test program have the ability to detect leaks smaller than would be detected by the Type A test.

For a two-ply bellows that leaks through both plies, this revised exemption allows: (1) A valid Type B test using one of various developed alternatives to ensure compliance to license limits, or (2) a Type A test as required in the original exemption and, before the return to power in a subsequent refuel outage, replacement of the bellows with a testable bellows assembly or a valid Type B test to ensure license limits are met.

The staff finds that the underlying purpose of the regulation will be met in that the proposed testing program will detect bellows assemblies with significant flaws and result in replacement of flawed assemblies within one operating cycle, or be tested with a Type B test to ensure license limits are met during which period there is reasonable assurance that the bellows assemblies will not suffer excessive degradation. If the licensee should propose to wait longer than one cycle to replace any bellows assembly, the staff must evaluate and approve the request at that time.

IV

Accordingly, the Commission has determined that, pursuant to 10 CFR 50.12(a)(i) and (a)(2)(ii), that (1) the Exemption from appendix J is authorized by law, will not present an undue risk to the public health and safety, and is consistent with the common defense and security, and (2) application of the regulation in this particular circumstance is not necessary to achieve the underlying purpose of its rule.

The Commission concludes that the testing and replacement program for the containment penetration bellows assemblies is an acceptable alternative to the existing appendix J testing requirement. Accordingly, the Commission hereby grants the Exemption from appendix J.

Pursuant to 10 CFR 51.32, the Commission has determined that the granting of this Exemption will have no significant impact on the quality of the human environment (59 FR 64001).

This exemption is effective upon issuance.

Dated at Rockville, Maryland this 9th day of February 1995.

For the Nuclear Regulatory Commission.

Jack W. Roe,

Director, Division of Reactor Projects III/IV, Office of Nuclear Reactor Regulation.

[FR Doc. 95–3879 Filed 2–15–95; 8:45 am]

BILLING CODE 7590–01–M

[Docket No. 50–213]

Connecticut Yankee Atomic Power Co.; Notice of Issuance of Amendment To Facility Operating License

The U.S. Nuclear Regulatory Commission (Commission) has issued Amendment No. 180 to Facility Operating License No. DPR–61 issued to the Connecticut Yankee Atomic Power Company (the licensee), which revised the Technical Specifications for operation of the Haddam Neck Plant located in Middlesex County, Connecticut. The amendment is effective as of the date of issuance to be implemented within 30 days of issuance.

The amendment revises Technical Specifications (TS) 3.1.1.3, ''Shutdown Margin,'' and TS 3.3.3.9. ''Boron Dilution Alarm,'' and their associated Bases sections and add a new TS 3.1.1.4, ''Shutdown Margin.'' TSs 3.1.2.2, 3.1.2.4, and 3.1.2.6, will be revised to reference TS 3.1.1.3 rather than specify the required shutdown margin at 200 ° F. In addition, editorial changes will be made to a reference on TS pages 3/4 1–13 and 14 to reletter surveillance specification 4.5.1.c.3 to 4.5.1.b.3.

The application for the amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

Notice of Consideration of Issuance of Amendment and Opportunity for Hearing in connection with this action was published in the **Federal Register** on September 28, 1994 (59 FR 49454). No request for a hearing or petition for leave to intervene was filed following the notice.

The Commission has prepared an Environmental Assessment related to the action and has determined not to prepare an environmental impact statement. Based upon the environmental assessment, the Commission has concluded that the issuance of the amendment will not have a significant effect on the quality of the human environment (60 FR 7799).

For further details with respect to the action see (1) the application for amendment dated September 7, 1994, (2) Amendment No. 180 to License No. DPR–61, (3) the Commission's related Safety Evaluation, and (4) the Commission's Environmental Assessment. All of these items are available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street NW., Washington, DC, and at the local public document room located at the Russell Library, 123 Broad Street, Middletown, Connecticut 06457.

Dated at Rockville, Maryland, this 9th day of February 1995.

For the Nuclear Regulatory Commission.

Alan B. Wang,

Project Manager, Project Directorate I–4, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 95–3874 Filed 2–15–95; 8:45 am]

BILLING CODE 7590–01–M

[Docket No. 030–15139; License No. 37–04594–11; EA No. 94–167]

Drexel University, Philadelphia, Pennsylvania; Order Imposing a Civil Monetary Penalty

I

Drexel University (Licensee) is the holder of Byproduct Materials License No. 37–04594–11 (License) issued by the Nuclear Regulatory Commission (NRC or Commission) on October 31, 1979. The License authorizes the Licensee to possess and use certain byproduct materials in accordance with the conditions specified therein at its facility in Philadelphia, Pennsylvania.

II

An inspection of the Licensee's activities was conducted on July 22, July 27, and August 1, 1994, at the Licensee's facility located in Philadelphia, Pennsylvania. The result 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 October 17, 1994. The Notice states the nature of the violations, the provisions of the NRC requirements that the Licensee had violated, and the amount of the civil penalty proposed for the violations.

The Licensee responded to the Notice in two letters, both dated November 14, 1994, and a letter dated January 17, 1995. In its responses, the Licensee denies Violations A.2 and A.6; denies in part Violation B; admits Violations A.1, A.3, A.4, A.5, C, D, and E; disagrees with the classification of the violations collectively at Severity Level III; and requests mitigation of the penalty.

III

After consideration of the Licensee's response and the statements of fact,

explanation, and argument contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that: (1) Violation B should be modified to withdraw one of the examples; (2) the remaining violations occurred as stated in the Notice; (3) the violations were appropriately classified collectively at Severity Level III; (4) partial mitigation of the penalty should be allowed based on the Licensee's corrective actions; and (5) a penalty of $5,000 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 $5,000 within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852–2738.

V

The Licensee may request a hearing within 30 days of the date of this Order. A request for a hearing should be clearly marked as a ''Request for an Enforcement Hearing'' and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, with a copy to the Commission's Document Control Desk, Washington, DC 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, PA 19406.

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, 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:

(a) Whether the Licensee was in violation of the Commission's requirements as set forth in Violations A.2 and A.6 of the Notice referenced in Section II above, and Violation B as amended in the Appendix to this Order; and

(b) Whether on the basis of such violations, and the additional violations set forth in the Notice of Violations that the Licensee admitted, this Order should be sustained.

Dated at Rockville, Maryland this 8th day of February 1995.

For the Nuclear Regulatory Commission.

Hugh L. Thompson, Jr.,

Deputy Executive Director for Nuclear Materials Safety, Safeguards and Operations Support.

Appendix—Evaluations and Conclusion

On October 17, 1994, a Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was issued for violations identified during an NRC inspection. Drexel University (Licensee) responded to the Notice in two letters, both dated November 14, 1994, and a letter dated January 17, 1995. In its responses, the Licensee denies Violations A.2 and A.6; denies in part Violation B; admits the remaining violations (A.1, A.3, A.4, A.5, C, D, and E); disagrees with the classification of the violations collectively as a Severity Level III Problem; and requests mitigation of the penalty. The NRC's evaluation and conclusion regarding the Licensee's requests are as follows:

Restatement of Violation A.2

Condition 21 of License No. 37–04594–11 requires that licensed material be possessed and used in accordance with the statements, representations, and procedures contained in the Licensee's application dated April 1, 1991.

Item 10.4.1(d) of the application requires that students, laboratory technicians and physical plant workmen including housekeeping and security, all receive formal training workshops concerning laboratory hazards including radioactive material.

Contrary to the above, from January 1992 to August 1994, certain personnel working in restricted areas, including students, laboratory technicians and physical plant workmen (housekeeping and security), did not receive formal training workshops concerning laboratory hazards including radioactive material. Specifically, formal training workshops were not held for housekeeping, even though housekeeping staff entered restricted areas. In addition, training sessions held for graduate students were inadequate in that several students interviewed were not aware of appropriate procedures for using survey instruments or for cleaning up contamination. In addition, the Assistant Radiation Safety Officer (RSO) was not aware of the meaning of radioactive labels on radioactive materials packages which he is required to survey.

Summary of Licensee's Response to Violation A.2

The Licensee denies violation A.2, stating that training is held for students and staff who use radioactive materials (RAM), and that training takes the form of both formal instruction, as well as one-on-one between faculty and student. The licensee also states that if the students join a laboratory at random times during the year, the students receive instructions and training on the requisite laboratory hazards, and training records are maintained. The Licensee does not challenge the inspector's finding that isolated incidents may have been uncovered revealing possible incomplete knowledge on the part of a student. However, the Licensee contends that this does not represent a failure to provide radiation safety training to the staff.

The Licensee also states that the NRC was informed, at the time of the enforcement conference on September 9, 1994, that neither housekeeping staff nor physical plant workmen are permitted to enter restricted areas unescorted. The licensee further indicates that the laboratories are locked when unoccupied and are removed from the building master key system, thereby requiring escorted entry if that should become necessary. The Licensee notes that it confirmed with the manager of the housekeeping staff that the staff are given explicit instructions that they do not have unescorted access, and when escorted, they are not to handle any trash or other containers labeled with signs or other indications of hazardous materials. The Licensee states that there is no evidence that housekeeping staff or other workmen untrained in radiation safety entered restricted areas unescorted.

The Licensee further states that at the enforcement conference on September 9, 1994, the University representative informed the NRC that a new Assistant Radiation Safety Officer (ARSO), with appropriate technical background, had been appointed. Furthermore, arrangements had already been made for the new ARSO to receive a week of full-time training and education on the fundamentals in an accredited short course on radiation safety at the end of September, and that the ARSO is receiving additional on-campus training through a graduate course given by a certified health physicist.

NRC Evaluation of Licensee's Response to Violation A.2

The Licensee's training program as described in Section 10.4.1(d) (''Instructions for personnel working in restricted areas'') of its License application, requires that students, laboratory technicians and physical plant workmen, including housekeeping and security, all receive formal training workshops concerning laboratory hazards including radioactive materials. The Licensee's application does not identify any exceptions concerning whether an individual is escorted or not. The inspector questioned several students and found that the students did not know how to use a survey meter or what to do in the event of a spill or accident. In fact, the RSO stated to the inspector that no formal training had been provided to housekeeping and security staffs from January 1992 to August 1994. In addition, the inspector learned that ARSO had not been instructed on the meaning of various radioactive package labels.

These findings indicate that adequate training was not provided to some of the Licensee's staff. Some of the identified examples involved users of phosphorus-32, which, if mishandled, could result in a

significant contamination event. Although the Licensee may have conducted some training, the Licensee: (1) did not assure adequate training of all individuals covered by Item 10.4.1(d) of the license application as referenced in License Condition 21; and (2) did not verify that those who were trained understood the training that had been provided. Therefore, the NRC maintains that the violation occurred as stated in the Notice.

Restatement of Violation A.6

Condition 21 of License No. 37–04594–11 requires that licensed material be possessed and used in accordance with the statements, representations, and procedures contained in the Licensee's application dated April 1, 1991.

Item 10.3.1(j) requires that the RSO conduct periodic reviews of the terms and conditions of the license to ensure compliance with requirements.

Contrary to the above, between January 1992 and July 1994, the RSO did not conduct periodic reviews of the terms and conditions of the license, as evidenced by the fact that the RSO was unaware of the requirements specified in the licensee's application dated April 1, 1991.

Summary of Licensee's Response to Violation A.6

The Licensee denies the violation and indicates that there were differences of interpretation between the RSO and NRC, and that those differences arose as a result of the process of the Licensee proposing procedures in amendment applications and the NRC formally incorporating those procedures into the license by amendment. The Licensee also states that the RSO and RSC have thoroughly reviewed the license, including the basic document and all letters of additional commitments. The Licensee indicates that, based upon its review and discussion with the NRC Regional Office, it is the Licensee's intent to apply for modifications to the license which will meet the Licensee's actual and limited need. The Licensee also states that upon satisfactory resolution of the current issues with the NRC, it expects to request modification to a more limited license and to delete some of the current commitments which are not reasonable for the circumstances of this Licensee's use of radioactive materials.

NRC Evaluation of Licensee's Response to Violation A.6

License Condition 21 requires that licensed material be possessed and used in accordance with the statements, representations, and procedures contained in certain specified applications and letters submitted by the Licensee. The requirement is clear and leaves no room for differences of interpretation. As required by License Condition 21, application dated April 1, 1991, Item 10.3.1(j), the RSO is required to conduct periodic reviews of the terms and conditions of the license to ensure compliance with requirements.

Although the Licensee describes certain actions taken by the RSO and RSC in reviewing the license, it appears that the Licensee is referring to actions taken subsequent to the inspection. As documented in the inspection report, the RSO was not aware of the requirements for leak testing and physical inventory of sealed sources, and was unfamiliar with area survey requirements for authorized users, all of which are required by conditions of the license. Therefore, the NRC concludes that the violation occurred as stated in the Notice.

Restatement of Violation B

Condition 14 of the license requires that sealed sources and detector cells not in storage and containing greater than 100 microcuries of gamma emitting radioactive material be tested for leakage and/or contamination at intervals not to exceed 6 months or at such other intervals as are specified by the certificate of registration referred to in 10 CFR 32.210.

Contrary to the above, sealed sources and detector cells not in storage and containing greater than 100 microcuries of gamma emitting radioactive material were not tested for leakage and/or contamination at intervals not to exceed 6 months and no other intervals were specified by the certificate of registration referred to in 10 CFR 32.210. Specifically, a cesium-137 and cobalt-60 source with activities greater than 100 microcuries of gamma emitting radioactive material per source and in use by the licensee, were not tested for leakage and/or contamination during the period August 1991 to August 1994, an interval in excess of six months.

Summary of Licensee's Response to Violation B

The Licensee states that the only sealed source not in storage and requiring leak testing at the time of the NRC inspection was a 1.06 mCi cesium-137 source used once or twice a year in the Physics and Atmospheric Sciences Department. The Licensee also states that the cobalt-60 source, having decayed to 64 μCi, does not require leak testing and, for more than three years, has not required it. In addition, the Licensee notes that subsequent to the NRC inspection, the Cs-137 source was assayed on September 14, 1994, and again in October 1994 and leak tested with no evidence of any leakage found.

NRC Evaluation of Licensee's Response to Violation B

Since the Licensee acknowledges that leak-testing did not occur with respect to the cesium-137 source, the NRC concludes that this aspect of the violation occurred as stated in the Notice. Based on the additional information which has now been provided by the Licensee, but which was unavailable at the time of the inspection, the aspect of the violation regarding the cobalt-60 source is hereby withdrawn. The withdrawal of one example of a violation does not change the fact that the violation occurred, nor does it change the amount of the civil penalty assessed for the violations in this case.

Summary of Licensee's Response Regarding Severity Level

The Licensee states that it does not concur with the NRC classification of the violations collectively as a Severity Level III Problem, contending that in a number of instances, the NRC extrapolated a single, or even several replications of the identical, adverse findings among many activities and personnel, to suggest widespread disregard for either its radiation safety program or its responsibility in its oversight and management. The Licensee contends that it takes the protection of public health and safety as a serious responsibility, and to suggest otherwise from the violations cited by the NRC is a significant inaccuracy.

The Licensee also states that it finds it disturbing that the October 17, 1994, letter transmitting the civil penalty suggests that the NRC had an expectation that the corrective actions were to be completed prior to the enforcement conference, and not having them completed was a factor in classifying the violations at Severity Level III.

The Licensee further states that since the 1991 inspection, those involved at the time in the Radiation Safety Program leadership and management are no longer with the Licensee and significant change has taken place. The Licensee also states that the Provost and Senior Vice President for Academic Affairs, Senior Vice President for Administration and Finance, Vice Provost for Research and Graduate Studies, Radiation Safety Officer, and the New Chief Executive Officer of the University are all very seriously committed to a Radiation Safety Program which is in complete accord with NRC requirements.

NRC Evaluation of the Licensee's Response Regarding Severity Level

The violations identified during the 1994 inspection indicated a lack of management attention to the radiation safety program, as described in the October 17, 1994 letter transmitting the Notice. This NRC determination of a lack of adequate management attention was based on the fact that ten violations of NRC requirements were identified and cited, and more importantly, five of those violations were repetitive. If appropriate management attention had been provided, appropriate corrective actions would have been taken after the previous NRC findings in 1991, and these violations would not have recurred, or would have been promptly identified and corrected by current management. That did not happen. Rather, the violations were identified by the NRC.

The NRC did not suggest, in its letter, that there was widespread disregard for the program. If that had been the case, the NRC would have proposed a more severe sanction. However, given the number of violations, the repetitive nature of some of them, and the fact that the violations would have been identified by the RSO or RSC if adequate management attention was provided to the program, the NRC concludes that the violations were appropriately categorized collectively at Severity Level III.

The Licensee has confused the failure to take lasting corrective action to prevent the recurrence of the violations identified during the 1991 inspection with the issue of corrective actions for the violations identified during the July 1994 inspection. The latter issue was not a basis for considering the 1994 violations collectively as a Severity Level III problem; however, it was considered in determining the amount of the civil penalty for this Severity level III problem.

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 ROS 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