



DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration  
National Health Physics Program  
2200 Fort Roots Drive  
North Little Rock, AR 72114

DEC 27 2001

In Reply Refer To: 598/115HP/NLR

U. S. Nuclear Regulatory Commission (NRC)  
Region III  
801 Warrenville Road  
Lisle, Illinois 60532-4351

We are forwarding the enclosed letter from the Department of Veterans Affairs Medical Center, St. Louis, Missouri, NRC License Number 24-00144-05, to your office for consideration. The letter provides the medical center response to apparent violations resulting from a November 2001 NRC inspection. The letter is dated December 18, 2001, and was received on December 26, 2001.

Please provide a copy of any correspondence related to this medical center to:

National Health Physics Program (115HP/NLR)  
Department of Veterans Affairs  
Veterans Health Administration  
2200 Fort Roots Drive  
North Little Rock, Arkansas 72114

If you have any questions, please contact Gary E. Williams, VHA National Health Physics Program, at (501) 257-1572.

Sincerely,

Handwritten signature of Gary E. Williams in cursive.

Handwritten initials "ELM" in cursive.  
E. Lynn McGuire  
Director, National Health Physics Program

Enclosure



DEPARTMENT OF VETERANS AFFAIRS  
Medical Center  
915 N. Grand  
St. Louis, MO 63106

December 18, 2001

In reply refer to: 657/DSL JC

Ms. Cynthia Pederson  
Director of the Division of Nuclear Materials Safety  
US Nuclear Regulatory Commission, Region III  
801 Warrenville Road  
Lisle, IL 60532

THRU

National Health Physics Program (115HP/NLR)  
Department of Veterans Affairs  
Veterans Health Administration  
2200 Fort Roots Drive  
North Little Rock, AR. 72114

Dear Ms. Pederson;

Thank you for this opportunity to respond to the apparent violations resulting from your inspection of Nov. 27. It is our intent in this letter to reiterate what has been discussed by phone and fax to date, therefore do not hesitate to contact us should there be any confusion over our intentions.

The apparent violation regarding failure to secure radiomaterial occurred because the receptionist in Nuclear Medicine was called away from her desk, where the package had just been delivered. In her concern over patient-related issues, she momentarily neglected the package.

In response to this incident, the clerical staff and other support staff no longer actively participate in the delivery of radiomaterial packages. All personnel not authorized for participation have been trained to not handle packages unless they find one unsecured and unattended. Further, the procedure for receipt of packages at Nuclear Medicine has been refined by the addition of several details. These details include advance notification from the mailroom of an impending delivery, designation of nuclear medicine personnel (to include technologists, the radiopharmacy tech, and RSO staff) approved to receive the package upon arrival, and a requirement that the package be secured immediately upon arrival by transporting it directly to the radiopharmacy without interruption or delay. The radiopharmacy will remain locked when unattended. All employees authorized to receive these packages have already been trained in this procedure.

To prevent recurrence of this error, these new elements of training will be included during annual refresher training offered to all affected employees. The content of the training has already been upgraded to include these elements.

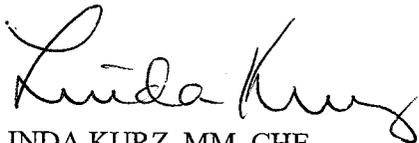
In regard to the apparent violation regarding unauthorized disposal of radiomaterial, our investigation revealed that an Environmental Management Service (EMS) employee-in-training had inadvertently emptied the radwaste into the regular waste while his field trainer was out of the room. Within a few days, the new employee had been given his permanent assignment in another area, so recurrence was not a concern in the immediate term. An assessment of impact to personnel as a result of this incident indicated no personnel exposure. However, the markings on the particular trash container were upgraded, and the trainer was re-instructed in proper procedure. Remedial training began with EMS employees who had been hired since the last annual refresher training (March 2001), and will conclude on Dec. 20, 2001, when all EMS will have been retrained in the proper procedure.

To prevent occurrence in the future, proper radwaste handling has been added to the new employee orientation so that total reliance upon field trainers will not be necessary. The issue will be reinforced during field training in research areas, as has always been the case.

The apparent violation regarding the notice of the location of posted documents occurred because the wording used in our notice appeared to us to satisfy the requirements that the notice "describes the documents" as stated in 10CFR 19.11 and 21.6. Our wording had survived numerous previous NRC and NHPP inspections at the eight sites under the license. Correction was made by immediately rewriting the description of these documents in the notice so as to name them individually rather than describe them; the revised notice has been attached to NRC form 3 wherever it is posted. This correction has already been implemented license-wide.

To prevent recurrence in the future, this wording has been stored on a word processor and the notices will remain taped to NRC form 3 so that they can be renewed whenever form 3 is updated.

If you have any questions about this response please contact Larry Chandler at 314-289-6348.



LINDA KURZ, MM, CHE  
Medical Center Director