed persons who engage in deliberate misconduct that causes a licensee to be in violation of any NRC requirement and who provide information to an NRC licensee that the person knows to be incomplete or inaccurate in some respect material to the NRC. For example, an order may be issued to prohibit an individual from engaging in all NRC-licensed activities. A violation of this regulation may also lead to criminal prosecution.

Although the NRC has taken enforcement action against CTI (a copy is provided as Enclosure 2) based on its responsibility as a licensee of the NRC, your actions clearly were unacceptable because they placed the licensee, CTI, in violation of regulatory requirements and subjected CTI to an enforcement action. While the NRC has decided not to take enforcement action against you at this time, you are on notice that willful violations on your part in the future may result in significant action against you. You are not required to respond to this letter but if you desire to respond, please mail your response within 30 days of the date of this letter to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011.

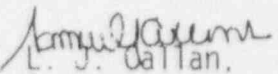
In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, records or documents compiled for enforcement purposes are placed in the NRC Public Document Room (PDR). A copy of this letter with your address removed, and your response if any, will be

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placed in the PDR. A copy also will be forwarded to the addressees identified below, in the distribution.

Sincerely,


L. J. Gallan,
Regional Administrator

Enclosures:

1. 10 CFR 30.10, "Deliberate Misconduct"
2. Notice of Violation and Proposed
Imposition of Civil Penalties Issued to CTI

cc w/o Enclosures:

CTI Alaska, Inc.
Mr. George Haugen, President
4831 Old Seward Highway, Suite 107
Anchorage, Alaska 99503

Alaska Radiation Control Program Director

American Society for Nondestructive Testing, Inc.
ATTN: Technical Services Manager
1711 Arlingate Lane
P.O. Box 28518
Columbus, OH 43228-0518

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