PDR

OCT - 6 1989

04-00689-07

Docket No. 030-01215

Veterans Administration Medical Center
5901 E. Seventh Street
Long Beach, California 90822

Attention: Dean R. Stordahl
Medical Center Director

Gentlemen:

Thank you for your letter of September 12, 1989, in response to our Notice of Violation and Inspection Report No. 89-01, dated August 2, 1989, informing us of the steps you have taken to correct the items which we brought to your attention. Your corrective actions will be verified during a future inspection.

Your letter addressed the need for additional personnel to assist the Radiation Safety Officer. Since you have identified inadequate staffing as a root cause of the violations cited in our inspection report, we will look for improvement in this area during our next inspection.

In our August 2, 1989 letter, we also expressed our concern about and asked you to address the management support function which permits the Radiation Safety Committee (RSC) to effectively control individual investigators who use licensed radioactive material in an unsafe manner. Specifically you need to describe:

A. The RSC's authority to discipline users who fail to follow your radiation safety procedures or NRC regulations.

B. Specifically who in management is responsible for insuring that the committee possesses and, if necessary, uses this authority?

C. The type of actions the RSC is authorized to take when users fail to follow your radiation safety procedures or NRC regulations.

Once you have adequately responded to A, B and C above we will consider your reply to the inspection and notice of violation complete. Your reply should be submitted to this office within 20 days of the date of this letter.

Sincerely,

Original Signed

Robert J. Pate, Chief
Nuclear Material Safety and
Safeguards Branch

1/1

IE07

bcc w/copy of letter dated 9/12/89:
State of California
B. Faulkenberry
J. Martin
docket file
A. Johnson

REGION V
JMontgomery
9/28/89

RJPate
9/28/89

REQUEST COPY	REQUEST COPY
YES / NO	YES / NO

SEND TO PDR
YES / NO

Medical Center
5901 East Seventh Street
Long Beach CA 90822

Veterans Administration

September 12, 1989

In Reply Refer To: 600/138

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

Enclosed is the response to your inspection of June 12-14, 1989, Notice of Violation, NRC License No. 00689-07.

We are also responding to the Inspector's request as to what actions have been taken or planned to improve the effectiveness of the overall management control and record system. At present, we feel that the Radiation Safety Program is effective and has met its obligations within the available resources; however, as pointed out by your inspection, there are areas in need of improvement.

Our Radiation Safety Program was reorganized three years ago and the ceiling was increased to include a Radiation Safety Technician. Since then the complexities and demands of running a comprehensive Radiation Safety program have compounded and we now see the need again for additional Radiation Safety personnel. We intend to add an additional person to the program. The duties and major responsibilities will be in support of the areas of greatest need, such as education and surveys. These actions should be completed within three months, with a visible improvement in the overall Radiation Safety Program.

Major effort is going into recruiting to fill the vacancies in the Radiation Safety Program. Action is also underway to assist in the record keeping by employing a part-time Secretary as well as authorizing overtime to those in Radiation Safety.

Sincerely yours,

Dean Stordahl

Dean R. Stordahl
Medical Center Director

Enclosure

cc: NRC Region V

VIOLATION "A": License Condition No. 22.A, Item #23 and #12.

1. Item #23, the failure to perform, iodine bioassays on personnel in Research Laboratory Rm 240 occurred because the personnel failed to report to Radiation Safety. Since the time of this NRC Inspection, there has been a four-hour training session with the Research personnel of Lab 240. In this training session the requirements for a bioassay, when a bioassay is performed, and how the bioassay is recorded was outlined. From this training an immediate corrective response should be achieved. There will be a reminder notice sent to the Chief of Research, indicating that bioassays are needed for radiation safety.

2. Item #12, identified the failure to provide training for all radiation workers. Since the time of the NRC Inspection, an eight-hour training session was given to the new radiation workers. To assist in this training on a continual basis, a request to increase the FTE in Radiation Safety has been sent to Resource Management for approval. It is expected when approved that in three months full compliance will be achieved.

VIOLATION "B": 10CFR 35.14(5)(v), conduct quarterly physical inventories to account for all received and possessed sealed sources.

1 & 2. The failure to conduct a physical inventory of the sealed sources in the fourth calendar quarter, 1988 occurred because of time constraints. The Radiation Safety program includes Diagnostic X-ray; therefore, the RSO has these additional X-ray Radiation Safety duties. This problem appears to be solved by the requested increase in Radiation Safety's FTE. It is expected that in three months full compliance will be achieved.

VIOLATION "C": 10CFR 20.401(b), records of surveys, radiation monitoring and disposal.

1. The results of Radiation Surveys performed by the RSO were not recorded because of time constraints. This problem is now solved as overtime has been approved to complete assigned tasks. The filing of the vacant position in Nuclear Medicine and Radiation Therapy should reduce these omissions.

2. The bioassay measurements were not recorded. The method for assuring that a bioassay is done is as follows: Radiation Safety will send to Chief, Nuclear Medicine and to Chief, Research, a list of staff members to be measured for internal iodine concentration. Those who fail to show for their bioassay will have their privileges curtailed. The Radiation Safety Committee will be reviewing these bioassays at each committee meeting.

3. The wipe tests were not reported to DPM. The conversion to DPM is in process and should be implemented by December 1989.

VIOLATION "D": License Condition no. 15.D, recording leak test results in units of microcuries

The recording of the leak test in final report will be in units of microcuries. This recording will be done the next time the leak tests are done.

VIOLATION "E": 10CFR 30.51, disposal of licensed material to the sanitary sewer system in the Radiopharmacy Laboratory.

Disposal of licensed material into this sink is not authorized and Nuclear Medicine staff has been made aware of this through their latest staff meetings. Daily area survey will include monitoring this area.