

September 24, 2008

EA-08-255

EA-08-256

City Design Group, Inc.
Mr. Bernard Simington
President
115 Branch Street
St. Louis, MO 63147

SUBJECT: NRC ROUTINE INSPECTION REPORT 030-36218/2008-001(DNMS) -
CITY DESIGN GROUP, INC

Dear Mr. Simington:

This refers to the routine inspection conducted on August 13 and 14, 2008, at your St. Louis, Missouri facility. The purpose of this inspection was to examine activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions in your license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel. The enclosed report presents the results of this inspection, which were discussed during an exit meeting at your facility on August 14, 2008, and during a final exit telephone conference on August 25, 2008. During the August 25, 2008, teleconference we discussed your corrective actions that were completed subsequent to our inspection.

Based on the results of this inspection, two apparent violations were identified and are being considered for escalated enforcement action in accordance with 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>). The first apparent violation involved five examples of inadequate oversight of the Radiation Protection Program. The examples included failure to replace the Radiation Safety Officer, the failure to conduct inventory checks, the failure to conduct leak tests, the failure to use personnel monitoring devices, and the failure to maintain a survey meter in accordance with license conditions.

The second apparent violation involved two examples of failing to secure radioactive material. The first example was associated with the requirements in 10 CFR 30.34(i) and involved a failure to use two independent physical controls to form a tangible barrier to secure a gauge in the back of an open-bed pick-up truck. The second example was a failure to prevent unauthorized or accidental removal of the sealed source from the shielded position as required by license conditions. These are described in the enclosed report.

Before the NRC makes its enforcement decision, we are providing you an opportunity to either: (1) respond to the apparent violations addressed in this inspection report within 30 days of the date of this letter; or (2) request a Pre-decisional Enforcement Conference (PEC). If a PEC is held, it will be open for public observation. The NRC will also issue a press release to announce the conference. Please contact Patrick Loudon at (630) 829-9627 within seven 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 a "Response to Apparent Violations in Inspection Report No.030-36218/2008-001; EA-08-255 and 256" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation; (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 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 the enclosed excerpt from NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be helpful. 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: 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 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 the enclosed excerpt from NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be helpful.

In addition, please be advised that the number and characterization of 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 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 made available electronically for public inspection in the NRC Public Document Room or from the NRC's document 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 personnel privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

B. Simington

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If you have any questions concerning this matter, please contact Patrick Loudon of my staff at (630) 829-9627.

Sincerely,

/RA by John R. Madera acting for/

Steven A. Reynolds, Director
Division of Nuclear Materials Safety

Docket No. 030-36218
License No. 24-32442-01

Enclosures:

1. Inspection Report 030-36218/2008-001
2. Excerpt from NRC Information Notice 96-28

cc: State of Missouri

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Letter to Bernard Simington from Steven A. Reynolds dated September 24, 2008.

SUBJECT: NRC ROUTINE INSPECTION REPORT 030-36218/2008-01(DNMS) -
CITY DESIGN GROUP

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REGION III

Docket No. 030-36218

License No. 24-32442-01

Report No: 030-36218/2008-001(DNMS)

Licensee: City Design Group, Inc.

Location Inspected: 115 Branch St.
St. Louis, Missouri

Inspection Date: August 13-14, 2008

Exit Meeting: August 25, 2008

Inspectors: Edward Kulzer, Health Physicist
Darrel Wiedeman, Senior Health Physicist

Approved by: Patrick Loudon, Chief
Materials Inspection Branch

Enclosure

EXECUTIVE SUMMARY

**City Design Group
St. Louis, Missouri
NRC Inspection Report 030-36218/2008-001(DNMS)**

This was a routine inspection initiated on August 13-14, 2008, to review the activities at the St. Louis, Missouri, office and did not include an inspection at a temporary job site because no licensed activities were being conducted on the days of the inspection. The purpose of the inspection was to evaluate the licensee's performance and compliance with NRC regulations and license conditions. The inspectors reviewed several program areas including security, radiation protection, transportation, posting and labeling, and training. The inspectors identified several deficiencies of NRC requirements and concerns regarding the management oversight of the radiation safety program.

During the inspection two apparent violations were identified. The first apparent violation that was identified involved five examples of inadequate oversight of the Radiation Protection Program. The examples included failure to replace the Radiation Safety Officer, the failure to conduct inventory checks, the failure to conduct leak tests, the failure to use personnel monitoring devices, and the failure to maintain a survey meter in accordance with license conditions.

The second apparent violation involved two examples of failing to secure radioactive material. The first example was associated with the requirements in 10 CFR 30.34(i) and involved a failure to use two independent physical controls to form a tangible barrier to secure a gauge in the back of an open-bed pick-up truck. The second example was a failure to prevent unauthorized or accidental removal of the sealed source from the shielded position as required by license conditions. These are described in the enclosed report.

The root cause of the apparent violations was inadequate management oversight of the radiation safety program. A contributing cause was the licensee management was unaware of the requirements in their license.

At the time of the inspection the licensee took immediate corrective actions for the above referenced apparent violations. These corrective actions included: (1) amending the license to name a new Radiation Safety Officer; (2) contacting the gauge manufacturer and arrange for immediate leak tests; (3) documenting on the licensee's maintenance schedule, the dates of the future 6-month inventories; (4) purchasing pad locks for the gauge cases; (5) promptly securing the gauges from unauthorized access, and discussions with gauge users concerning gauge security and transportation requirements; and (6) arranging for dosimetry and a survey instrument.

Report Details

1 Program Scope and Inspection History

City Design Group, Inc. (licensee) is a private construction, engineering, and environmental consulting firm employing five individuals. The company operates out of a single office located in St. Louis, Missouri. Collectively, the company possessed five portable moisture/density gauges that were used for measuring the properties of construction materials at various temporary job sites. The licensee approved three individuals as authorized gauge users.

The NRC last inspected the licensee's activities on July 24, 2003, with no violations identified.

2 Management Oversight and Duties of the Radiation Safety Officer

2.1 Inspection Scope

The inspectors reviewed the licensee's management of the radiation safety program. The inspectors interviewed the company president, a director of marketing, and a gauge user. On August 13, 2008, the inspectors attempted to contact the Radiation Safety Officer (RSO) listed on the license to review selected records, observe gauges storage and review transportation issues, and interview selected licensee staff.

2.2 Observations and Findings

Upon arriving at the facility, the inspectors were informed that the former Radiation Safety Officer left the company over two and one half years ago. The inspectors were told that the company president was now in charge of the program and he was not in the office. Previously the RSO reported directly to the president. The previous RSO was based at the St. Louis, Missouri office and was responsible for implementing the entire radiation safety program.

The inspectors noted that when the former RSO left the company the licensee failed to amend their license to reflect a change of RSO. This is an apparent violation of License Condition No. 12 of NRC License No. 24-32442-01. The root cause of this violation was the fact that the president was not aware that the license must be amended when a change of RSO occurs.

License Condition 21.A. of License No. 24-32442-01 (tie down) references the license application dated December 18, 2002. The attachment entitled, "RADIATION SAFETY PROGRAM" Item 1, "Radiation Safety Officer," specifies the duties and responsibilities of the Radiation Safety Officer. The duties of the Radiation Safety Officer included, in part: (1) to assure that all terms and conditions of the license are being adhered to and that the information contained in the license is current and accurate; (2) to verify that the equipment (portable gauges) has been leak tested in the required time frame; (3) to assure that the use of the equipment (portable gauges) is only by individuals who wear personnel monitoring equipment when utilizing the equipment; (4) to see that the equipment is properly secured against unauthorized removal at all times when not in use; (5) to perform an annual audit, documenting license activities and making corrective

actions if necessary; and (6) to develop, implement and document corrective actions when violations of regulations or weaknesses of the program are identified.

The inspectors identified deficiencies in the licensee's radiation safety program which occurred after the former RSO left the company. The above referenced duties were not being completed when the former RSO left the company. The extent of inspection findings and number of apparent violations identified during this inspection indicated that the current RSO failed to provide oversight of the radiation safety program in that he failed to perform his duties as described in the licensee's application dated December 18, 2002, and referenced in License Condition 21.A.

2.2 Conclusions

The inspectors identified deficiencies associated with RSO's responsibility for providing oversight of the radiation safety program. One apparent violation of License Condition No. 12 was identified. The licensee's corrective action for this apparent violation was to amend the license requesting a replacement for Radiation Safety Officer.

3 **Security of Licensed Material**

3.1 Inspection Scope

The inspectors toured the gauge storage location at the St. Louis, Missouri, facility. The inspectors interviewed selected staff to evaluate how the licensee secured licensed material from unauthorized access.

3.2 Observations and Findings

The gauge units were stored within a locked storage room inside the laboratory at the St. Louis, Missouri office. The laboratory is also locked when not attended by licensee staff. According to the licensee's practices, each unit was stored within its approved transport container. Authorized gauge users were issued the keys to the gauges and keys to the gauge storage room. The inspectors determined that the licensee's office facilities observed during this inspection were the same as those described in the licensee's NRC license application. Gauges used locally were also required to be returned to the office upon completion of the shift.

During the inspection on August 13, 2008, the inspectors observed that five portable gauges were stored in a locked storage room at the licensee's locked laboratory. The inspectors noted that all five portable gauge transport cases were unlocked containing a gauge with the gauge operating handle (source rod) which was also unlocked.

When not in use at a temporary job site, the gauges are stored in the rear of the licensee's open-bed pick up truck. The inspectors observed that a gauge was stored within the transport case with a lock securing the transport case. The inspectors observed that the gauge was secured in the back of an open bed pick-up secured with a single chain and lock.

Title 10 CFR 30.34(i) requires that each portable gauge licensee use a minimum of two independent physical controls that form tangible barriers to secure portable gauges from unauthorized removal, whenever portable gauges are not under the control and constant

surveillance of the licensee. In addition, Condition 18 of License Number 24-32442-01 requires, in part, that each portable gauge or its container must be locked when in transport, storage, or when not under the direct surveillance of an authorized user.

The licensee's failure to use a minimum of two independent controls that form tangible barriers to secure portable gauge from unauthorized removal, when the portable gauge was not under the control and constant surveillance of the licensee is an apparent violation of 10 CFR 30.34(i). The licensee's failure to lock a portable gauge or its container when in storage at the St. Louis office is an apparent violation of License Condition No.18.

3.3 Conclusions

The inspectors identified one apparent violation associated with the licensee's failure to use two independent physical controls that form tangible barriers to secure its portable gauges from unauthorized removal. The inspectors also identified an apparent violation associated with the licensee's failure to ensure that gauges or the containers stored within the St. Louis facility were locked.

4 Physical Inventory and Leak Testing of Sealed Sources

4.1 Inspection Scope

The inspectors reviewed records of sealed source leak tests and inventory records and interviewed the RSO and selected licensee staff.

4.2 Observations and Findings

According to the licensee's records, the most current leak tests on the gauges were conducted on May 18, 2007. Condition No. 14 A. of NRC License No. 24-32442-01 requires that sealed sources be tested for leakage and/or contamination at intervals not to exceed the intervals specified in the certificate of registration issued by NRC under 10 CFR 32.210. The certificate of registration for the gauges possessed by the licensee specifies leak testing at six month intervals. Discussions concerning sealed source leak tests revealed that the acting RSO failed to collect leak tests samples on five gauges in November 2007 and May 2008.

Condition 16 of NRC License No. 24-32442-01 requires the licensee to conduct a physical inventory every six months, or at other intervals approved by the NRC to account for all sources and/or devices received and possessed under the license. Physical inventories of the gauges had not been documented since the previous routine inspection in 2003.

The licensee's failure to perform sealed source leak tests and physical inventories at the required frequencies are apparent violations of License Conditions 14(a) and 16.

4.3 Conclusions

Two apparent violations of NRC requirements were identified regarding the licensee's failures to perform leak tests and physical inventory of its portable gauges at six month intervals.

5 Personnel Monitoring

5.1 Inspection Scope

The inspectors interviewed the president and acting RSO, and selected licensee personnel.

5.2 Observations and Findings

Condition 21.A. of License No. 24-32442-01, requires the licensee to conduct its program in accordance with the statements, representations and procedures contained in application dated December 18, 2002. The licensee's application dated December 18, 2002, requires, in part, that the licensee will provide dosimetry to its employees who use moisture/density gauges and that the dosimetry processed and evaluated by a NAVLAP-approved processor.

During the August 13-14, 2008, inspection the licensee's president and acting RSO indicated that apparently some time after the former RSO left the company two and a half years ago, dosimetry was discontinued. The licensee's failure to provide dosimetry badges is an apparent violation of License Condition No. 21.A.

5.3 Conclusions

The inspectors concluded that the licensee failed to provide personnel monitoring to gauge users which is an apparent violation of License Condition No. 21.A.

6 Exit Meeting Summary

The inspectors discussed the preliminary conclusions with licensee management during the exit meeting conducted at the licensee's facilities on August 14, 2008, and during an August 25, 2008, teleconference. The licensee did not identify any information reviewed during the inspection and proposed for inclusion in the inspection report as proprietary in nature.

PARTIAL LIST OF PERSONNEL CONTACTED

*Bernard Simington, President
William Gay, Director of Marketing

* attended the exit meeting on August 25, 2008