DEPARTMENT OF VETERANS AFFAIRS
Samuel S. Stratton
Medical Center
113 Holland Avenue
Albany NY 12208

November 5, 1991

In Reply Refer To:

500/11

Director, Office of Enforcement
US Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

SUBJ: Reply to a Notice of Violation

RE: Docket No: 030-10026
License No: 31-02755-05
EA 91-050

Gentlemen:

This correspondence is forwarded in reply to your Notice of Violation dated November 4, 1991.

Regulation:

10 CFR 3b.59(g) requires, in part, that a licensee in possession of a sealed source or brachytherapy source conduct a quarterly physical inventory of all such sources in its possession and shall retain each inventory record for five years.

Violation #1

Contrary to the above, the licensee did not complete a physical inventory of all sealed sources in its possession between April and December 1990, a period in excess of a calendar quarter. Specifically, during this period, a comprehensive determination of the location of all sealed sources and whether any such sources were missing was not performed.

Regulation:

10 CFR 30.9(a) requires, in part, that information provided to the Commission by a licensee, or information required by the Commission's regulations to be maintained by the licensee, shall be complete and accurate in all material respects.

Violation #2

Contrary to the above, between April 1990 and November 21,

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1990, the licensee maintained inaccurate written records dated April 10, 1990, July 10, 1990, and October 14, 1990, documenting three quarterly physical inventories of sealed sources; and, during an inspection conducted on November 20-21, 1990, these records were presented to an NRC inspector for review. The records were inaccurate in that the quarterly physical inventories that they documented had not, in fact, been completed. The inaccurate information was material in that it directly related to compliance with NRC requirements.

In reference to the above two violations we present the following information:

1. The findings are correct, specifically stated above.

2. The violations were committed, because the radiation safety officer, at the time, Dr. S. Andrew Kang, did not adhere to the regulations for proper inventory procedure and record keeping. Dr. Kang did not inform management of his lack of understanding of the regulations, nor did he ask for assistance. Dr. Kang consistently reported to his supervisor that everything was being performed according to regulation.

3. As a response to the inspection by Mr. Christopher Eckert, of your office of November 20-21, 1990, when these violations were first encountered, a certified health physicist was hired, and a complete inventory was completed.

The results of this inventory dated 12/3-4/90 were reported to you on 12/7/90.

As a result of the enforcement conference conducted on 12/13/90, which demonstrated Dr. Kang's lack of understanding of the regulations involved, and further discussions with Dr. Ronald Belamy, of your office, we removed Dr. Kang as Radiation Safety Officer, and Chairman of the Radiation Safety Committee.

This is reflected in our license amendment dated 1/17/91.

Subsequent inventories were conducted personally by Dr. Lawrence Flesh, RSO, on March 1, 1991, and June 6, 1991.

On June 16, 1991, the Albany VA Medical Center hired a full-time Health Physicist, Mr. David Rhoe, working for and under the supervision of Dr. Flesh. Mr. Rhoe conducted the sealed source inventory on September 9, 1991 under the scrutiny of Dr. Flesh. The next inventory/leak test is scheduled for December 1991.

Since taking over as Radiation Safety Officer, we have discarded 62 sealed sources, according to regulation. We

currently have 38 sources in our inventory.

We have a license amendment pending action by you to name Mr. Rhoe as Radiation Safety Officer. Should this action be approved, Mr. Rhoe will continue to report directly to the Chief of Staff. Mr. Rhoe has been trained by the states of Texas and Georgia, and he is well versed in NRC rules and regulations.

As a result of your letter dated June 26, 1991, and the subsequent enforcement conference on July 8, 1991, which reported the finding by the NRC Office of Investigation that Dr. Kang falsified the records mentioned above, Management at VAMC Albany, elected to remove Dr. Kang from his position as Chief of Nuclear Medicine Service. Dr. Kang now serves as a staff physician in Nuclear Medicine Service. Dr. Mahin Heravi is now acting as Chief, Nuclear Medicine Service (full-time), and has complete administrative responsibility for the Service, including adherence to NRC regulations, specifically related to 10 CFR 35. Dr. Heravi attended the Radiation Safety Officer training course given by the NRC, in Little Rock, Arkansas, on May 30-June 1, 1991.

4. A fully trained Health Physicist was hired, in order to prevent further violations. The health physicist will faithfully keep up with all new regulations, as will the current Radiation Safety Officer/Chief of Staff.

In addition, Management will continue to closely supervise the Radiation Safety program, to ascertain that the Physicist/RSO are performing their duties within the scope of our license.

5. - Full compliance was achieved, for the two violations stated on 12/4/90, when the first complete and accurate survey was performed by the contract physicist. Compliance has been complete, accurate, and documented since that time, and will continue to be so. In addition, the Radiation Safety Officer/Health Physicist will continue to take periodic refresher courses, and continuing education pertaining to NRC regulations, and principles and practices of Health Physics. Mr. Rhoe is scheduled to attend a regional meeting in West Point, this month.

In addition, it must be stated, that during an unscheduled inspection of our facility, on March 28-29, 1991, by Mr. Christopher Eckert, the above information was verified, and that there were no irregularities of the sealed source inventory, or their associated records.

For the record, the VA Medical Center in Albany, takes exception to the statement that Management demonstrated "careless disregard for meeting regulatory requirements....". Periodic reviews of the Radiation Safety program by the Chief

of Staff, and the Radiation Safety Committee did not disclose the falsified records, which were discovered by the NRC Office of Investigation. Dr. Kang consistently reported to his supervisor that all regulations were being performed. Dr. Kang never asked for assistance, and never expressed concern over his apparent lack of knowledge. Management would have provided whatever help was needed, had it been requested to do so. Management is also well aware of its responsibilities related to the license, and acted promptly when the issues surfaced.

In addition, it should be noted that although the position of Radiation Safety Officer/Health Physicist is considered as a full-time position, these duties were completely performed by Dr. Flesh, assisted by Dr. Heravi, and a part-time consultant, when they were called upon to do so. Dr. Kang obviously was not able to so perform, despite the same level of assistance and support. We believe that Dr. Kang deliberately failed to keep management informed, failed to keep the Radiation Safety Committee informed, and failed to satisfactorily manage radiation safety activities that were clearly within the scope of his professional abilities and his assigned resources. While the management of this Medical Center does now and continues to accept full responsibility for the violations and the circumstances leading up to those violations, we do not believe that any documentation or evidence supports a finding of careless disregard for radiation safety requirements. The management of this Medical Center heard Dr. Kang's concerns expressions of inadequacy and inability only doing after the NRC began to look into these matters.

We categorically do not concur with your indictment of management, based on the failure to perform, of one individual, although we do recognize that ultimately it is the responsibility of management to remove such an individual and replace them with properly trained and experienced personnel.

F. L. MALPHURS
Director

cc: Thomas T. Martin
Regional Director
Nuclear Regulatory Commission