DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

January 30, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2755

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the W. G. (Bill) Hefner Department of Veterans Affairs (VA) Medical Center, Salisbury, North Carolina (hereafter the Medical Center). The whistleblower alleged that the Medical Center had long wait times, mishandled radioactive materials, failed to monitor patients during cardiac stress tests, and repeatedly committed patient confidentiality breaches. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector, who assembled and led VA teams to investigate these allegations. In accordance with instructions from the Chief, Disclosure Unit, Office of Special Counsel, VA did not investigate the allegation regarding wait times. The teams conducted two visits to the Medical Center in 2014, the first team, from the National Health Physics Program, on June 18, and the OMI-led clinical team on October 14, to investigate the other three allegations. VA did not substantiate any of those three allegations.

VA did not make any recommendations for the Medical Center. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-14-2755

Department of Veterans Affairs
W. G. (Bill) Hefner Veterans Affairs Medical Center
Salisbury, North Carolina

Report Date: January 27, 2015

TRIM 2014-D-1263

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

The Interim Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) assemble and lead the Department of Veterans Affairs (VA) teams to investigate allegations lodged with the Office of Special Counsel (OSC) by (b) (6) (hereafter, the whistleblower), a former nuclear medicine supervisor at the W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina (hereafter, the Medical Center). The whistleblower alleged that the Medical Center may have engaged in actions that constitute a violation of law, rule or regulation, gross mismanagement, an abuse of authority, and a substantial and specific danger to public health and safety. He disclosed excessive delays in access to radiology department services, mishandling of radioactive materials, failure to appropriately monitor patients during cardiac stress tests, and repeated breaches of patient confidentiality. VA made two visits to the Medical Center in 2014, the first team on June 18, and the OMI-led team on October 14.

Specific Allegations of the Whistleblower

1. The Hefner VA Hospital Radiology Department currently has a patient waiting list of roughly 3,300 individuals, including patients who have been waiting for tests since 2007;

2. There has been mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas;

3. Hospital staff have failed to appropriately monitor patients during cardiac stress tests; and

4. The physical arrangement of hospital office space has resulted in repeated breaches of patient confidentiality.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions about whether the alleged event or action took place with reasonable certainty.

After careful review of the findings, VA makes the following conclusions and recommendations.

Conclusion for Allegation 1

- In accordance with instructions received from the Chief, Disclosure Unit, OSC, on September 22, 2014, VA did not investigate this allegation.

Recommendation for Allegation 1

No recommendation.

Conclusion for Allegation 2

- VA **did not substantiate** that there has been a mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas.

Recommendation for Allegation 2

No recommendation.

Additional Findings Based on Investigation of Allegation 2

Although VA did not substantiate the whistleblower's second allegation, we did find two violations of rules. The first was one the Medical Center identified in which the external surface of some packages labeled as containing radioactive materials had not been tested for the presence of those materials. The second was a Level IV violation for not reporting the change of location where radioactive materials had been used and administered to patients. A Level IV violation is the least serious rule violation assigned by an external inspector.

Conclusion for Additional Findings

- Although in violation of 10 CFR 20.1906(b) and 10 CFR 20.1906(c), VA concluded that the first rule violation did not pose substantial and specific danger to public health and safety for the following reasons: the limited number of instances of occurrence; the lack of indications of contamination on daily surveys; and the history of absence of contaminated packages received by the Medical Center from vendors.

- VA concluded that the Medical Center took appropriate administrative action by removing the employee from handling radioactive materials. Due to other deficiencies in job performance, this probationary employee was terminated from government service 3 days later.

- Regarding the second rule violation, while the National Health Physics Program (NHPP) cited the Medical Center for a Level IV violation for not reporting a change in the location of radioactive material use and not performing closeout surveys, VA did not find that this violation posed substantial and specific danger to public health and safety. Technetium 99m (Tc-99m) was the only radioactive material used in the room which was to be cleared for general use. Because the maximum dose of Tc-99m used in the room at any one time was small and the half-life of Tc-99m is very short, the risk to the public from this violation was minimal.

- VA concluded that the Medical Center took appropriate instructional action in response to the second rule violation.

Recommendation for Additional Findings

No recommendation.

Conclusion for Allegation 3

- VA **did not substantiate** that hospital staff has failed to appropriately monitor patients during cardiac stress tests. In our review of electronic health records (EHR), we found that patients were monitored by cardiologists during the stress period and only released from monitoring after the cardiologist had assessed them to be recovered from the stress and stable. Patients cleared by the cardiologist to go to the Nuclear Medicine department were clinically ready to go home if no post-test had been required. Patients walking from the cardiology clinic to Nuclear Medicine after this evaluation were at no more risk for adverse outcomes than other outpatients. Also, we found that patients were appropriately monitored while undergoing the nuclear scans. A Nuclear Medicine Technologist (NMT) always had verbal contact with patients undergoing scans. Electrocardiogram (ECG) monitoring there was only to ensure an adequate study was performed. We found this to be the case in all records reviewed.

Recommendation for Allegation 3

No recommendation.

Conclusion for Allegation 4

- VA **did not substantiate** that the physical arrangement of the hospital office space that the whistleblower occupied had resulted in breaches of patient confidentiality. We found that every member of the Nuclear Medicine department interviewed was able to describe the procedures to protect patient privacy on those occasions when rooms were used both for administrative and patient care purposes. The room used for administrative purposes by the whistleblower and the medical support assistant (MSA) was designated for patient care only twice, on the same day, during the whistleblower's period of employment, and the MSA stated she was not in the room during any of those procedures. Due to the whistleblower's need to be familiar with the Medical Center's Nuclear Medicine standard operating procedures (SOP), had he been in the room during those procedures, it would not have constituted a violation of patient confidentiality.

Recommendation for Allegation 4

No recommendation.

VI. Summary Statement

OMI has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found two violations of Federal regulations, namely 10 CFR 20.1906(b) and 20.1906(c), but concluded that neither violation posed any substantial and specific danger to public health and safety. VA will take no actions as a result of the investigation. While additional findings unrelated to the referred allegations found violations of specific regulations administered by the Nuclear Regulatory Commission, all appropriate actions to resolve those issues were already taken.

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I. Introduction

The Interim USH requested that OMI assemble and lead VA teams to investigate allegations lodged with OSC by the whistleblower, a former nuclear medicine supervisor at the Medical Center. The whistleblower alleged that the Medical Center may have engaged in actions that constitute a violation of law, rule or regulation, gross mismanagement, an abuse of authority, and a substantial and specific danger to public health and safety. He disclosed excessive delays in access to radiology department services, mishandling of radioactive materials, failure to appropriately monitor patients during cardiac stress tests, and repeated breaches of patient confidentiality.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network 6, serves Veterans in the Central Piedmont geographical region of North Carolina. Inpatient services include cardiology, nuclear medicine, acute medicine, surgery, psychiatry and physical medicine and rehabilitation, as well as sub-acute and extended care. Primary and specialized outpatient services are provided at the Medical Center complex and community-based outpatient clinics. The Medical Center has a primary clinical academic affiliation with the Wake Forest University School of Medicine in Winston-Salem, North Carolina.

III. Specific Allegations of the Whistleblower

The whistleblower alleged:

1. The Hefner VA Hospital Radiology Department currently has a patient waiting list of roughly 3,300 individuals, including patients who have been waiting for tests since 2007;

2. There has been mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas;

3. Hospital staff have failed to appropriately monitor patients during cardiac stress tests; and

4. The physical arrangement of hospital office space has resulted in repeated breaches of patient confidentiality.

IV. Conduct of the Investigation

The VA investigation was conducted by two teams:

Team 1 was comprised of (b) (6) PhD, and (b) (6) both from VHA's NHPP. Both are health physicists and serve as Program Managers for NHPP. This program provides regulatory oversight of VHA receipt, use, and storage of therapeutic

and diagnostic radioactive materials. In addition, NHPP personnel perform on-site inspections, and investigate allegations, medical events, and incidents involving nuclear materials. NHPP Program Managers are approved by the VHA National Radiation Safety Committee to complete inspections and investigations using training and qualification criteria established by the Nuclear Regulatory Commission (NRC). Team 1 investigated the second allegation.

Team 2 was comprised of (b) (6) MD, Deputy Medical Inspector and (b) (6) (b) (6) PhD, MPH, Epidemiologist, of OMI; (b) (6) JD, RHIA, VHA Privacy Officer; and (b) (6) VHA HR Specialist. Team 2 investigated the third and fourth allegations.

On June 17, 2014, (b) (6) of Team 1 interviewed the whistleblower by telephone regarding his second allegation. On the following day Team 1 held an entrance briefing with the Medical Center Director, Associate Director (AD), Chief of Staff (CoS), and Radiation Safety Officer (RSO). On June 19, the Team held an exit briefing with the Medical Center Director, AD, CoS, RSO, and the Chief Technologist of Imaging Service (CTI).

During the visit, Team 1 interviewed the following:

- (b) (6) American Registry of Radiologic Technologists (Nuclear) (ARRT(N)), Nuclear Medicine Technologist (NMT)
- (b) (6) MD, RSO
- (b) (6) MBA, American Registry of Radiologic Technologists (Radiologic)(Vascular) (ARRT (R)(V))
- (b) (6) Certified Nuclear Medicine Technologist (CNMT), NMT
- (b) (6) CNMT, NMT

On October 7, 2014, Team 2 interviewed the whistleblower by telephone regarding his third and fourth allegations. On October 14, 2014, the Team held an entrance briefing with the Medical Center Director, AD, CoS, Nurse Executive, Quality Manager, and Executive Assistant to the CoS. The Team also toured the Nuclear Medicine and Cardiology Clinics. The following day, it held an exit briefing with the Medical Center Director, CoS, Executive Nurse, Quality Manager, and Executive Assistant to the CoS.

During the site visit, Team 2 interviewed the following:

- (b) (6) Registered Nurse Certified (RNC), BSN, Cardiology Staff Nurse
- (b) (6) CNMT, NMT
- (b) (6) MD, Chief/Cardiology
- (b) (6) ARRT(N), NMT
- (b) (6) MSA, Nuclear Medicine
- (b) (6) CNMT, NMT
- (b) (6) MD, RSO

- (b) (6) MD, Interim Chief/Imaging
- (b) (6) MBA, ARRT (R)(V), CTI
- (b) (6) Privacy Officer
- (b) (6) Assistant Chief Technologist

Both investigative teams reviewed relevant policies, procedures, reports, memoranda, and other documents listed in Attachment A.

V. Findings, Conclusions, and Recommendations

Allegation 1

The Hefner VA Hospital Radiology Department currently has a patient waiting list of roughly 3,300 individuals, including patients who have been waiting for tests since 2007.

In accordance with instruction in Attachment B, received from the Chief, Disclosure Unit, OSC, on September 22, 2014, VA did not investigate this allegation.

Allegation 2

There has been mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas.

Findings

Team 1 investigated this allegation and their report is in Attachment E.

Conclusion for Allegation 2

- VA **did not substantiate** that there had been mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas.

Recommendation for Allegation 2

No recommendation.

Additional Findings Based on Investigation of Allegation 2

Team 1 identified two rule violations unrelated to the allegation. One was a non-cited violation, since it was identified and corrected by the Medical Center. The second was cited at Severity Level IV, the lowest of four severity levels the NRC assigns to violations. The NRC Enforcement Policy defines Severity Level IV as violations that are, "less serious, but are of more than minor concern, that resulted in no or relatively inappreciable potential safety or security consequences (e.g., violations that created the

potential of more than minor safety or security consequences). The NRC definition of severity levels is in Attachment C.

Non-Cited Violation

According to 10 CFR 20.1906(b) and 10 CFR 20.1906(c), the Medical Center must test the external surfaces of labeled radioactive material packages received from vendors for radioactive contamination within 3 hours of receipt.

During the site visit, the Medical Center informed Team 1 of a previously self-identified and corrected violation where the external surfaces of some packages labeled as containing radioactive materials were not tested for the presence of those materials that may have contaminated the surface during packaging. The Medical Center traced this violation to a single staff member who failed to test packages received on March 6, 7, 19, 20, and 21, 2014. On March 25, 2014, the Medical Center removed this staff member from handling radioactive materials, and due to other instances of nonperformance, removed this probationary employee from government service 3 days later. Since this violation was self-identified and corrected, Team 1 issued a non-cited violation to the Medical Center.

According to NRC's Event Notification Reports, vendor contamination of packaging is rare in the United States. Attachment A has a link to the NRC public web page where these reports are displayed. The Medical Center has not documented an instance of vendor packaging contamination, because if it had, a report would have been required. The Medical Center's RSO or an NMT would have contacted NHPP with the report information, and NHPP would have then made the report to the NRC Operations Center. NRC would have posted the report on their public web page. The NHPP has not received a report from the Medical Center documenting vendor packaging contamination, and the NRC public web page has no report of vendor packaging contamination.

Team 1 reviewed the Medical Center's daily surveys of radioactive material use areas and found no indications of contamination on the days in question. A daily survey is an evaluation of the areas where radioactive materials are used to determine whether any significant radioactive contamination might have been inadvertently spread to surfaces within the work area. A daily survey consists of a NMT walking through use areas with a portable radiation detector to determine whether radiation levels are above action levels that are indicative of significant contamination.

Conclusion

- Although in violation of 10 CFR 20.1906(b) and 10 CFR 20.1906(c), VA concluded that the first rule violation did not pose substantial and specific danger to public health and safety for the following reasons: the limited number of instances of occurrence; the lack of indications of contamination on daily surveys; and the history of absence of contaminated packages received by the Medical Center from vendors.

- VA concluded that the Medical Center took appropriate administrative action by removing the employee from handling radioactive materials. Due to other deficiencies in job performance, this probationary employee was terminated from government service 3 days later.

Recommendation

No recommendation.

Cited Severity Level IV Violation

In accordance with 10 CFR 35.14(b)(5), the Medical Center must notify NHPP within 30 days of adding or changing the location of areas where radioactive materials are used. In addition, the Medical Center must perform area surveys for radioactive materials pursuant to 10 CFR 20.1501(a) and must complete a closeout survey of areas where radioactive materials are no longer in use before releasing the area for general use, pursuant to 10 CFR 20.1402.

In 2010, the Medical Center moved the cardiology stress laboratory from the second to the fifth floor of Building 2. In this laboratory, radioactive materials were administered to patients as part of their cardiac evaluation. Team 1 found that the Medical Center had not notified NHPP of the move and that staff could not locate the required closeout survey record to demonstrate that the vacated area on the second floor had been cleared for unrestricted use. Team 1 issued the Medical Center a Severity Level IV Violation for failing to notify the NHPP of the room change and complete closeout surveys for the vacated room.

On June 18, 2014, Team 1 took corrective action by reinstructing the Nuclear Medicine staff of notification and survey requirements. The Medical Center sent written notification to NHPP about the location change of the cardiology stress laboratory the next day.

Tc-99m was the only radioactive material that the Medical Center used in this laboratory on the second floor.[1] This radioactive tracer has a short half-life of 6 hours and is given in doses of 10–30 millicuries (mCi).[2] A 30-mCi dose decays to less than 10 percent of

[1] In Tc-99m the m denotes metastable nuclear state which is the state that decays and produces the radioactive effect.
[2] A curie is a measure of radioactive decay.

that dose in 24 hours. Residual quantities of Tc 99m greater than 30-mCi were never present in the room because the room was never used to store the tracer. Assuming a hypothetical exposure to the entire 30-mCi dose of Tc-99m by an unshielded individual 1 meter distant from the radioactive material, the individual would receive at most 32 mrem.[3] This exposure is less than 1 percent of the annual occupational exposure limit (5,000 mrem) for health care workers who have received radiation safety training.

Therefore, Team 1 determined that no significant residual radioactive materials could have remained in the vacated room at the time it was released from radiological restrictions 4 years ago.

Facility Management is responsible for notifying NHPP of changes in areas of use. NHPP recognizes reports from a member of executive management, the Chair of the facility's Radiation Safety Committee, or the RSO. Facility Management normally delegates the responsibility for making such reports to the RSO. Neither the RSO nor the senior imaging technologist responsible for filing this notification 4 years ago are now employed by the Medical Center.

Conclusions

- Regarding the second rule violation, while the NHPP cited the Medical Center for a Level IV violation for not reporting a change in the location of radioactive material use and not performing closeout surveys, VA did not find that this violation posed substantial and specific danger to public health and safety. Tc-99m was the only radioactive material used in the room which was to be cleared for general use. Because the maximum dose of Tc-99m used in the room at any one time was small and the half-life of Tc-99m very short, the risk to the public from this violation was minimal.

- VA concluded that the Medical Center took appropriate instructional action in response to the second rule violation.

Recommendation

No recommendation.

Allegation 3

Hospital staff have failed to appropriately monitor patients during cardiac stress tests.

[3] Rem (roentgen equivalent in man) is a measurement unit of the biologic effect of ionizing radiation.

Background

A nuclear cardiac stress test is an outpatient procedure that compares blood flow to the heart muscle, at rest and during stress, to identify areas of damaged heart muscle and low blood flow through it. This test is a three-part procedure:

1. At the Nuclear Medicine Department, an NMT injects Tc-99m and images the patient's heart at rest. Since acquiring an image suitable for interpretation requires the synchronization of data acquisition with the patient's heartbeat, an ECG is performed for the sole purpose of synchronizing the imaging camera for data acquisition.

2. At the Cardiology Department, a cardiologist, assisted by cardiology nurses, performs the cardiac stress test. This test can be done either pharmacologically by injecting a medication that stresses the heart, or physically by asking the patient to walk on a treadmill while the cardiologist gradually increases the speed and inclination of the treadmill belt. In both tests, the cardiologist and nurses monitor the patient's heart rate, heart rhythm, blood pressure, and ECG throughout the entire testing period and into the recovery period. To induce stress pharmacologically, the Cardiology Department uses regadenoson, the stress effects of which are resolved 30 minutes after injection. When the cardiologist determines the patient's ECG readings and vital signs have returned to baseline after stress, he or she releases the patient from further medical monitoring and directs him or her to the Nuclear Medicine area where the post-stress image is collected.

3. At the Nuclear Medicine Department, the NMT injects another dose of Tc-99m and images the heart again. ECG monitoring is performed during this imaging session but again only for data acquisition purposes.

Because a nuclear cardiac stress test is designed to expose a patient's heart to a measured, limited degree of pharmacologic or physical stress, it is not indicated for high risk or unstable patients. Patients suitable for this test are usually outpatients who are discharged to home after the stress has resolved; the supervising cardiologist clears the patient before the patient goes down to the Nuclear Medicine Department for post-test images.

Findings

The whistleblower alleged that Nuclear Medicine staff failed to appropriately monitor patients during post-test imaging. He also claimed that the Cardiology Department endangered patients by sending them unattended to Nuclear Medicine after undergoing pharmacologic or physical stress. In particular, the whistleblower states that on February 24, 2014, he discovered a patient unattended on the imaging table for more than 30 minutes, generating an abnormal ECG. VA could find no corroboration of this event, and given the outcomes of the patients tested at that time, suspects the

abnormal ECG was more likely the effect of a detached lead than of a patient's symptom.

Team 2 interviewed all three NMTs, all of whom said patients were never left unattended during nuclear cardiac stress tests. From February 24 to March 28, 2014, nuclear imaging performed before and after cardiac stress was always conducted in rooms 2107 and 2108, which are connected by a doorway. If one of the two NMTs performing the tests was required to leave during a nuclear cardiac scan, the remaining NMT monitored both patients through the doorway. The NMTs said that they were always able to hear, and speak to both patients whenever covering both rooms. They further maintained that the ECG's only function was to synchronize the camera to the patient's heartbeat, so images suitable for interpretation could be obtained. Not only are these ECGs nondiagnostic in purpose, but when we reviewed the competencies of the NMTs, we found that they had no training in the clinical interpretation of ECGs.

On February 24, 2014, six patients underwent nuclear cardiac stress tests at the Medical Center. Their EHRs revealed no evidence of complications during or after the test. In each case, we found documentation that a staff cardiologist and a cardiology fellow monitored the patient during the stress portion and released him or her from the Cardiology Department to the Nuclear Medicine Department. The EHR reflects that all images collected for all six patients were adequate for interpretation.

Team 2 found an email indicating that the events prompting this allegation may possibly have occurred on February 26, 2014, rather than February 24 (Attachment D). When we reviewed the EHRs of the six patients who underwent nuclear stress tests on February 26, we found that the stress portions of the tests were appropriately monitored by a cardiologist, and we found no evidence of complications during or after the test. The images collected for all six patients were adequate for interpretation.

Conclusion for Allegation 3

- VA **did not substantiate** that hospital staff had failed to appropriately monitor patients during cardiac stress tests. In our review of EHRs and in interviews, we found that patients were monitored by cardiologists during the stress period and only released from monitoring after the cardiologist had assessed them to be recovered from the stress and stable. Patients cleared by the cardiologist to go to the Nuclear Medicine Department were clinically ready to go home if no post-test had been required. Patients walking from the cardiology clinic to nuclear medicine after this evaluation were at no more risk for adverse outcomes than other outpatients. VHA Directive 2006-041, cited by the whistleblower, expired in 2011, and Handbook 1101.10 directs the management of Patient Aligned Care Teams in primary care services, not specialty clinics. In addition to appropriate monitoring during stress tests, we found that patients were appropriately monitored while undergoing the nuclear scans. An NMT always had verbal contact with patients undergoing scans. ECG monitoring there was only to ensure an adequate study was performed, which we found to be the case in all records we reviewed.

Recommendation for Allegation 3

No recommendation.

Allegation 4

The physical arrangement of hospital office space has resulted in repeated breaches of patient confidentiality.

Findings

Per VHA Handbook 1605.1, *Privacy and Release of Information*, VHA employees may use information contained in VHA records, such as EHRs, when they need the records in the official performance of their duties for treatment, payment, and health care operations purposes (Handbook Para. 3b.). Further, individually-identifiable health information acquired in person or verbally from a patient may be used on a need-to-know basis by VHA personnel for the purposes of treatment, payment, or health care operations without the written authorization of the individual or patient (Handbook, Para. 12). The Handbook requires each health care facility to develop clear and explicit policies governing employees' auditory privacy practices when verbally discussing sensitive patient care issues, including for treatment, payment or health care operations (Handbook, Para. 3d.). The Medical Center's privacy policy requires that its health care providers and staff maintain auditory privacy "by refraining from discussing patient information within hearing distance range of anyone who is not on the patient's treatment team, or does not have a need to know the specific patient information unless an emergent condition arises whereby auditory privacy cannot be maintained" (Medical Center Memorandum 659-00-8). This privacy policy places reasonable safeguards around auditory discussions to prevent incidental use or disclosure of patient information as prescribed by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR § 164.530(c)(2)(ii)).

The whistleblower worked at the Medical Center between February 24 and March 28, 2014. He was assigned to room 2161 in building 2 for the duration of his employment. Team 2 learned through interviews that during that time, this room contained one computer and one clinical imaging camera that could only be used for one nuclear medicine test, a thyroid uptake scan.[4] On Tuesdays and Thursdays, the whistleblower shared the room with an MSA who performed nuclear medicine scheduling.

In interviews with the NMTs, Team 2 learned that newly hired NMTs always underwent a period of "shadowing" by other experienced NMTs to obtain training in the Medical Center's SOPs for performing nuclear medicine tests. The "shadowing" period was variable and depended on the proctoring NMTs' impression of the competency of the

[4] A thyroid uptake scan measures the thyroid gland's ability to concentrate a measured dose of radioactive iodine in the gland. The test is two phase: an initial dosing with the orally administered radioactive iodine followed by thyroid scanning 4 to 6 hours later.

newly hired NMT, but usually lasted 4 to 6 weeks. The whistleblower had "shadowed" other NMTs during his brief employment at the Medical Center.

Team 2 found that between February 24 and March 28, 2014, room 2161 had been used only twice for thyroid uptake scanning. Both studies took place on Thursday, February 27, 2014, when both oral dosing and scanning were performed. Interviews with the NMTs and the MSA revealed that during these procedures, the NMT made sure that nonessential staff, including the MSA, vacated the room before the patient entered. The NMT conducting the procedure escorted the patient into the room and closed the door for the duration of the procedure. From our interviews, we could not determine whether the whistleblower had been in the room during the procedures. However, since the whistleblower was being trained to perform such procedures, his presence would have been for training purposes and authorized under HIPAA.

Conclusion for Allegation 4

- VA **did not substantiate** that the physical arrangement of the hospital office space that the whistleblower occupied had resulted in breaches of patient confidentiality. We found that every member of the Nuclear Medicine Department interviewed was able to describe the procedures to protect patient privacy on those occasions when rooms were used both for administrative and patient care purposes. The room used for administrative purposes by the whistleblower and the MSA was designated for patient care only twice, on the same day, during the whistleblower's period of employment, and the MSA stated she was not in the room during any of those procedures. Due to the whistleblower's need to be familiar with the Medical Center's Nuclear Medicine SOP, had he been in the room during those procedures, it would not have constituted a violation of patient confidentiality.

Recommendation

- No recommendation.

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and the OAR has examined the issues from a Human Resources perspective to establish accountability, when appropriate, for improper personnel practices. VA found two violations of Federal regulations, namely 10 CFR 20.1906(b) and 20.1906(c), but concluded that neither violation posed any substantial and specific danger to public health and safety. VA will take no actions as a result of the investigation. While additional findings unrelated to the referred allegations found violations of specific regulations administered by the Nuclear Regulatory Commission, all appropriate actions to resolve those issues were already taken.

Attachment A

Documents Reviewed by Team 1

1. Event Notification Reports, Nuclear Regulatory Commission: http://www.nrc.gov/reading-rm/doc-collections/event-status/event/

2. Enforcement Policy, Nuclear Regulatory Commission: http://pbadupws.nrc.gov/docs/ML1322/ML13228A199.pdf

3. NRC Regulations Title 10, Code of Federal Regulations: http://www.nrc.gov/reading-rm/doc-collections/cfr/

Documents Reviewed by Team 2

4. Memorandum 659-00-8, VHA Privacy Policy And Procedure, W.G. (Bill) Hefner Medical Center, Salisbury, North Carolina, February 3, 2011.

5. VHA Handbook 1605.1, Privacy and Release of Information, May 17, 2006.

6. Nuclear Stress Test Nursing Procedure, W.G. (Bill) Hefner Medical Center, Salisbury, North Carolina, February 7, 2014.

7. VHA Handbook 1101.10, Patient Aligned Care Team (Pact) Handbook, February 5, 2014.

8. VHA Directive 2006-041, Veterans Health Care Service Standards, June 27, 2006.

9. VHA Handbook 1605.1, Privacy And Release Of Information, May 17, 2006.

Attachment B

(b) (6)

Subject: FW: OSC/OIG Monthly Conference Call - OSC File Nos. DI-14-2755 and DI-14-3424

From: (b) (6)
Sent: Monday, September 22, 2014 1:24 PM
(b) (6)
Subject: [EXTERNAL] RE: OSC/OIG Monthly Conference Call - OSC File Nos. DI-14-2755 and DI-14-3424

Pursuant to our telephone conference call on Thursday, September 18, the following are the two matters that have public health and safety allegations that require immediate investigation as well as scheduling allegations, which are being investigated criminally. As discussed, the OIG is not conducting a criminal investigation into these disclosures. Therefore, a report on the below-noted allegations is due in 60 days, on November 24, 2014. Please let me know if you have any questions. Thank you.

OSC File No. DI-14-2755
William Hefner VA Hospital, Salisbury, North Carolina
Referred: June 5, 2014

Allegations To Be Investigated:

- There has been mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas;
- Hospital staff have failed to appropriately monitor patients during cardiac stress tests; and
- The physical arrangement of hospital office space has resulted in repeated breaches of patient confidentiality.

OSC File No. DI-14-3424
Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas
Referred: July 1, 2014

Allegations To Be Investigated:

- Patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients,
- Deficiencies in the PACT telephone system create barriers to patient care; and

(b) (6)

1

Attachment C

The severity level of violations is established using criteria in the NRC Enforcement Policy which is published at the following link: http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html

Quoting from the Enforcement Policy:

"Severity level (SL) designations reflect different degrees of significance depending on the activity area in which the severity level is designated...

a. SL I violations are those that resulted in or could have resulted in serious safety or security consequences (e.g., violations that created the substantial potential for serious safety or security consequences or violations that involved systems failing when actually called on to prevent or mitigate a serious safety or security event).

b. SL II violations are those that resulted in or could have resulted in significant safety or security consequences (e.g., violations that created the potential for substantial safety or security consequences or violations that involved systems not being capable, for an extended period, of preventing or mitigating a serious safety or security event).

c. SL III violations are those that resulted in or could have resulted in moderate safety or security consequences (e.g., violations that created a potential for moderate safety or security consequences or violations that involved systems not being capable, for a relatively short period, of preventing or mitigating a serious safety or security event).

d. SL IV violations are those that are less serious, but are of more than minor concern, that resulted in no or relatively inappreciable potential safety or security consequences (e.g., violations that created the potential of more than minor safety or security consequences).

e. Minor Violations are those that are less significant than a SL IV violation. Minor violations do not warrant enforcement action and are not normally documented in inspection reports. However, minor violations must be corrected." [Page 13 of Enforcement Policy]

In addition, NHPP may disposition a violation as a Non-Cited Violation (NCV) in the following case [based on pages 14-15 of the Enforcement Policy]:

1. The permittee identified the violation.

2. The permittee corrected or committed to correcting the violation within a reasonable period of time by specific corrective action committed to by the end of the inspection, including immediate corrective action and comprehensive action to prevent recurrence.

3. The violation is not repetitive as a result of inadequate corrective action.

4. The violation is not willful. Notwithstanding willfulness, an NCV may still be appropriate if it meets other criteria in the NRC Enforcement Policy.

Attachment D

From: (b) (6)
Sent: Wednesday, March 26, 2014 11:30 AM
To: (b) (6)
Subject: FW: Patient Neglect, 03/26/2014

fyi

From: (b) (6)
Sent: Wednesday, March 26, 2014 9:57 AM
To: (b) (6)
Subject: Patient Neglect, 03/26/2014

(b) (6)

On February 26, 2014, I observed a patient being neglected in Room 1 of the Nuclear Medicine Department. His scan was only supposed to last 12-14 minutes. But this patient had been scanning for 33 minutes and counting. His cardiac gate signal was not making good connection, or he was experiencing significant arrhythmia. I inquired with (b) (6) (b) (6) CNMT, the technologist scanning the patient. He informed me this patient had a pace maker. This meant it was possible that (b) (6) did not hook the patient up to the electrodes securely. I asked (b) (6) to take note and trouble shoot the problem. He refused and said it would be all right. I disagreed, and started to trouble shoot the problem myself. As I started working to sort out the problem, (b) (6) began to make a half- hearted effort to assist. At this point, the scan ended.

I asked (b) (6) how long the patient had been on the camera? He said he did not know. I inquired as to when the problem with the patient began? He said he did not know. (b) (6) said he was not sure where the information I asked for could be found. (b) (6) has worked with the Phillips Bright View Gamma camera extensively. I had never worked with this camera before. But with a couple clicks the chronology time was right in front of me. I interpreted this as an effort to hide the truth. I looked at the monitor and discovered the patient had been on the camera 33 minutes, and counting.

(b) (6) said, he noticed the problem half way through the test. If indeed that were true, he should have realized he had a problem at 6-8 minutes, instead of 12-16 minutes. I said as much. At this point, the technologist became defensive, and argumentative. I diffused this situation but time and again that day and for the next 5 working days, and some were separated by a weekend, the tech wanted to re-approach the conversation. His last effort ended with a subtle threat of Union action.

Furthermore, while the patient lay on the camera with his arms still above his head, (b) (6) said he wanted to leave the room and go down the hall to speak with another patient. I instructed him to wait because I wanted to go with him and observe his routine. I advised (b) (6) his patient was still on the camera, and inside the camera scanning, with the detectors running, and s/p cardiac stress, could not be left unattended. He disagreed, and while I walked away to adjacent room 2 to ask (b) (6) to watch the patient for us, (b) (6) abandoned his patient and left the room. He would later say he did not hear me; however, we were standing together.

Sincerely,

(b) (6)

Attachment E

SalisNHPPReport.pdf

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: JUL 01 2014

From: Director, National Health Physics Program (NHPP)

Subj: Investigation for Allegation Circumstances at the W.G. (Bill) Hefner VA Medical Center

To: Chair, National Radiation Safety Committee, and National Director, Nuclear Medicine & Radiation Safety Services

1. NHPP investigated the allegation circumstances listed in the U.S. Office of Special Counsel (OSC) letter dated June 5, 2014, for subject facility. The investigation included an on-site inspection at the facility, interviews with facility staff and the alleger named in the letter, and review of available documents related to the facility. Our investigation was limited to issues under Nuclear Regulatory Commission (NRC) regulatory purview.

2. For your consideration, we are providing the following attachments.

a. Attachment A has statements of findings, conclusions, and recommendations for the allegations considered to be under NHPP/NRC purview in the OSC letter.

b. Attachment B contains NHPP inspection documents including the inspection plan, inspection record, and transmittal memorandum to the facility with attached NHPP Form 591. For the inspection, we cited one Severity Level IV violation (lowest severity level), unrelated to the allegations in the OSC letter, for a notification error related to changes to areas of use. We also identified a non-cited violation for a self-identified and self-corrected deficiency related to failure to perform package surveys during an isolated period of time. When the cited violation was identified to the facility during the on-site inspection, a plan for corrective action was promptly established and completed.

c. Attachment C is a record of contact (referenced in the inspection record) dated March 24, 2014, between NHPP and the facility Radiation Safety Officer. This contact predated the OSC letter. We had planned to follow up on the items identified at the next routine inspection. The items were reviewed during this inspection.

3. In sum, we did not substantiate the allegations that specific regulatory requirements under NRC or NHPP purview (radiation safety related issues) were violated. We did identify two minor violations, one cited at Severity Level IV and one non-cited (described

in paragraph 2 above) which were unrelated to the specific allegations. We concluded that the violations did not have a significant impact on worker, public, or patient health and safety.

4. Please let me know if you have any questions or comments.

(b) (6)

Attachments

Attachment A

This attachment is for a memorandum from the Director, National Health Physics Program (NHPP) to the Chair, National Radiation Safety Committee, and National Director, Nuclear Medicine and Radiation Safety Services. The attachment includes statements of findings, conclusions, and recommendations for the allegations in an Office of Special Counsel (OSC) letter dated June 5, 2014.

For a response to the letter, NHPP completed an announced inspection at W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina, to review allegation items related to safe and compliant use of radioactive materials.[1] (b) (6) Ph.D., and (b) (6) NHPP Program Managers, performed the inspection.

The inspection scope for NHPP was limited to allegation items in the OSC letter which are under NHPP purview (i.e., items associated with the conduct of the radiation safety program). The NHPP inspectors toured nuclear medicine areas, observed operations pertinent to radiation safety compliance, and reviewed relevant records required by the Nuclear Regulatory Commission (NRC), including, but not limited to, records for decay-in-storage of radioactive wastes, patient administrations involving radioactive materials, and personnel dosimetry results. The inspectors held entrance and exit briefings with medical center leadership, including the Director and Chief of Staff. NHPP issued an inspection report, which is included as Attachment B, to document inspection findings.

(b) (6) interviewed the whistleblower (named in the OSC letter) by telephone on June 17, 2014. The NHPP inspectors also interviewed the following facility individuals during the on-site inspection.

- (b) (6) M.D., Acting Chief, Nuclear Medicine Service, and Radiation Safety Officer (RSO)
- (b) (6) MBA, R.T.(R), Supervisory Diagnostic Radiology Technician, and Administrative Officer, Imaging Service
- (b) (6) (b) (6) and (b) (6) nuclear medicine technologists

For additional information, NHPP has regulatory files for the facility with previous routine inspection results, permitting actions that approve uses of radioactive materials or key staff such as the RSO, and records of contact with key staff. The findings, conclusions, and recommendations below consider all available information.

[1] NHPP reviewed allegations under NHPP regulatory purview, including allegations that specific requirements of the Nuclear Regulatory Commission were not followed. Other items in Sections I, III, and IV of the OSC letter are not under NHPP purview and were not investigated by NHPP.

Findings, Conclusions, and Recommendations

Allegation

The whistleblower, a former nuclear medicine technology supervisor and candidate to be named as RSO on the facility radioactive materials permit (referred to as the concerned individual, or CI, throughout the remainder of this attachment), alleged mishandling of radioactive materials, improper record keeping, and lack of proper signage for radioactive material treatment areas. The allegation is detailed in Section II on pages 3 and 4 of the OSC letter.

Findings

The findings below are referenced to paragraphs under Section II of the OSC letter.

Paragraphs 1 and 2

NHPP confirms the accuracy of statements in the first two paragraphs on page 3 of the OSC letter in that requirements in the regulations are correctly stated. However, NHPP adds that 10 CFR 20.1903 must also be considered since that regulation describes exceptions to posting requirements which are pertinent to this investigation. Similarly, 10 CFR 20.1905 must be considered since that regulation describes exemptions to labeling requirements pertinent to this investigation.

As additional information confirmed by NHPP during the on-site inspection at the facility, the CI reported for duty at the facility to be the supervisory nuclear medicine technologist on or about February 24, 2014. The CI was also hired to be named eventually as the RSO on the facility radioactive materials use permit. On March 25, 2014, the current RSO (b) (6) removed the CI from all duties involving radiation safety and nuclear medicine processes due to apparent performance issues related to certain basic radiation safety and nuclear medicine tasks.

Based on discussions with the Nuclear Medicine Service staff, the NHPP inspectors concluded that removal of the CI from these duties did not result from the CI identifying or reporting safety concerns, but were based on performance issues related to basic radiation safety and nuclear medicine tasks.

Paragraph 3 (initial work area and posting requirements)

NHPP reviewed statements in the OSC letter about the CI's initial duty station and required postings for that room. Some details about his initial work station were not substantiated. According to interviews with nuclear medicine staff, when the CI began working at the medical center around February 24, 2014, his initial duty station was in Room 2161. The nuclear medicine technologists interviewed for the inspection stated that patient thyroid uptake scans are performed in this room, but not patient injections of radiopharmaceuticals. During the NHPP inspection on June 18-19, 2014, a new cardiac

scanning device was in Room 2161; but as of the inspection date, the device had not been made operational. According to interviews with the other nuclear medicine technologists, injections are and have been performed either in the hot laboratory area (which is located in a smaller room within Room 2107 (across the hallway from the CI's initial duty station) or in the cardiac stress test labs, Rooms 5008 and 5009, which are on a different floor of the medical center.

The CI alleged that his initial duty room and the scanning room lacked federally required signage (i.e., radiation signs or postings) specific to radioactive materials. NHPP did not substantiate this allegation. NHPP reviewed all radioactive material use rooms in the nuclear medicine department (Building 2, 2nd floor: Rooms 2107, 2108, 2161, and the hot laboratory room within 2107) and two cardiac stress labs (Building 2, 5th floor: Rooms 5008 and 5009) and determined that the only room which requires a posting for radioactive materials under 10 CFR 20.1902 and 20.1903 is the hot laboratory, which is a smaller room with its own door, located within Room 2107.

The inspectors observed that the hot laboratory, where radiopharmaceutical dosages are received, prepared, and stored along with other quality control sources, was properly posted with a "Caution, Radioactive Materials" sign on the door. While the inspectors acknowledge that it is common practice for nuclear medicine departments to post all rooms in which radioactive materials are used, many rooms are not required to be posted under regulations because they meet the posting exceptions in 10 CFR 20.1903. These exceptions are satisfied because radioactive materials are not present in the rooms for more than 8 hours and when materials are present, they are either under the direct control of a nuclear medicine technologist or administered to a patient; and patients who are administered radioactive materials (per 10 CFR 35.100 and 35.200, which are the only uses under this permit) are readily releasable under conditions of 10 CFR 35.75.

Therefore, while NHPP did observe that some rooms at the facility had not been posted as radioactive material use areas, NHPP did not substantiate any specific circumstance that violated NRC regulations in 10 CFR Part 20.

Paragraph 3 (last sentence, disposal log issue)

The CI alleged that the department did not maintain a radioactive decay-in-storage log, in violation of NRC regulations. NHPP did not substantiate this allegation. The NRC regulations require the permittee to maintain a minimum of 3 years of disposal records for decay-in-storage. During the NHPP inspection, (b) (6) (nuclear medicine technologist with primary responsibility for waste disposals) readily retrieved 3 years of decay-in-storage records, which were maintained electronically on a computer system in the nuclear medicine hot laboratory.

The inspectors noted that (b) (6) had to use a special query screen to retrieve records prior to 2012; however, the records were readily retrieved. The records had the minimum information specified in 10 CFR 35.2092 including the date of the disposal, the

survey instrument used, the background radiation level, the radiation level measured at the surface of each waste container, and the name of the individual who performed the survey.

Paragraphs 4, 5, and 6 (food products, labeling, and waste disposal practices)

The CI alleged that during the week of March 17, 2014, he found six containers of non-labeled waste materials (including food products) in the hot laboratory which posed a biohazard and contamination hazard and required disposal as radioactive waste. Based on observations of work areas and interviews with the three nuclear medicine technologists assigned to work in the area, NHPP did not substantiate this specific allegation circumstance. However, the NHPP inspectors did substantiate that the facility does routinely perform nuclear medicine procedures which involve dosing food products resulting in generation of wastes of a similar nature, which require proper disposal and handling as radioactive materials.

The following procedure for handling radiopharmaceutical-dosed food products was described to the NHPP inspectors by the three technologists: The medical center does not use eggs, toast, or juice, as a medium for delivery of any radiopharmaceuticals. For gastric emptying studies (typically no more than one per day and three per week), the Nuclear Medicine Service uses only a microwaveable, commercially available, food product (i.e., Dinty Moore® beef stew manufactured by Hormel Foods, LLC) which is provided in its own microwavable plastic serving container. As part of preparation for the study, the patient is instructed to bring the food product with them, such that the food preparation does not take place until the patient is present in the Nuclear Medicine Service for the procedure.

After warming in a microwave, the radiopharmaceutical dosage (around 1 millicurie of technetium 99m diluted in a saline solution) is added to the food product by injecting it into the meat portion of the product in the hot laboratory. This process is performed while the container is sitting on a plastic-backed absorbent pad in case of any spillage or inadvertent contamination to prevent contamination of hot laboratory surfaces. The dosed food product remains in the plastic container on the pad and the container does not come into direct contact with the laboratory counter surfaces. The patient is provided the dosed food product with a plastic utensil and is instructed to consume all of the product.

Any residual radioactivity in the food dish is a very small fraction of the starting activity and less than a few microcuries. After the patient consumes the food, the nuclear medicine technologist places the spent food container and plastic utensil inside a disposable glove and then seals the item in another plastic bag in the hot laboratory for added contamination control. The absorbent pad is also disposed of as radioactive waste for decay-in-storage. The bagged item is stored in the hot laboratory, which is a restricted area for purposes of controlling radiation exposures and contamination. To minimize exposures to technologists, the bagged item is stored behind the L-block shielding for about a day and then consolidated with other waste items in a designated

radioactive waste bin in the hot laboratory for decay-in-storage. The usual process is that once an entire waste bin is full, which can take multiple days, the bin is closed and the entire container is placed into the decay-in-storage process for disposition in accordance with 10 CFR 35.92. The waste bin is required to be held for decay-in-storage until no residual activity above background levels remains, as determined by a radiation survey.

Due to the very low residual activity, the bagged item is exempt from labeling as radioactive material per 10 CFR 20.1905 (i.e., the activity is well below the quantity for technetium 99m in Appendix C to 10 CFR 20, i.e., 1 millicurie). The regulations do not have a specified time frame by which the bagged item must be placed into a decay-in-storage bin; however, the item must be controlled from unauthorized removal or access per NRC requirements in 10 CFR 20.1801 and 20.1802. Such control is provided by keeping waste materials in the hot laboratory which is locked when nuclear medicine technologists are not present. NHPP did not substantiate or identify any specific mishandling or loss of control of radioactive waste materials for this procedure.

As discussed above (for paragraph 3, last sentence), the facility retrieved records for the inspectors' review of waste disposals which showed the required information was being maintained. The inspectors did not identify any violations of NRC requirements for the process described by the technologists. In addition, none of the three technologists had any awareness of an instance during the week of March 17, 2014, in which "six empty food containers, including Styrofoam boxes and cups containing uneaten food" were left on the hot laboratory counter. The technologists also stated to the inspectors that they do not and have not used the hot laboratory as an area for their own eating purposes.

Additional Comment from Alleger Interview

During the telephone discussion between (b) (6) and the CI on June 17, 2014, prior to the on-site inspection, the CI stated that he did not think the computer system being used for certain record keeping tasks in the nuclear medicine hot laboratory was maintaining information on dosages administered to patients for the required time period. This issue was reviewed by NHPP during the on-site inspection. The inspectors observed that the facility was maintaining the required dosage records for the minimum 3-year retention time per 10 CFR 35.63 and 35.2063. The dosage information was being maintained in hard copy format rather than on the computer system. NHPP did not identify a violation or deficiency for record keeping related to patient dosages.

Additional Information for NHPP Inspection

In addition to specific review of allegation circumstances identified in the OSC letter, NHPP performed a core inspection of activities under the radioactive materials permit. The inspection report and associated inspection documents are included as Attachment B. The inspection identified one violation, unrelated to the allegation circumstances, for failure to notify NHPP per 10 CFR 35.14 of changes to areas of use under the permit

back in the 2010 time frame. The inspection identified a non-cited violation for failure to perform removable contamination surveys per 10 CFR 20.1906 on external surfaces of incoming radioactive material packages. This latter issue was non-recurring and was self-identified and self-corrected by the permittee such that NHPP, following the NRC Enforcement Policy, exercised discretion and did not cite this violation.

Conclusions

With respect to radiation safety items under NHPP purview, NHPP did not substantiate any regulatory violations or significant deviations from health physics best practices for the allegations raised by the CI in the OSC letter or during the telephonic interview on June 17, 2014.

Recommendations

NHPP did not have any specific recommendations to facility management or staff related to the allegation circumstances identified by the CI.

Attachment B

VHA National Health Physics Program (NHPP) Inspection Plan
W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
June 18-19, 2014

1. Tour radioactive material use, storage, and waste collection/storage areas. Perform spot-check radiation measurements.

2. Use risk-informed, performance-based inspection approach by observing any ongoing work, interviewing workers, and asking workers to demonstrate capability to perform basic radiation safety practices. Use applicable Nuclear Regulatory Commission (NRC) inspection procedures based on the radiation safety program areas evaluated.

3. Determine the type and extent of records to review based on performance-based inspection results to include, as needed, records since the most recent NHPP inspection for incidents, spills, dosimetry, and Radiation Safety Committee meetings. Review all records since the most recent NHPP inspection for written directives and annual radiation safety program reviews.

4. Evaluate radioactive material locations of use, review the decommissioning file, if required, for authorized radioactive materials, and compare current locations of use to those listed in the decommissioning file and those authorized by permit conditions.

5. Follow-up on permittee specific issues.

a. Corrective actions for most recent NRC inspection: Not applicable; an NRC inspection has not occurred since the most recent NHPP inspection of December 17, 2013.

b. Results from Nuclear Materials Events Database (NMED) review: Not applicable; no event reports added to NMED since last NHPP inspection (review date: June 16, 2014).

c. Other issues identified during review of permit files:

(1) Correspondence: No issues were identified for follow-up during this inspection.

(2) Inspections: Review implementation and effectiveness of corrective actions for the two violations cited by NHPP at last routine inspection on December 17, 2013. One violation was issued for failure to sign Radiation Safety Committee minutes within 45 days of meetings. The other violation was for failure to have trained/tested employees who prepared radioactive materials for shipping.

(3) Other Information: Follow-up on Record of Contact dated March 24, 2014, between NHPP and RSO and review permittee corrective and preventive actions for self-identified deficiencies.

(4) Permits: No additional follow-up items from those stated above were identified.

d. Review radiation safety-related issues identified in complaint from Office of Special Counsel.

VHA National Health Physics Program (NHPP) Inspection Plan
W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
June 18-19, 2014

6. Review current generic inspection issues approved by National Radiation Safety Committee.

a. Use of training and information resources including "RSO Webinar Training" and NHPP Intranet Web site.

b. Awareness of facility-level incident reporting system and coordination with Patient Safety Officer and quality management staff.

c. Safety culture awareness, reporting concerns, and safety conscious work environment.

d. Management oversight for safe use of radioactive materials including policy requirements in VHA Directive 1105.01.

e. Training and procedures for proper receipt and shipping of radioactive materials packages.

8. Conduct entrance and exit meetings with representatives of executive management.

Submitted by: (b) (6) Date: June 16, 2014

Approved by (b) (6) Date: 16 Jun 14

VHA National Health Physics Program (NHPP) Inspection Record

Inspection report number: 659-14-I01 Permit number: 32-15483-01

Permittee (name and address): W.G. (Bill) Hefner VA Medical Center
1601 Brenner Avenue
Salisbury, North Carolina 28144

Locations of use being inspected: same as above

Permittee contact (name and telephone number): (b) (6)
Radiation Safety Officer (RSO)
704-638-9000, x2398

Permit priority: 3 Permit program code: 2120/0000

Date of last NHPP inspection: December 17, 2013

Date of last NRC inspection: March 17, 2011

Date of this inspection: June 18-19, 2014

Type of inspection: (X) Announced ( ) Unannounced
( ) Initial (X) Routine (X) Special

Next inspection date: June 2017 (normal, unless modified by NHPP inspection algorithm)

Summary of findings/actions

( ) No violations (inspection report or NHPP Form 591 issued)
(X) Severity Level IV and/or non-cited violations (NHPP Form 591 issued)
( ) Severity Level IV and/or non-cited violations (inspection report and NHPP Form 591 issued)
( ) Severity Level I, II, or III violations (inspection report and NOV issued)
(X) Follow-up on previous violations

Inspector(s): (b) (6) Date: June 25, 2014

(b) (6) Date: June 25, 2014

Approved: (b) (6) Date: 30 Jun 14

VHA National Health Physics Program (NHPP) Inspection Record

PART I - PERMIT, INSPECTION, INCIDENT/EVENT, AND ENFORCEMENT HISTORY

1. AMENDMENTS AND PROGRAM CHANGES

Amendment No. 48, dated June 25, 2014, updated areas of use.

Amendment No. 47, dated January 3, 2014, added an authorized user.

2. INSPECTION AND ENFORCEMENT HISTORY

The previous NHPP inspection on December 17, 2013, cited two minor violations at Severity Level IV. The first violation was for the Director not signing Radiation Safety Committee (RSC) minutes within 45 days after meetings. The second violation was for not having documented training and testing as specified in 49 CFR 172.702 for employees who prepared and/or shipped radioactive materials. During this inspection, the inspectors reviewed implementation and effectiveness of corrective actions completed for these violations and considered the actions adequate to close the violations.

The previous NRC inspection on March 17, 2011, cited no violations.

3. INCIDENT/EVENT HISTORY

Review of the NRC Nuclear Material Events Database on June 16, 2014, identified no new event reports since the last NHPP inspection. No reportable events were identified during the inspection.

PART II - INSPECTION DOCUMENTATION

1. ORGANIZATION AND SCOPE OF PROGRAM

W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina, utilizes radioactive materials under a limited-scope permit for diagnostic medical uses (10 CFR 35.100 and 35.200 only) at a single street address. The permittee performs around 12-14 diagnostic procedures per day with three nuclear medicine technologists. The permittee utilizes unit doses obtained from a commercial radiopharmacy. Radionuclide generators are not used. PET/CT imaging is not performed. The facility does not perform therapeutic uses of unsealed radionuclides or uses of I-131 sodium iodide greater than 30 μCi (i.e., medical uses under 10 CFR 35.300). The scope of the program remains relatively unchanged from the previous NHPP inspection in December 2013.

The RSO is a full-time employee of the permittee and is an authorized user on the permit. The RSO reports to the Chief of Staff. The RSO has complete autonomy with regard to radiation safety program implementation and stop-work authority, and coordinates the radiation safety program through the RSC and executive management.

The RSC submits minutes to the facility's Environment of Care Committee. The RSC meets at least twice each year. RSC minutes are timely signed by the Director, since the last NHPP inspection, and consistent with VHA requirements. The inspectors reviewed executive management oversight of the radiation safety program per VHA Directive 1105.01 and did not identify any oversight issues. The

inspectors reviewed the use of external consultants and did not identify undue reliance of management on affiliate universities or consultants for implementation of the radiation safety program.

The inspectors interviewed all three technologists in nuclear medicine to assess their willingness to raise safety concerns, if needed, and determined that the individuals were knowledgeable of methods for reporting concerns and appeared to be willing to report concerns both internally and externally if needed. Executive management and employees appeared dedicated to putting safety first, having a questioning attitude, and a willingness to stop work, if needed, for regulatory compliance. The inspectors noted that the RSO and management appeared to resolve radiation safety issues that were identified to them in a timely and effective manner consistent with maintaining a positive safety culture and a safety-conscious work environment.

2. INSPECTION SCOPE AND NRC INSPECTION PROCEDURES USED

The inspection followed a pre-approved inspection plan. The inspection focus was risk-informed and performance-based. The inspection consisted of an examination of rooms and equipment used for nuclear medicine, review of radiation safety practices, and observations of and interviews with facility staff. All items on the inspection plan were completed. The inspectors observed a nuclear medicine technologist perform a package receipt in the hot laboratory and a patient administration of radioactive material.

The inspectors used NRC inspection procedure IP 87130, "Nuclear Medicine Programs, Written Directives Not Required." The inspectors used the focus areas in the NRC procedure (i.e., security and control of radioactive materials, shielding, comprehensive safety measures, dosimeter, instrumentation and surveys, training and practices, and management oversight) and determined the adequacy of the radiation safety program following a performance-based approach.

Records reviewed included the following

Dosimetry results for 2013 and 2014 (available through April 30, 2014)
RSC minutes for 2014
Sealed source inventories and leak tests for 2014
Records for spills or reportable incidents (none indicated)

3. INDEPENDENT AND CONFIRMATORY MEASUREMENTS

The inspectors completed independent survey measurements in the nuclear medicine hot laboratory and scanning areas with a Ludlum Model 2401-P GM tube survey meter, Serial Number 295260, calibrated September 17, 2013. Measurements did not identify any radioactive contamination. The highest exposure reading was 0.06 mR/hr, and was consistent with areas being maintained as low as reasonably achievable (ALARA) and well below levels that would cause a regulatory dose limit to be exceeded for staff or members of the public.

4. FINDINGS AND RECOMMENDATIONS

Sealed sources on site were consistent with those listed on NHPP's Web-based sealed-source

inventory.

The RSO and other key staff were aware of the NHPP Intranet Web site and RSO Webinar training.

The nuclear medicine staff was aware of facility-level requirements for reporting incidents in coordination with other facility-level groups, such as the Patient Safety Officer and quality management groups.

The inspectors followed up on permittee-identified items discussed, prior to the inspection, by telephone between the RSO and NHPP on March 24, 2014. The items included purported performance deficiencies with a newly hired supervisory technologist, who was also hired to eventually be appointed as the RSO, in areas of wipe testing of incoming packages, leak testing for newly acquired sealed sources, performing physical inventory of sealed sources, preparing shipping paperwork for radioactive materials, disposing of permitted materials, and routinely wearing personnel dosimetry. As an overall corrective action for the issues, on March 25, 2014, the RSO removed the individual from duties involving radiation safety and nuclear medicine processes, including handling of radioactive materials. The inspectors' impressions and conclusions for these specific items are discussed below.

For incoming packages, the inspectors concurred that the individual failed to perform and/or document performance of wipe surveys on incoming packages on several days. This failure was a violation of NRC requirements; however, since the permittee self-identified and corrected the issue prior to the inspection, and since the issue has not repeated, the inspectors identified this item as a non-cited violation. Additional details are provided below in Section 5.

For leak testing of sealed sources, the RSO noted that the individual had difficulties performing a leak test on a newly acquired sealed source. NHPP inspectors determined that leak tests were within required timeframes per 10 CFR 35.67 because the new source had been leak tested by the source manufacturer within 6 months prior to receipt of the source by the permittee. While it is desirable for a supervisory nuclear medicine technologist to have basic knowledge about how to perform these tests, the inspectors did not identify a specific violation for this item.

For the issue related to performing physical inventory of sealed sources, the RSO noted that the individual had difficulties converting between basic units of activity for entry into NHPP's Web-based sealed source inventory system. This system is an internal VHA system and is not required by NRC regulations. While it is highly desirable for a supervisory nuclear medicine technologist and RSO to have basic knowledge about how to perform activity unit conversions, the inspectors did not identify a specific violation of NRC requirements for this item.

For the issue related to preparing shipping paperwork for radioactive materials, the shipment was related to sending a low-activity (~ 2 mCi) spent Co-57 sealed source to a vendor. Based on the activity involved, the source in its shielded container would have qualified as a limited quantity shipment such that specific DOT shipping papers would not have been required. While it is important to follow vendor specific instructions for returning sources, the inspectors did not identify an NRC violation for this issue, although the circumstance did apparently create documentation issues that had to be resolved with the vendor who was taking possession of the source.

For the issue related to improper waste disposal, the RSO noted that on March 19, 2014, the individual placed a used radioactive needle in the regular trash. This circumstance could have resulted in a violation if the permittee had not retrieved the item prior to final disposal. While this is a performance deficiency, the inspectors did not identify a violation of NRC requirements for failure to control radioactive materials since other permittee staff identified the issue and the item was retrieved from the regular trash prior to final disposal and release from the permittee's control.

For the issue related to not wearing dosimetry, the inspectors were informed that the individual lost his finger-ring dosimeter on March 20, 2014, and worked without the finger-ring on March 20 and March 21, 2014. The facility's policy is that individuals who are issued a dosimeter must wear the dosimeter when handling radioactive materials. Upon identifying the lost ring, the individual should have reported the issue to the RSO and obtained a replacement badge before continuing to handle radioactive materials. While this represents a facility-specific performance deficiency, the inspectors did not identify a specific violation of NRC requirements because a review of past personnel dosimetry results revealed that it was unlikely for the individual to exceed the monitoring threshold stated in 10 CFR 20.1502(a) - specifically 5000 mrem per year to extremities. As additional information, the maximum extremity dose for calendar year 2013 for technologists was 2560 mrem and the scope of use had not significantly changed.

In additional discussions during the inspection, other nuclear medicine technologists revealed that the individual did not document personal surveys on several days from February 24, 2014, through March 17, 2014. The inspectors agree that such surveys are common practice for nuclear medicine staff. Based on standard safety practices observed and used by technologists (e.g., use of disposable gloves and routine area surveys), it is unlikely that any significant contamination would have been inadvertently removed from the area during the period by the individual. However, NHPP inspectors agree that end-of-day personnel surveys are a best practice and all individuals who handle radioactive materials should follow internal policies established by the RSO and permittee management. The inspectors did not identify a specific violation of NRC requirements since no objective evidence was provided to indicate that contamination was actually removed from the facility and since the RSO took corrective actions to remedy the circumstances by revoking the subject individual's radioactive material use privileges.

As described above, the inspectors evaluated training and procedures for proper receipt and shipping of radioactive materials packages and identified several occasions (discussed below) where surveys were not performed or documented. The failure was self-identified in that two nuclear medicine technologists reported the deficiencies to the RSO, and the RSO took prompt corrective actions to address the issue. In addition, the technologists present during the inspection appeared knowledgeable of the methods and requirements for performing package receipt surveys. The permittee also maintained staff that was trained and tested per DOT requirements for shipping.

The inspectors reviewed radiation postings in area of use and determined that postings conformed to requirements in 10 CFR 20.1902 and 20.1903.

The inspectors reviewed practices for disposal of radioactive materials by decay in storage, including maintenance of disposal records for at least 3 years. The inspectors determined that disposal practices and records conformed to requirements in 10 CFR 35.92 and 35.2092.

The inspectors reviewed practices associated with labeling and storage of radioactive wastes associated with gastric emptying studies. The inspectors determined that labeling conformed to requirements in 10 CFR 20.1904 and 20.1905 and that handling of these wastes conformed to requirements in 10 CFR 20.1801, 20.1802, 35.92, and 35.2092.

The inspectors reviewed the location of routine duty stations of technologists in concert with areas of material use and historical personnel radiation dosimetry results. No individuals exceeded the monitoring thresholds in 10 CFR 20.1502 for external doses during 2013, and there was no indication that work stations subjected workers to doses levels that were inconsistent with the ALARA philosophy.

The inspectors reviewed practices for determining activity and for recording patient dosages for the minimum 3-year period required by NRC. The inspectors determined that dosage preparation and record keeping practices conformed to requirements in 10 CFR 35.63 and 35.2063.

5. VIOLATIONS, NCVs, AND OTHER SAFETY ISSUES

Cited Violation:

The inspectors identified one violation at Severity Level IV (minor violation) due to failure to make a required notification and perform a survey for changes to area of use. During the inspection, the rooms identified in NHPP permit files were compared with those at the address of use, and the inspectors determined the facility moved the cardiology stress lab in 2010 from the second floor to the fifth floor of Building 2. Prior to the move, the stress lab area comprised Rooms 2042A (subsequently relabeled as 2046A) and 2042B (subsequently relabeled as 2046). Current stress labs are located in Rooms 5008 and 5009. Contrary to 10 CFR 35.14(b)(5), the facility failed to notify NHPP of the changes within 30 days after the change. In addition, permittee staff was not able to locate any survey records to demonstrate that the former stress labs had been surveyed for release for unrestricted use with respect to radioactive materials per 10 CFR 20.1402 and 20.1501.

The notification and survey deficiencies are characterized as a single violation because they are associated with the same event. The cause of the violation was not determined with complete certainty because key staff (i.e., the RSO and Imaging Supervisor), at the time of the relocation, are no longer employed by the permittee. The violation was likely caused by a lack of understanding about regulatory requirements for notifications and release survey documentation. Due to the short half-life of the radionuclides used for stress tests (e.g., 6-hour half-life for Tc-99m) and routine policies of (1) performing daily surveys in area of use and (2) not storing radioactive materials in stress test areas, the former stress test areas are expected to have met unrestricted use requirements in 10 CFR 20.1402 at the time of release and would not have posed a significant health and safety risk to other workers and members of the public. The areas have been renovated into office areas. This violation is categorized in accordance with NRC enforcement policy as a Severity Level IV violation. Corrective actions included reinstruction of the RSO of notification and survey requirements in 10 CFR 35.14 and

20.1501 by the NHPP inspectors on June 18, 2014, and written notification to NHPP on June 19, 2014, about the location changes.

Non-Cited Violation (NCV):

The inspectors identified a non-cited violation as follows: 10 CFR 20.1906(c) requires in part that the permittee shall perform the monitoring required by 10 CFR 20.1906(b) not later than 3 hours after a labeled package of radioactive materials is received. Contrary to this requirement, for packages received during normal working hours on March 6, 7, 19, 20, and 21, 2014, the permittee could not provide documentation that external surfaces of the packages had been properly monitored. This violation was self-identified and self-corrected by the permittee prior to the inspection. The violation is attributed to human performance difficulties in that the staff member who received packages on these days either did not perform wipe samples, properly operate the counting equipment, or document the count information. The inspectors did not identify recurrence of this violation after corrective actions were taken. Corrective actions involved removing the specific individual associated with the deficiency from duties involving radioactive materials on March 25, 2014.

6. KEY PERSONNEL CONTACTED

(b) (6) FACHE, Director [1,2]
(b) (6) MSN, R.N., Associate Director [1,2]
(b) (6) M.D., Chief of Staff [1,2]
(b) (6) M.D., Radiation Safety Officer, Authorized User [1,2,3]
(b) (6) MBA, R.T.(R), Administrative Officer, and Chief Technologist, Imaging Service [2,3]
(b) (6) Nuclear Medicine Technologist [3]
(b) (6) Nuclear Medicine Technologist [3]
(b) (6) Nuclear Medicine Technologist [3]

[1] Individual(s) present at entrance meeting
[2] Individual(s) present at exit meeting
[3] Individual(s) present or participating in inspection discussions

7. ATTACHMENTS

None

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: JUN 30 2014

From: Director, VHA National Health Physics Program (NHPP) (115HP/NLR)

Subj: Radiation Safety Program Inspection and Notice of Violation - Inspection Report 659-14-I01

To: Director (659/00), W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

1. (b) (6) Ph.D., and (b) (6) NHPP, inspected the radiation safety program at the W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina, on June 18-19, 2014.

2. The inspection report is attached. The report consists of an NHPP Form 591 citing one minor violation at Severity Level IV and identifying one non-cited violation. The violations represent a deviation from Nuclear Regulatory Commission requirements for radioactive material use.

3. You should note the NHPP Form 591 summarizes the violation, corrective actions, and full-compliance date. You must sign and return the NHPP Form 591 within 30 days of the date of this memorandum.

4. Thank you for the courtesy and cooperation extended during the inspection. Please contact (b) (6) at 501-257-1578, if you have any questions about the inspection.

(b) (6)

Attachment

cc: Chair, National Radiation Safety Committee
Network Director, VISN 06 (10N06)

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

. PERMITTEE/PERMIT NUMBER: W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina 32-15483-01	2. LOCATION(S) INSPECTED: 1061 Brenner Avenue Salisbury, North Carolina 28144
. INSPECTION DATE(S): June 18-19, 2014	4. INSPECTION REPORT NUMBER: 659-14-I01

PERMITTEE:
The inspection was an examination of activities under your permit as they relate to radiation safety and compliance with Nuclear Regulatory Commission (NRC) rules and regulations and your permit conditions. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and performance-based observations by the inspector. The inspection findings are as follows:

☐ 1. Based on the inspection findings, no violations were identified.

☒ 2. Previous violation(s) closed.

☒ 3. The violation(s), specifically described to you by the inspector as non-cited, are not being cited because they were self-identified, non-repetitive, corrective action was or is being taken, and the remaining criteria in the NRC Enforcement Policy, NUREG-1600, to exercise discretion, were satisfied. Non-cited violation(s) were discussed involving the following requirement(s) and corrective action(s):

10 CFR 20.1906(c) requires in part that the permittee perform monitoring of external package surfaces as required by 10 CFR 20.1906(b) not later than 3 hours after a labeled package of radioactive materials is received. Contrary to this requirement, for packages received during normal working hours on March 6, 7, 19, 20, and 21, 2014, the permittee did not have documentation to support that external surfaces of the packages had been monitored for removable radioactivity. The violation was self-identified and self-corrected by the permittee prior to the inspection. The violation is attributed to human performance difficulties in that the staff member assigned to receive packages on these days did not correctly operate sample counting equipment and record counting information. The inspectors did not identify recurrence of this violation after corrective actions were taken, which included permanently removing the staff member from duties involving radioactive materials on March 25, 2014.

☒ 4. During this inspection certain of your activities, as described below and/or attached, were in violation of VHA or NRC requirements and are being cited. This form is a NOTICE OF VIOLATION, which may be subject to posting per 10 CFR 19.11. The violations and corrective actions are as follows:

10 CFR 35.14(b)(5) requires a permittee to notify NHPP within 30 days after the permittee has added to or changed the areas of use identified in the application or on the permit where permitted material is used in accordance with 10 CFR 35.100 or 35.200. Additionally, 10 CFR 20.1501(a) requires that each permittee make surveys of areas as may be necessary for the permittee to comply with the regulations in 10 CFR 20. Contrary to these requirements, during 2010 the permittee moved the cardiology stress test area and did not notify NHPP of the change or complete closeout surveys in the former stress test area to comply with 10 CFR 20.1402. The cause of the violation was not determined with certainty because key staff (i.e., the Radiation Safety Officer and Imaging Supervisor), at the time of the relocation, are no longer employed by the permittee. The violation was likely caused by a lack of understanding about regulatory requirements for notifications and release survey documentation. Due to the very short half-life of the radionuclides used for stress tests, normal procedures of performing daily surveys in areas of use, and not storing radioactive materials in stress test areas, the former stress test areas are expected to have met unrestricted use requirements in 10 CFR 20.1402 at the time of release such that the areas would not have posed a

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

significant health and safety risk to other workers and members of the public. Corrective actions included reinstruction of the Radiation Safety Officer and Imaging Supervisor of notification and survey requirements in 10 CFR 35.14 and 10 CFR 20.1501 by the NHPP inspectors on June 18, 2014, and written notification to NHPP on June 19, 2014, about the area changes. The full-compliance date for corrective actions is June 19, 2014. This is a Severity Level IV violation.

STATEMENT OF CORRECTIVE ACTIONS

I hereby state that the actions described above will be taken to correct the violations identified. This statement of corrective actions is made per 10 CFR 2.201 (corrective steps already taken, corrective steps which will be taken, and date when full compliance will be achieved). I understand no further written response to NHPP will be required, unless specifically requested.

TITLE	PRINTED NAME	SIGNATURE	DATE
PERMITTEE			
NHPP INSPECTORS	(b) (6)	(b) (6)	June 25, 2014

Attachment C

From: (b) (6)
Sent: Monday, March 24, 2014 4:47 PM
To:
Cc: (b) (6)
Subject: RE: Salisbury RSO call

As a record of contact, (b) (6) (RSO at Salisbury) contacted me this afternoon to discuss some apparently recurring deficiencies by a specific nuclear medicine technologist. He was interested in understanding whether any such deficiencies required formal reporting to NHPP or NRC.

He outlined the items, which were minor in nature but did need to be resolved by the permittee. Some of the areas he is reviewing include: wipe testing of packages, leak tests for sealed sources, physical inventory of sealed sources, shipping paperwork for radioactive materials, proper disposal of permitted materials, and routine use of personnel dosimetry. I noted that formal reporting is not required unless the deficiencies were associated with an NRC-reportable event—and none of the items he described appeared to be reportable. The deficiencies appeared to be associated with a human performance issue. I outlined expectation for adequate and timely actions to correct deficiencies and prevent recurrence and noted that NHPP can normally give credit for self-identified, self-corrected deficiencies during our inspection process. Immediate corrective actions were noted to have been taken—primarily including removing an individual's privileges to use radioactive materials while further management reviews are conducted.

I did not identify any regulatory reportable items during the discussion. The RSO noted that he was made aware of issues yesterday—such that he appeared to be addressing the issues promptly and adequately for short term.

I do recommend that NHPP follow up with the RSO in 45 calendar days by phone to ensure long term resolution of the issues.

(b) (6) PhD, CHP, Program Manager/Health Physicist
VHA National Health Physics Program (10P4X)
2200 Ft. Roots Drive, North Little Rock, AR 72114 (115HP/NLR, Bldg 101, Rm 208)
Office: 501-257-1578; (b) (6) Fax: 501-257-1570

From: (b) (6)
Sent: Monday, March 24, 2014 9:12 AM
To:
Cc: (b) (6)
Subject: RE: Salisbury RSO call

(b) (6)

I received the message to call you. I am currently on an NRC conference call until around 11:30 am EDT. I will contact you after that call (assuming another NHPP staff member has not already contacted you sooner).

You may find the following NRC Information Notice helpful. Information Notice No. 96-28: Suggested Guidance Relating to Development and Implementation of Corrective Action:

http://www.nrc.gov/reading-rm/doc-collections/gen-comm/info-notices/1996/in96028.html

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