April 15, 1999

Dr. Shirley Strum-Kenny
[ ]
Stony Brook University Hospital
Administration Building, Room 310
Stony Brook, NY 11794-0701

Subject: Enforcement Letter (NTS-CH-BH-BNL-BNL-1998-0004)

EA-1999-02

Dear Dr. Strum-Kenny:

This letter refers to the Department of Energy's (DOE) evaluation of the facts and circumstances concerning an event at the Radiation Therapy Facility (RTF) occurring in March 1998. In November 1998, DOE conducted an investigation to determine whether violations of DOE's nuclear safety rules associated with the event had occurred. The resulting Investigation Summary Report was transmitted to you on February 19, 1999. On March 11, 1999, you participated in an Enforcement Conference, along with Brookhaven Science Associates (BSA) management, to discuss the occurrence, its safety significance, and the status of corrective actions.

The event that is the subject of this Enforcement Letter occurred on March 16, 1998, after one of the two microswitches served as a redundant interlock for the door to the linear electron accelerator room failed. The RTF is considered a high radiation area during patient treatment sessions. Operation of redundant interlocks is required to minimize the possibility of unplanned radiation exposure to personnel working at the facility during patient treatment.

After the one microswitch failed, Stony Brook University Hospital (SBUH) personnel called a service representative and authorized that person to bypass the malfunctioning microswitch by taping it closed. This action was approved by the RTF attending physician for the purpose of allowing continued operation of the accelerator. However, the attending physician was not authorized to make the decision to bypass the microswitch. Furthermore, SBUH personnel did not provide timely notification to BSA that the microswitch failed or that it had been subsequently bypassed. In fact, BSA did not become aware of the event until March 18, 1998, two days later.

Based upon our evaluation, we have concluded that violations of the entry control requirements of 10 CFR 835 (Occupational Radiation Protection Rule) occurred at the RTF. DOE recognizes that the actual safety significance of the violations is low

because one interlock on the door to the linear electron accelerator room still functioned. However, the lack of effective communication between SBUH and BSA regarding your regulatory obligations when conducting radiological activities at a DOE facility is of concern to DOE. DOE could issue an enforcement action to SBUH under the evaluation criteria described in the DOE Enforcement Policy (Appendix A 10 CFR 820). DOE has decided to defer enforcement action against SBUH because DOE finds it more appropriate in this case to hold its primary contractor accountable for ensuring that it's subcontractor is performing activities in accordance with established requirements. However, further violations by the SBUH may result in an enforcement action.

If you would like to discuss this matter further, please contact Sharon Hurley of my staff at 301-903-0110.

Sincerely,

R. Keith Christopher
Director
Office of Enforcement and Investigation

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