

Summary of Licensee's Request for Mitigation

The Licensee, in its response disagrees with the NRC statement in the October 17, 1994 letter that the Licensee's corrective actions were not sufficiently prompt and comprehensive to warrant any mitigation of the penalty. The Licensee indicates that the NRC failed to recognize very significant additional actions that had already been taken by the time of the Enforcement Conference. The licensee details the corrective actions, which include the establishment of additional management oversight and monitoring controls. In addition, the Licensee maintains that the measures taken were effective, timely, comprehensive, and pro-active, and demonstrated a serious commitment to a quality and effective radiation safety program.

NRC Evaluation of Licensee's Request for Mitigation

The NRC letter, dated October 17, 1994, transmitting the civil penalty, notes that no credit was provided for the Licensee's corrective actions. As a result, a penalty of \$6,250 was proposed. Upon reconsideration and evaluation of the licensee's corrective actions, after receipt of the Licensee's November 14, 1994 and January 17, 1995 responses, the NRC agrees that the actions taken subsequent to the inspection were prompt and comprehensive and that the full mitigation allowable based on corrective action should be applied. Therefore, 50% mitigation of the base civil penalty amount is being applied in this case based on the corrective actions, which reduces the civil penalty amount by \$1,250. The Licensee did not provide any basis for any further mitigation of the penalty. Accordingly, no further adjustment is warranted.

NRC Conclusion

The NRC has concluded that the violations occurred as stated in the Notice, although an example of Violation B should be withdrawn, as described herein. In addition, the NRC has concluded that the Licensee provided an adequate basis for reduction of the civil penalty based on its corrective actions. Accordingly, a civil penalty in the amount of \$5,000 should be imposed.

[FR Doc. 95-3878 Filed 2-15-95; 8:45 am]
BILLING CODE 7590-01-M

[Docket No. 030-12279, License No. 45-17151-01 EA 95-003]

Order Modifying License

In the Matter of Material Testing Laboratories, Inc.

I

Material Testing Laboratories, Inc. (Licensee) is the holder of Byproduct Material License No. 45-17151-01 (License) issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR parts 30 and 34. The License authorizes, in part, possession and use of byproduct

material not to exceed 200 curies of Iridium-192 per source in the operation of radiography exposure devices. The License further authorizes the Licensee to perform radiography at temporary job sites in accordance with the conditions specified therein. The License, originally issued on March 17, 1977, was renewed on December 16, 1993, and is due to expire on December 1, 1998.

II

On November 15, 1994, an inspection of NRC-licensed activities was conducted at a temporary job site in Northern Virginia and at the Licensee's office in Norfolk, Virginia. As a result of the inspection, apparent violations of NRC requirements were identified, which are the subject of a Notice of Violation and Proposed Imposition of Civil Penalty issued this date. The violations identified during the NRC inspection include:

1. Use of NRC-licensed material by an unauthorized and unqualified individual, in violation of 10 CFR 34.31(b);
2. Failure to maintain direct surveillance of radiographic operations by an authorized and qualified individual, in violation of 10 CFR 34.41;
3. Failure to perform an adequate survey following a radiographic exposure, in violation of 34.43(b);
4. Failure to post a high radiation area, in violation of 10 CFR 34.42; and
5. Failure to post the Licensee's radiography vehicle as a radioactive material storage area at a temporary job site, in violation of Condition 20 A. of the License.

A transcribed enforcement conference was conducted in the NRC Region II office in Atlanta, Georgia, on December 20, 1994, to discuss the violations, their cause, and the Licensee's corrective actions. During the enforcement conference, the Licensee acknowledged that weaknesses in management and in Radiation Safety Officer oversight of the Lorton, Virginia, field office activities contributed to the violations. These weaknesses included a lack of appreciation by management and the Radiation Safety Officer (RSO) of the effect of excessive overtime work on employees' performance and failure to promptly monitor work practices of the radiographer involved in the November 15, 1994, violations following the indications of his poor performance by a State of Maryland inspection which identified a failure to maintain a radiography exposure device under constant surveillance and control.

III

Based on the above, the NRC has concluded that the Licensee has violated NRC requirements. The performance of NRC-licensed activities requires use of appropriate safety procedures, training of personnel regarding those procedures, meticulous attention to detail by personnel conducting radiography, and proper oversight by Licensee management to ensure these activities are conducted safely and in accordance with NRC requirements. This attention is particularly important during the performance of radiography given the high radiation levels that can result from use of the sources. The failure to properly control the use of the radiography devices could result in significant radiation exposure to individuals, both employees and members of the general public. The radiographer who had primary responsibility for use and control of NRC-licensed material at the temporary job site failed to maintain proper control and surveillance during radiographic operations. The radiographer, as noted above, one month earlier also failed to maintain constant surveillance and control of a radiography exposure device in the State of Maryland. In addition, based on the violations and weaknesses identified above and information and statements obtained during the transcribed enforcement conference, the RSO, who has the responsibility for ensuring that NRC requirements are met, had not adequately controlled or maintained oversight of the Licensee's NRC-licensed activities in the Northern Virginia area to ensure compliance with all NRC requirements including the conditions of the License.

The violations described in Section II of this Order and the concerns set forth above demonstrate a significant lack of attention to required radiation safety requirements by the radiographer and lack of management control and oversight of radiographic operations by the RSO and Licensee management. Specifically, after the incident in Maryland, the RSO did not identify the root causes of the violations, the RSO did not perform a field audit of the radiographer's performance, and the retraining of the involved radiographer was not sufficient to prevent the November 15, 1994 incident which had similar violations. Consequently, I lack the requisite reasonable assurance that the Licensee's current operations can be conducted under License no. 45-17151-01 in compliance with the Commission's requirements and that the