UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE RD. SUITE 210
LISLE, IL 60532-4352

July 27, 2016

Mr. Craig Adams, Director
National Health Physics Program (115HP/NLR)
Department of Veterans Affairs
Veterans Health Administration
2200 Foot Roots Drive
Little Rock, AR 72114

SUBJECT: NRC OFFICE OF INVESTIGATIONS REPORT NO. 3-2015-019

Dear Mr. Adams:

This refers to an investigation conducted by the U.S. Nuclear Regulatory Commission (NRC) Office of Investigations (OI) to determine: (1) whether nuclear medicine personnel at the Department of Veterans Affairs (DVA) Medical Center in Salt Lake City, Utah, deliberately failed to perform calibration of a well counter from March 3-9, 2015; (2) whether nuclear medicine personnel deliberately failed to monitor external surfaces of labeled packages for radioactive contamination; and (3) whether an assistant radiation safety officer deliberately placed the DVA facility in violation of NRC regulations by hiding the check source and preventing staff from performing quality assurance of the instrument and conducting adequate surveys. Based on the evidence developed during the investigation, we did not substantiate the allegations. The synopsis from the OI Report of Investigation is enclosed.

If you have any questions or comments regarding this matter, please contact an NRC Region III Office Allegation Coordinator by calling (800) 522-3025. The NRC Region III Office Allegation Coordinators are Jim Heller, Paul Pelke, Magdalena Gryglak, and Sarah Bakhsh.

In accordance with Title 10 of the Code of Federal Regulations (10 CFR) 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if any, will be available electronically for public inspection in the NRC Public Document Room or from the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room). You should note that final NRC documents, including the final OI reports, may be made available to the public under the Freedom of Information Act (FOIA) subject to redaction of information pursuant to the FOIA. Requests under the FOIA should be made in accordance

with 10 CFR 9.23, Request for Records. The instructions for making a request for information under the FOIA are accessible at http://www.nrc.gov/reading-rm/foia/foia-request.html.

Sincerely,

/RA/

Patricia J. Pelke, Chief
Materials Licensing Branch
Division of Nuclear Materials Safety

Docket No. 030-34325
License No. 03-23853-01VA

Enclosure:
OI Synopsis

with 10 CFR 9.23, Request for Records. The instructions for making a request for information under the FOIA are accessible at http://www.nrc.gov/reading-rm/foia/foia-request.html.

Sincerely,

/RA/

Patricia J. Pelke, Chief
Materials Licensing Branch
Division of Nuclear Materials Safety

Docket No. 030-34325
License No. 03-23853-01VA

Enclosure:
OI Synopsis

bcc w/encl: AMS File No. RIII-2015-A-0026

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OFFICE	RIII	N	OI:RIII	N	RIII	N	RIII	N
NAME	PRPelke		Langan*		Skokowski** Jim Heller for		PJPelke	
DATE	07/26/16		07/26/16		07/26/16		07/27/16	

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* For permission to release OI synopsis. ** The 3-week e-mail has expired.

Note: 3-week emailed dated 6/16/16 and timed out 7/11/16. No comment provided as of 7/26/16.
J. Heller for R. Skokowski

OI SYNOPSIS

This investigation was initiated on September 1, 2015, by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations, Region III, to determine: (1) whether nuclear medicine personnel at the Department of Veterans Affairs (DVA) Medical Center in Salt Lake City, Utah, deliberately failed to perform calibration of a well counter from March 3-9, 2015; (2) whether nuclear medicine personnel deliberately failed to monitor external surfaces of labeled packages for radioactive contamination; and (3) whether an assistant radiation safety officer deliberately placed the DVA facility in violation of NRC regulations by hiding the check source and preventing staff from performing quality assurance of the instrument and conducting adequate surveys.

Based on the evidence, the allegation that nuclear medicine personnel at the DVA Medical Center in Salt Lake City, Utah, deliberately failed to perform calibration of a well counter from March 3-9, 2015, was not substantiated.

Based on the evidence, the allegation that nuclear medicine personnel deliberately failed to monitor external surfaces of labeled packages for radioactive contamination was not substantiated.

Based on the evidence, the allegation that an assistant radiation safety officer deliberately placed the DVA facility in violation of NRC regulations by hiding the check source and preventing staff from performing quality assurance of the instrument and conducting adequate surveys was not substantiated.