

OCT 17 1989

In Reply Refer To:  
License: 43-03299-01  
Docket: 30-03273/89-01

Veterans Administration Medical Center  
ATTN: W. L. Hodson, Director  
500 Foothill Drive  
Salt Lake City, Utah 84148

Gentlemen:

Thank you for your letter of October 6, 1989, in response to our letter and attached Notice of Violation both dated September 18, 1989. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine whether full compliance has been achieved and will be maintained.

Sincerely,  
*Original Signed By:*  
A. B. BEACH

A. Bill Beach, Director  
Division of Radiation Safety  
and Safeguards

cc:  
Utah Radiation Control Program Director

bcc w/copy of licensee letter:  
DMB - Original (IE-07)  
RDMartin  
ABBeach  
LAYandell  
LShea, RM/ALF (AR-2015)  
CLCain  
RJEverett  
DBSpitzberg  
NMSB  
MIS System  
RIV Files (2)  
RSTS Operator

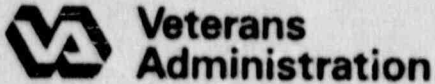
RIV:NMIST:SS  
DBSpitzberg:ch  
10/16/89

C:NMIST:CLC  
CLCain  
10/16/89

D:DRSS  
ABBeach  
10/16/89

IE-07  
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REG4 LIC30  
43-03299-01 FDC

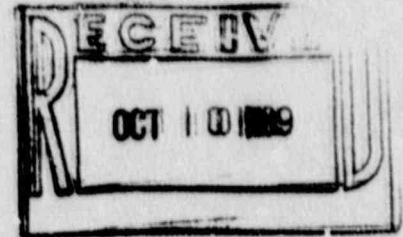


**Veterans  
Administration**

In Reply Refer To: 660/115

October 6, 1989

U.S. Nuclear Regulatory Commission  
ATTN: William L. Fisher, Chief  
Nuclear Materials Safety Branch  
6111 Ryan Plaza Drive, Suite 1000  
Arlington, Texas 76011



Subject: Response to Inspection of License: 43-03299-01,  
Docket: 30-03272/89-01, Dated 18 September 1989

Dear Mr. Fisher:

The violation will be discussed as requested in the notice of violation :

- 1: The technologist in question had a very heavy work load and forgot to have his thyroid counted until six days after the dose administration.
- 2: The technologists have been re-instructed to make sure they count their thyroids within three days of administration of a dose.
- 3: Same as 2.
- 4: Compliance has been achieved.

Sincerely,

  
W. L. Hodson  
Medical Center Director

cc: Nuclear Medicine Service (115)  
ATTN: Helen Malaskiewicz  
Department of Veterans Affairs  
810 Vermont Avenue, N.W.  
Washington, DC 20420

James W. Fletcher, M.D.  
Director  
Nuclear Medicine Service (115 JC)  
VA Medical Center  
915 North Grand  
St. Louis, Missouri 63106

IC-89-649

8910180079 1p.

IE07

SEP 18 1989

In Reply Refer To:  
License: 43-03299-01  
Docket: 30-03273/89-01

Veterans Administration Medical Center  
ATTN: W. L. Hodson, Director  
500 Foothill Drive  
Salt Lake City, Utah 84148

Gentlemen:

This refers to the routine, unannounced radiation safety inspection conducted by Dr. D. B. Spitzberg of this office on August 21-24, 1989, of the activities authorized by NRC Byproduct Material License 43-03299-01, and to the discussion of our findings held by the inspector with members of your staff at the conclusion of the inspection.

The inspection was an examination of the activities conducted under the license as they relate to radiation safety and to compliance with the Commission's rules and regulations and the conditions of the license. The inspection consisted of selective examinations of procedures and representative records, interviews of personnel, independent measurements, and observations by the inspector.

During this inspection, certain of your activities were found not to be conducted in full compliance with NRC requirements. Consequently, you are required to respond to this matter in writing, in accordance with the provisions of Section 2.201 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations. Your response should be based on the specifics contained in the Notice of Violation enclosed with this letter.

The inspector also reviewed the actions you had taken with respect to the violations observed during our previous inspection conducted on April 23-24, 1987. He verified that corrective actions for the violations had been implemented as required by the NRC Form 591 and that these actions had been effective at preventing a recurrence of the violations noted.

The response directed by this letter and the accompanying Notice is not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, PL 96-511.

RIV:NMIS ~~DBS~~  
DBSpitzberg:lm  
9/15/89

C:NMIS ~~CLC~~  
CLCain  
9/15/89

C:NMSB ~~WLF~~  
WLFisher  
9/18/89

8909250232 *DBS*

IF-07

Veterans Administration Medical  
Center

-2-

Should you have any questions concerning this letter, we will be pleased to discuss them with you.

Sincerely,

**Original Signed By:  
William L. Fisher**

William L. Fisher, Chief  
Nuclear Materials Safety Branch

Enclosure:  
Appendix - Notice of Violation

cc:  
Utah Radiation Control Program Director

bcc:  
DMB - Original (1E-07)  
RDMartin  
ABBeach  
LAYandell  
WLFisher  
LShea, RM/ALF (AR-2015)

\*CLCain  
\*RJEverett  
\*DBSpitzberg  
\*NMSB  
\*MIS System  
\*RIV Files (2)  
\*RSTS Operator

\*W/766

APPENDIX

NOTICE OF VIOLATION

Veterans Administration Medical Center  
Salt Lake City, Utah

Docket: 30-03273/89-01  
License: 43-03299-01

During an NRC inspection conducted on August 21-24, 1989, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1989) (Enforcement Policy), the violation is listed below:

10 CFR 35.315 (a)(8) requires, in part, that for each patient receiving radiopharmaceutical therapy and hospitalized for compliance with § 35.75 of this chapter, a licensee shall measure the thyroid burden of each individual who helped prepare or administer a dosage of iodine-131 within 3 days after administering the dosage, and retain for the period required by § 20.401(c)(1) a record of each thyroid burden measurement, its date, the name of the individual whose thyroid burden was measured, and the initials of the individual who made the measurements.

Contrary to the above, the thyroid burden of a technologist was not measured until 6 days following his administration to a patient of 147 millicuries of iodine-131 on March 21, 1989. The same technologist administered a 148-millicurie iodine-131 therapy dose to a patient on October 25, 1989, and while his thyroid burden was subsequently measured, there was no date indicated for this measurement.

This is a Severity Level IV violation. (Supplement VI)

Pursuant to the provisions of 10 CFR 2.201, Veterans Administration Medical Center is hereby required to submit to this office, within 30 days of the date of the letter transmitting this Notice, a written statement or explanation in reply, including for each violation: (1) the reason for the violation if admitted, (2) the corrective steps which have been taken and the results achieved, (3) the corrective steps which will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Where good cause is shown, consideration will be given to extending the response time.

Dated at Arlington, Texas,  
this 18th day of September 1989

8909250233 1p



**INSPECTOR'S REPORT**  
**(Continuation)**  
Office of Inspection and Enforcement

DOCKET NO. (8 digits) OR LICENSE NO. (BY PRODUCT) (13 digits)		REPORT		MODULE NUMBER		SITE RELATED
03003273		NO	SEQ	583822		
		8901	A	VIOLATION SEVERITY OR DEVIATION		A C
			B	1	2	3
			C	4	5	6
			D			

VIOLATION OR DEVIATION (Enter up to 2400 characters for each item. If the text exceeds this number, it will be necessary to paraphrase. Limit lines to 50 characters each.)

10 CFR 35.315 (a)(8) requires, in part, that for each patient receiving radiopharmaceutical therapy and hospitalized for compliance with §35.75 of this chapter, a licensee shall measure the thyroid burden of each individual who helped prepare or administer a dosage of iodine-131 within 3 days after administering the dosage, and retain for the period required by §20.401(c)(1) a record of each thyroid burden measurement, its date, the name of the individual whose thyroid burden was measured, and the initials of the individual who made the measurements.

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