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USNRC

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OFFICE OF SECRETARY
RULEMAKINGS AND
ADJUDICATIONS STAFF

Dear Ms. Katz and Mr. Marshall:

Enclosed please find a corrected copy of page 27 of the Director's Decision (DD-97-22) I sent to you on September 17, 1997, in regard to the National Institutes of Health. The second paragraph, first sentence of Section G, *NIH conduct of surveys after contamination incident,* contained an incorrect date of July 14, 1997, rather than the correct date of July 14, 1995.

A corrected copy of page 27 has been placed in the public document room and provided to all individuals who received distribution copies of DD-97-22.

Sincerely,
ORIGINAL SIGNED BY
Carl J. Paperiello, Director
Office of Nuclear Material Safety
and Safeguards

cc: Michael M. Gottesman, M.D., NIH
Robert B. Lanman, NIH
Burt M. Kahn, Esq.

Enclosure: Corrected page 27 of DD-97-22

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NRC concludes that NIH took all reasonable measures to secure the scene after responding to the event.

G. NIH conduct of surveys after contamination incident

Petitioners state that in violation of 10 C.F.R. §20.201(b) and an October 14, 1992, commitment by NIH to emphasize to all users the importance of notifying Radiation Safety promptly of spills of radioactive materials when there is personnel contamination, NIH failed to conduct surveys reasonably necessary under the circumstances surrounding discovery of Dr. Ma's contamination on June 29, 1995, and thus failed to detect P-32 contamination of a water cooler until July 14, 1995, which caused an additional 26 people, including Dr. Zheng, to become internally contaminated.

NRC stated in its AIT report of January 13, 1997, that because NIH did not survey the water cooler in the corridor near Petitioners' laboratory until July 14, 1995, 26 other individuals (besides Dr. Ma) were internally contaminated with P-32 by drinking water from the cooler. After review of all the evidence, however, the staff concludes that, although it would have led to a more desirable outcome to have identified the contaminated water cooler earlier, under the circumstances, NIH conducted all reasonably necessary surveys. When NIH safety response personnel were called to the scene, Dr. Ma and Dr. Zheng insisted that Dr. Ma had been contaminated by food that she had stored in the conference room refrigerator. Dr. Ma and Dr. Zheng also told RSB personnel that they brought all their own food and beverages to work with them. Immediately after the event, Dr. Ma and Dr. Zheng denied that they drank any liquid from Building 37, and stated that they brought all liquids from home. In the days after the