March 11, 1997

EA 97-093

Professional Service Industries, Inc.
ATTN: Mr. Michael Kesselmayer, P. E.
Administrative Coordinator
510 East 22nd Street
Lombard, Illinois 60148

SUBJECT: AUGMENTED INSPECTION TEAM REPORT NO. 45-25088-01/96-01

Dear Mr. Kesselmayer:

The Nuclear Regulatory Commission (NRC) Region II has recently completed its review of the NRC inspection findings documented in Inspection Report No. 45-25088-01/96-01. The report was transmitted to you by letter dated January 21, 1997. The purpose of the review was to determine whether any violations of NRC requirements occurred and covered the data collected from the special inspection conducted during the period November 13 through 21 and December 4, 1996, by the NRC's Augmented Inspection Team (AIT) at your Bristol, Virginia; Ann Arbor, Michigan; Lansing, Michigan; Detroit, Michigan; St. Louis, Missouri; and Roanoke, Virginia facilities.

Based on the results of our review, six apparent violations were identified at your Bristol, Virginia facility and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. Consequently, no Notice of Violation is being issued at this time. The apparent violations are described in the enclosure and were discussed in detail in the subject inspection report. As discussed with you on March 6, 1997, the apparent violations involve multiple failures of Professional Services Industries, Inc. (PSI) to comply with regulatory and license requirements in the area of exposure monitoring, training, and gauge storage/maintenance activities. The apparent violations are of concern because they appear to represent a potential lack of management attention to and oversight of certain licensed activities.

The circumstances surrounding these apparent violations, the significance of the issues, and the need for lasting and effective corrective action were discussed with members of your staff at the inspection exit meeting on December 4, 1996. As a result, it may not be necessary to conduct a predecisional enforcement conference in order to enable the NRC to make an enforcement decision. Before the NRC makes its enforcement decision, we are providing you an opportunity to either: (1) respond to the apparent violations addressed in this letter within 30 days of the date of this letter or (2) request a predecisional enforcement conference. Please contact Thomas R. Decker, Acting Chief, Material Licensing/Inspection Branch 1, at (404) 331-5549, within seven days of the date of this letter to notify the NRC of your intended response.

IE07

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

March 11, 1997

EA 97-093

Professional Service Industries, Inc.
ATTN: Mr. Michael Kesselmayer, P. E.
Administrative Coordinator
510 East 22nd Street
Lombard, Illinois 60148

SUBJECT: AUGMENTED INSPECTION TEAM REPORT NO. 45-25088-01/96-01

Dear Mr. Kesselmayer:

The Nuclear Regulatory Commission (NRC) Region II has recently completed its review of the NRC inspection findings documented in Inspection Report No. 45-25088-01/96-01. The report was transmitted to you by letter dated January 21, 1997. The purpose of the review was to determine whether any violations of NRC requirements occurred and covered the data collected from the special inspection conducted during the period November 13 through 21 and December 4, 1996, by the NRC's Augmented Inspection Team (AIT) at your Bristol, Virginia; Ann Arbor, Michigan; Lansing, Michigan; Detroit, Michigan; St. Louis, Missouri; and Roanoke, Virginia facilities.

Based on the results of our review, six apparent violations were identified at your Bristol, Virginia facility and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. Consequently, no Notice of Violation is being issued at this time. The apparent violations are described in the enclosure and were discussed in detail in the subject inspection report. As discussed with you on March 6, 1997, the apparent violations involve multiple failures of Professional Services Industries, Inc. (PSI) to comply with regulatory and license requirements in the area of exposure monitoring, training, and gauge storage/maintenance activities. The apparent violations are of concern because they appear to represent a potential lack of management attention to and oversight of certain licensed activities.

The circumstances surrounding these apparent violations, the significance of the issues, and the need for lasting and effective corrective action were discussed with members of your staff at the inspection exit meeting on December 4, 1996. As a result, it may not be necessary to conduct a predecisional enforcement conference in order to enable the NRC to make an enforcement decision. Before the NRC makes its enforcement decision, we are providing you an opportunity to either: (1) respond to the apparent violations addressed in this letter within 30 days of the date of this letter or (2) request a predecisional enforcement conference. Please contact Thomas R. Decker, Acting Chief, Material Licensing/Inspection Branch 1, at (404) 331-5549, 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 Related to Inspection Report No. 45-25088-01/96-01" and should include for each apparent violation: (1) the reason for the apparent violation, or, if contested, the basis for disputing the apparent 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 addition to the apparent violations described in the enclosure, other inadequacies in the implementation of your technician training program and adherence to procedures were identified during the AIT inspection at your Bristol, Virginia facility, as well as at several other of your NRC licensed facilities. One of these issues involved the failure to properly secure licensed material at your Detroit, Michigan facility which was the subject of a Severity Level III Notice of Violation issued on February 28, 1997. The AIT also found that management oversight of licensed activities at the branch, district and corporate levels was less than adequate. Specifically, your oversight program failed to identify problems or inadequacies in the implementation of several aspects of your radiation safety program. Consequently, in preparing your written response to the apparent violations, we request that you also provide a description of the actions you have taken or plan to take to address the findings of the AIT with regard to management oversight, technician training, and adherence to procedures from a corporate perspective as it relates to all your NRC-licensed facilities.

In discussing 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 NRC Information Notice 96-28, "SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION," may be helpful. Your response should be submitted under oath or affirmation and 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 requested and granted by the NRC, the NRC will either proceed with its enforcement decision or schedule a predecisional enforcement conference.

Please be advised that the number and characterization of apparent violations 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 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response (if you choose to provide one) will be placed in the NRC Public Document Room (PDR). To the extent possible,

your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

Sincerely,

Bruce S. Mallett

Bruce S. Mallett, Director
Division of Nuclear Materials Safety

Docket No. 030-31566
License No. 45-25088-01

Enclosures: 1. Summary of Issues
2. NRC Information Notice 96-28

cc w/encls:
Commonwealth of Virginia
State of Michigan
State of Missouri

Distribution w/encls:
PUBLIC
LReyes, RII
JLieberman, OE
NMamish, OE
OE:EA File (BSummers, OE) (2 ltrhd)
DCool, NMSS
DFlack, NMSS
CPederson, RIII
CEvans, RII
BUryc, RII
BMallett, RII
CHosey, RII
TDecker, RII
BParker, RII
ABoland, RII

PLACE IN THE PUBLIC DOCUMENT ROOM? (YES) / NO

OFFICE	RII:DNMS	RII:DNMS	RII:EICS	RII:ORA	
SIGNATURE				NLO w/changes	
NAME	TDecker	CHosey	BUryc	CEvans	
DATE	03 / / 97	03 / 7 / 97	03 / 07 / 97	03 / 07 / 97	03 / / 97
COPY?	YES (NO)	(YES) NO	YES (NO)	YES (NO)	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: H:\197open.enf\97093psi.dir\choice.dft

SUMMARY OF ISSUES

The apparent violations summarized below were based on an in-depth review of data collected and conclusions derived from the special inspection conducted during the period November 13 through 21 and December 4, 1996, by the NRC Augmented Inspection Team (AIT) at several of your facilities in Virginia, Michigan, and Missouri. The AIT inspection included a review of the facts and circumstances related to a November 6, 1996, report to the NRC regarding an apparent overexposure at your Bristol, Virginia facility. The AIT results were documented in Inspection Report No. 45-25088-01/96-01.

A. During the period January 1 through November 1, 1996, PSI failed to make surveys to assure compliance with 10 CFR 20, as required by 10 CFR 20.1501. Specifically, a total of 12 film badge dosimeters assigned to individuals for one month periods during the time period specified were lost or misplaced, and PSI failed to evaluate the doses received by the individuals during those periods. [Reference: Inspection Report No. 45-25088-01/96-01, Section 7.6]

B. PSI permitted two technicians to routinely use moisture/density gauges even though they had not successfully completed a manufacturer's training course or PSI's in-house radiation safety training program, as required by License Condition No. 23 and Item 8 of the License application. [Reference: Inspection Report No. 45-25088-01/96-01, Section 4.1]

C. PSI failed to provide a technician with five to six hours of formal classroom radiation safety training by a PSI certified Radiation Safety Office/Instructor, as required by License Condition No. 23 and Item 8 of the License application. [Reference: Inspection Report No. 45-25088-01/96-01, Section 4.1]

D. From approximately August 1 through November 5, 1996, a gauge was stored at a technician's residence for extended periods of time, a location which is specifically prohibited by License Condition No. 23 and Item 9 of the License application. [Reference: Inspection Report No. 45-25088-01/96-01, Sections 3.2 and 5.2]

E. From approximately August 1 through November 5, 1996, a technician performed maintenance on a gauge which included extension of the source rod on numerous occasions. Maintenance or repairs involving removal of the sealed sources from the gauge, removal or extension of the source rod are prohibited by License Condition No. 23 and Item 10 of the License application. [Reference: Inspection Report No. 45-25088-01/96-01, Sections 3.2, 3.3, and 5.2]

F. From approximately April 1 though November 1, 1996, PSI failed to provide or assign personnel dosimetry to a gauge operator (technician) who frequently used a gauge, as required by License Condition No. 23 and Item 11 of the License application. [Reference: Inspection Report No. 45-25088-01/96-01, Section 7.6]

UNITED STATES
NUCLEAR REGULATORY COMMISSION
OFFICE OF NUCLEAR MATERIAL SAFETY AND SAFEGUARDS
WASHINGTON, D.C. 20555

May 1, 1996

NRC INFORMATION NOTICE 96-28: SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION

Addressees

All material and fuel cycle licensees.

Purpose

The U.S. Nuclear Regulatory Commission (NRC) is issuing this information notice to provide addressees with guidance relating to development and implementation of corrective actions that should be considered after identification of violation(s) of NRC requirements. It is expected that recipients will review this information for applicability to their facilities and consider actions, as appropriate, to avoid similar problems. However, suggestions contained in this information notice are not new NRC requirements; therefore, no specific action nor written response is required.

Background

On June 30, 1995, NRC revised its Enforcement Policy (NUREG-1600)[1] 60 FR 34381, to clarify the enforcement program's focus by, in part, emphasizing the importance of identifying problems before events occur, and of taking prompt, comprehensive corrective action when problems are identified. Consistent with the revised Enforcement Policy, NRC encourages and expects identification and prompt, comprehensive correction of violations.

In many cases, licensees who identify and promptly correct non-recurring Severity Level IV violations, without NRC involvement, will not be subject to formal enforcement action. Such violations will be characterized as "non-cited" violations as provided in Section VII.B.1 of the Enforcement Policy. Minor violations are not subject to formal enforcement action. Nevertheless, the root cause(s) of minor violations must be identified and appropriate corrective action must be taken to prevent recurrence.

If violations of more than a minor concern are identified by the NRC during an inspection, licensees will be subject to a Notice of Violation and may need to provide a written response, as required by 10 CFR 2.201, addressing the causes of the violations and corrective actions taken to prevent recurrence. In some cases, minor violations are documented on Form 591 (for materials licensees)

[1]Copies of NUREG-1600 can be obtained by calling the contacts listed at the end of the Information Notice.

which constitutes a notice of violation that requires corrective action but does not require a written response. If a significant violation is involved, a predecisional enforcement conference may be held to discuss those actions. The quality of a licensee's root cause analysis and plans for corrective actions may affect the NRC's decision regarding both the need to hold a predecisional enforcement conference with the licensee and the level of sanction proposed or imposed.

Discussion

Comprehensive corrective action is required for all violations. In most cases, NRC does not propose imposition of a civil penalty where the licensee promptly identifies and comprehensively corrects violations. However, a Severity Level III violation will almost always result in a civil penalty if a licensee does not take prompt and comprehensive corrective actions to address the violation.

It is important for licensees, upon identification of a violation, to take the necessary corrective action to address the noncompliant condition and to prevent recurrence of the violation and the occurrence of similar violations. Prompt comprehensive action to improve safety is not only in the public interest, but is also in the interest of licensees and their employees. In addition, it will lessen the likelihood of receiving a civil penalty. Comprehensive corrective action cannot be developed without a full understanding of the root causes of the violation.

Therefore, to assist licensees, the NRC staff has prepared the following guidance, that may be used for developing and implementing corrective action. Corrective action should be appropriately comprehensive to not only prevent recurrence of the violation at issue, but also to prevent occurrence of similar violations. The guidance should help in focusing corrective actions broadly to the general area of concern rather than narrowly to the specific violations. The actions that need to be taken are dependent on the facts and circumstances of the particular case.

The corrective action process should involve the following three steps:

1. Conduct a complete and thorough review of the circumstances that led to the violation. Typically, such reviews include:

   - Interviews with individuals who are either directly or indirectly involved in the violation, including management personnel and those responsible for training or procedure development/guidance. Particular attention should be paid to lines of communication between supervisors and workers.

- Tours and observations of the area where the violation occurred, particularly when those reviewing the incident do not have day-to-day contact with the operation under review. During the tour, individuals should look for items that may have contributed to the violation as well as those items that may result in future violations. Reenactments (without use of radiation sources, if they were involved in the original incident) may be warranted to better understand what actually occurred.

- Review of programs, procedures, audits, and records that relate directly or indirectly to the violation. The program should be reviewed to ensure that its overall objectives and requirements are clearly stated and implemented. Procedures should be reviewed to determine whether they are complete, logical, understandable, and meet their objectives (i.e., they should ensure compliance with the current requirements). Records should be reviewed to determine whether there is sufficient documentation of necessary tasks to provide an auditable record and to determine whether similar violations have occurred previously. Particular attention should be paid to training and qualification records of individuals involved with the violation.

2. Identify the root cause of the violation.

Corrective action is not comprehensive unless it addresses the root cause(s) of the violation. It is essential, therefore, that the root cause(s) of a violation be identified so that appropriate action can be taken to prevent further noncompliance in this area, as well as other potentially affected areas. Violations typically have direct and indirect cause(s). As each cause is identified, ask what other factors could have contributed to the cause. When it is no longer possible to identify other contributing factors, the root causes probably have been identified. For example, the direct cause of a violation may be a failure to follow procedures; the indirect causes may be inadequate training, lack of attention to detail, and inadequate time to carry out an activity. These factors may have been caused by a lack of staff resources that, in turn, are indicative of lack of management support. Each of these factors must be addressed before corrective action is considered to be comprehensive.

3. Take prompt and comprehensive corrective action that will address the immediate concerns and prevent recurrence of the violation.

   It is important to take immediate corrective action to address the specific findings of the violation. For example, if the violation was issued because radioactive material was found in an unrestricted area, immediate corrective action must be taken to place the material under licensee control in authorized locations. After the immediate safety concerns have been addressed, timely action must be taken to prevent future recurrence of the violation. Corrective action is sufficiently comprehensive when corrective action is broad enough to reasonably prevent recurrence of the specific violation as well as prevent similar violations.

In evaluating the root causes of a violation and developing effective corrective action, consider the following:

1. Has management been informed of the violation(s)?

2. Have the programmatic implications of the cited violation(s) and the potential presence of similar weaknesses in other program areas been considered in formulating corrective actions so that both areas are adequately addressed?

3. Have precursor events been considered and factored into the corrective actions?

4. In the event of loss of radioactive material, should security of radioactive material be enhanced?

5. Has your staff been adequately trained on the applicable requirements?

6. Should personnel be re-tested to determine whether re-training should be emphasized for a given area? Is testing adequate to ensure understanding of requirements and procedures?

7. Has your staff been notified of the violation and of the applicable corrective action?

8. Are audits sufficiently detailed and frequently performed? Should the frequency of periodic audits be increased?

9. Is there a need for retaining an independent technical consultant to audit the area of concern or revise your procedures?

10. Are the procedures consistent with current NRC requirements, should they be clarified, or should new procedures be developed?

11. Is a system in place for keeping abreast of new or modified NRC requirements?

12. Does your staff appreciate the need to consider safety in approaching daily assignments?

13. Are resources adequate to perform, and maintain control over, the licensed activities? Has the radiation safety officer been provided sufficient time and resources to perform his or her oversight duties?

14. Have work hours affected the employees' ability to safely perform the job?

15. Should organizational changes be made (e.g., changing the reporting relationship of the radiation safety officer to provide increased independence)?

16. Are management and the radiation safety officer adequately involved in oversight and implementation of the licensed activities? Do supervisors adequately observe new employees and difficult, unique, or new operations?

17. Has management established a work environment that encourages employees to raise safety and compliance concerns?

18. Has management placed a premium on production over compliance and safety? Does management demonstrate a commitment to compliance and safety?

19. Has management communicated its expectations for safety and compliance?

20. Is there a published discipline policy for safety violations, and are employees aware of it? Is it being followed?

This information notice requires no specific action nor written response. If you have any questions about the information in this notice, please contact one of the technical contacts listed below.

Elizabeth Q. Ten Eyck, Director
Division of Fuel Cycle Safety
and Safeguards
Office of Nuclear Material Safety
and Safeguards

Donald A. Cool, Director
Division of Industrial
and Medical Safety
Office of Nuclear Material Safety
and Safeguards

Technical contacts: Nader L. Mamish, OE
(301) 415-2740
Internet:nlm@nrc.gov

Daniel J. Holody, RI
(610) 337-5312
Internet:djh@nrc.gov

Bruno Uryc, Jr., RII
(404) 331-5505
Internet:bxu@nrc.gov

Bruce L. Burgess, RIII
(708) 829-9666
Internet:blb@nrc.gov

Gary F. Sanborn, RIV
(817) 860-8222
Internet:gfs@nrc.gov

Attachments:
1. List of Recently Issued NMSS Information Notices
2. List of Recently Issued NRC Information Notices