



**Docket File Information**

**SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION**

1. LICENSEE/LOCATION INSPECTED:  ATC Group Services, Inc. d/b/a Cardno ATC 7988 Centerpoint Drive, Suite 100 Indianapolis, IN 46256  REPORT NUMBER(S) 2015-001	2. NRC/REGIONAL OFFICE  Region III U. S. Nuclear Regulatory Commission 2443 Warrenville Road, Suite 210 Lisle, IL 60532-4352
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3. DOCKET NUMBER(S)  030-13245	4. LICENSE NUMBER(S)  13-17732-01	5. DATE(S) OF INSPECTION  March 31, 2015
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6. INSPECTION PROCEDURES USED  87124	7. INSPECTION FOCUS AREAS  1, 3, 6, 7
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**SUPPLEMENTAL INSPECTION INFORMATION**

1. PROGRAM CODE(S)  03121	2. PRIORITY  5	3. LICENSEE CONTACT  Russ Bennett - RSO	4. TELEPHONE NUMBER  (317) 849-4990
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Main Office Inspection      Next Inspection Date:           No change          

Field Office Inspection      \_\_\_\_\_

Temporary Job Site Inspection      \_\_\_\_\_

**PROGRAM SCOPE**

This was an escalated enforcement follow-up inspection of a geotechnical engineering company authorized to possess and use portable moisture density gauges at various locations in Indiana and at temporary job sites within NRC jurisdiction. The purpose of this inspection was to verify completion and assess the effectiveness of corrective actions taken to address the potential for recurrence of a violation similar to the one identified during an NRC inspection on December 4, 2013. The licensee was cited for the failure to control and maintain constant surveillance of a portable gauge that a company employee had left locked in the back of an open-bed truck with the truck door unlocked and the keys in the ignition. The truck was promptly stolen, along with the gauge.

**PERFORMANCE OBSERVATIONS**

The inspector reviewed the licensee's initial and refresher training materials for gauge operators and the Driver Code of Conduct to verify that the licensee's training program had been maintained and implemented as described in the statement of corrective actions dated October 14, 2014. The inspector interviewed two of the company's eight gauge operators to confirm that the licensee had sent them a memo regarding the November 2013 incident and the Driver Code of Conduct, and that the licensee had also disseminated information regarding the incident during previous safety meetings. The inspector also confirmed that, as stated in their corrective actions, the licensee had voluntarily terminated the employee responsible for the incident. The licensee indicated that no additional incidents involving unsecured material had occurred since November 2013. However, at the time of the inspection, the stolen gauge had yet to be recovered.

The inspector identified no additional examples of the previously cited violation, and furthermore determined that the licensee implemented adequate corrective actions to address the recurrence of a similar violation. Therefore, the NRC considers the violation to be closed, pending payment of the civil penalty assessed in the final action dated March 30, 2015.

No other violations of NRC requirements were identified as a result of this inspection.