UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406

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Request No. RIR-90-017

TO: Chester W. White, Director
Office of Field Investigations, RI

FROM: Thomas T. Martin
Regional Administrator

REQUEST FOR INVESTIGATION

Veterans Administration Medical Center
Licensee

Docket No. 030-10026
License No. 31-02755-05

113 Holland Avenue
Albany, New York 12208
Facility or Site Location

Thomas T. Martin
Regional Administrator

December 3, 1990
Date

A. Request

What is the matter that is being requested for investigation? (Be as specific as possible regarding the underlying incident).

The matter to be investigated is the deliberate falsification of radioactive sealed source inventory records, dated October 14, 1990, by Dr. James Zhang, Acting RSO and the extent of the licensee's management and Radiation Safety Officer's (Dr. Andrew Kang) involvement.

B. Purpose of Investigation

1. What is the basis for the belief that the violation of a regulatory requirement is more likely to have been intentional or to have resulted from careless disregard or reckless indifference than from error or oversight? (Be as specific as possible).

Dr. James Zhang, Acting RSO, who performed the inventory, in conjunction with Dr. Andrew Kang, RSO, in October 1990 admitted to the inspector that the October 14, 1990 sealed source inventory was conducted but not all of the sources were located. Dr. Zhang (as opposed to Dr. Kang) stated that the sealed source computer inventory presented to the inspector was a copy of the sealed source inventory prepared by the previous RSO in October 1989. Dr. Zhang

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further stated that this inventory was signed by Dr. Kang, RSO and used as an accurate record even though they were not able to locate all of the sources listed. Dr. Zhang and Dr. Kang did not prepare a new inventory indicating which sources had not been located. No lost material report was filed with NRC as required.

2. What are the potential regulatory requirements that may have been violated?

   10 CFR 35.59(g), 10 CFR 30.9, and 10 CFR 20.402

3. If no violation is suspected, what is the specific regulatory concern?

   N/A

4. Why is an investigation needed for regulatory action and what is the regulatory impact of this matter, if true?

   The need for an investigation is to determine whether Dr. Kang, RSO, (as opposed to Dr. Zhang) who signed the inventory record actually took part in the physical inventory process and whether he was aware that not all sources had been found but signed the inventory record without taking the appropriate steps to find the missing sources or report their loss. The lack of these sealed sources accountability and control involves potential significant safety consequences.

C. Requestor's Priority

1. Is the priority of the investigation high, normal, or low?

   This is a high priority investigation.

2. What example from Appendix 0517, Part III, does this incident most closely fit, if any?

   Example #4 under "High Priority"

3. What is the estimated date when the results of the investigation are needed?

   12/13/90

4. What is the basis for the date and the impact of not meeting this date? (For example, is there an immediate safety issue that must be addressed or are the results necessary to resolve any ongoing regulatory issue and if so, what actions are dependent on the outcome of the investigation?)

The basis for this date is that the Radiation Safety Officer (RSO), an individual who plays an integral part in the oversight of the licensed program, may be involved in a deliberate falsification of the sealed source inventory records. Based on the number and significance of the numerous other violations identified during the inspection, the staff is also concerned with the ability of the RSO to properly administer and oversee the radiation safety program. If the investigation determines that the RSO was knowledgeable of, participated in, or condoned the deliberate falsification of inventory records, the staff would want to be informed of this as soon as possible to be able to take action appropriate to protecting public health and safety.

D. Actions by Staff

1. What actions have been taken by the staff (e.g., inspections, Notices of Violation, Enforcement Conferences, Confirmatory Action Letters, etc.)?

   There was an inspection on November 20 and 21, 1990 and a CAL was issued on 11/29/90. Also, an Enforcement Conference is scheduled for December 13, 1990 to discuss the several other violations identified during the inspection (these violations do not involve any apparent wrongdoing).

2. Actions to be taken if investigation is closed without a report (based on currently available information).

   Write a letter to the licensee requesting additional information about the role of the RSO (Dr. Kang) in the inventories, and why the NRC should have assurance that the RSO is maintaining proper program oversight.

E. Contact

1. Staff members: Christopher Eckert, Inspector - 346-5364
   Dr. Shanbaky, Chief, Section A - 346-5209

2. Alleger identification with address and telephone number if not confidential.

   N/A

Thomas T. Martin
Regional Administrator

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cc:
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