DCS

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

APR 13 1992

Mr. Fred L. Malphurs
Department of Veterans Affairs
Samuel S. Stratton Medical Center
113 Holland Avenue
Albany, New York 12208

Dear Mr. Malphurs:

This letter responds to your February 3, 1992, letter to the Nuclear Regulatory Commission's (NRC) Office of The Inspector General, which has been referred to me. We have considered the concerns which you have expressed. Nonetheless, your request to modify the letter accompanying the November 4, 1991 Notice of Violation (NOV) is denied.

One of your principal concerns appears to be that the NRC staff holds Veterans Affairs management entirely responsible for the two violations identified in the NOV involving incomplete and inaccurate information entered into license records. In fact, it is the staff's view that both Veterans Affairs management and Dr. Andrew Kang share responsibility for the violations. Further, the staff does not conclude that either Veterans Affairs management or Dr. Kang deliberately or intentionally violated NRC regulations.

Related to this same concern, you stated the decision in this case was not supported by the record, contrary to 10 CFR 2.760(c) which requires that an initial decision should be based on the whole record and supported by reliable, probative, and substantial evidence. 10 CFR 2.760 applies to an initial decision made by a licensing board or administrative law judge after an administrative hearing. The enforcement action taken by the NRC staff in this case did not involve an administrative hearing, because none was requested, and did not result in an "initial decision." Therefore, the provisions of 10 CFR 2.760(c) are not applicable to this matter. Nevertheless, the staff is satisfied that its actions are based on the whole record.

The NRC staff continues to hold the view that the Veterans Affairs' inadequate management control, for an extended period of time (1989-1991) related to the two violations in the NOV, constitutes careless disregard, because it represented a pattern of indifference to ensuring that regulatory requirements were met. Specifically, management's responsibility to ensure Dr. Kang's performance goes beyond selecting an individual who appears to be qualified and beyond accepting that person's verbal assurances that the program is functioning smoothly. It was also management's responsibility to confirm that the substantive aspects of Dr. Kang's duties were properly performed. This is of particular importance because of your decision to assign Dr. Kang the responsibilities of Radiation Safety Officer (RSO) on a part-time basis, when that position had previously required a full-time individual, who also held a doctorate in health physics. Dr. Kang's belief that a full-time individual was required, that he was not

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properly trained and that he was not given the proper time and resources to fulfill the RSO functions, were discussed at the July 8, 1991, Enforcement Conference. Neither you nor Dr. Lawrence Flesh took exception to Dr. Kang's remarks or made any comment on these issues at that time. Prior to the enforcement conference, the NRC staff was concerned that Dr. Kang's actions in creating inaccurate and incomplete records might have been intentional. During the conference, the staff developed the view that Dr. Kang's errors were not intentional, but that they resulted from both his failure to understand his responsibilities as RSO and from the lack of resources which he perceived Veterans Affairs management was making available to him. In short, the staff concludes Dr. Kang's errors were in part attributable to the fact that Veterans Affairs management had not provided sufficient guidance and resources to support Dr. Kang in his duties as RSO, although the need should have been readily apparent.

You also expressed a concern that subsequent to the enforcement conference on July 8, 1991, the NRC received and acted upon information provided by Dr. Kang and his attorney and that Veterans Affairs management did not have an opportunity to challenge that information in violation of 10 CFR §2.780. Although brief conversations occurred between the staff and Dr. Kang and his attorney at the close of the enforcement conference, these discussions were not of a substantive nature, and did not constitute prohibited ex parte communication.

10 CFR §2.780 prohibits ex parte communications made to or by "Commission adjudicatory employees" in "proceedings" initiated pursuant to 10 CFR §§2.104(a), 2.105(e)(2), 2.202(c), 2.204, 2.205(e) or 2.703. Unless a hearing is formerly requested and granted, enforcement proceedings are not proceedings within the meaning of 10 CFR 2.780. See 10 CFR 2.4. Moreover, none of the NRC staff who attended the July 8, 1991 enforcement conference were "Commission adjudicatory employees" as defined by 10 CFR 2.4. Thus, any conversation between the staff and Dr. Kang or his attorney, either at the enforcement conference or any time during this enforcement action, were not ex parte communications, just as any conversations between the staff and Veterans Affairs management were not ex parte communications.

Attachment E to your letter, the memo from Lawrence Flesh, M.D., refers to conversations on January 21, 1991 between Dr. Ronald Bellamy and Dr. Kang and between Dr. Bellamy and yourself. Because the staff was concerned about the potential impact of these discussions, Dr. Bellamy prepared his questions and statements and reviewed the purpose of these conversations with the Regional Administrator's office in Region I and the Regional Counsel prior to placing the telephone calls. Our documented records are clear. First, the conversations took place on January 17, 1991, not on January 21, 1991. With respect to the technical content of these conversations, Dr. Kang had previously indicated that he did not desire to be RSO and during the call, he indicated that he had no objection to being removed as RSO, but would not approach the Veterans Affairs management to request the change. The subsequent discussions held with you and Dr. Flesh were very cordial, and while the purpose of the call was to express our concern about the situation noted from the enforcement conference, i.e., an RSO who did not desire the position and who had questioned his training and resources available for the RSO position, it was agreed that Dr. Kang would no longer serve as RSO or Chairman of the Radiation Safety Committee. While you

and Dr. Flesh may have misunderstood, the staff has no recollection or record of making any affirmative statements to the effect that Dr. Kang was no longer acceptable as RSO or Chairman of the Radiation Safety Committee. We did not have to consider that issue because you agreed to replace Dr. Kang as both the RSO and Chairman of the Radiation Safety Committee. More importantly, the staff does not believe that there was any discussion which could have suggested that if Dr. Kang was not removed, your license would be immediately revoked. Our documented telephone logs support the staff's recollection, as does Ms. Karla Smith, Regional Counsel, who was present during each telephone conversation.

In conclusion, we are pleased to note that in your letter you recognize and accept the responsibility of Veterans Affairs management to ensure the proper conduct of the radiation safety program. It is our hope that we will be able to continue to work together to protect the health and safety of the public.

Sincerely,

Original Signed By
James Lieberman

James Lieberman, Director
Office of Enforcement

cc: D. Williams, IG
T. Martin, RA, Region I

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