Medical Center

4101 Woolworth Avenue
Omaha, NE 68105

Veterans Administration

October 10, 1989

William L. Fisher, Chief
Nuclear Materials Safety Branch - Region IV
U.S. Nuclear Regulatory Commission
611 Ryan Plaza Drive - Suite 1000
Arlington, Texas 76011

Dear Mr. Fisher:

Re: Docket: 030-02409/89-01
License: 26-00138-10

Pursuant to the provisions of 10 CFR 2.201, the following reply is submitted to the "Notice of Violation" for our NRC inspection conducted on August 7-8, 1989.

1. Item 1 - The Radiation Safety Officer (RSO) was aware of the annual audit requirement and had developed an "Audit Check List" which he submitted to the Radiation Safety Committee (RSC) at their July 17, 1989 meeting and subsequently showed to Mr. Vasquez during his visit. The subject of an audit was also discussed at the May 15, 1989 RCS meeting and the RSO informed the committee that he was developing an audit check list. However, the RSO misinterpreted 10 CFR 35.22(b)(6) and was of the impression that since his actions were being audited he should not participate in the audit. As a result it was difficult to gather an informed audit team and time slipped by. Parts of the radiation safety program are continuously reviewed by the RSC and the RSO but as noted in the inspection the complete program was not reviewed and documented. In the future the RSC will appoint a subcommittee each November to perform the annual audit and submit a written report by December 31. The requirement for the 1989 audit will be completed in December, 1989. The lack of a formal audit in 1987 and 1988 was an oversight.

2. Item 2 - The lack of a management representative on the RSC was due to the fact that the assigned individual was removed from a management position under protest and because of the long litigation involved a replacement was overlooked. The RSC now fully understands the requirement and will assure that a meeting will not be conducted unless a management representative and the RSO are present.

3. Item 3, 4c, and 5a - The reason for the gaps in recording the data described in item 3, 4c and 5a was primarily due to the fact that unbeknown to the Chief of Nuclear Medicine and the Radiation Safety Officer friction existed between the two technologists and since the daily surveys were assigned to one and the consistency checks assigned to the other, neither

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would perform the others duties when one was on vacation. This conflict has been resolved and the importance of performing each others job when the other is not present has been impressed on both technologists. The records will also be reviewed periodically at the RSC meetings.

4. Item 4a - The Radiation Safety Committee meeting is scheduled for the third Monday of each month so that we can be assured that all members can plan in advance to attend each meeting. On occasions when a quorum can not be assembled the meeting is cancelled. Since it has been found to be difficult to reschedule the meeting during the month and 10 CFR 35.22(2) states that the committee must meet at least quarterly, the meeting was not rescheduled during the month. The committee members lost sight of the fact that they would be held to Hospital Memorandum 115-1, dated August 27, 1984, stating that the RSC will meet monthly. Subsequent to the August 7, 1989 inspection, an application requesting that our license be amended to read "The Committee will meet as often as necessary to conduct its business but not less than once in each calendar quarter." The amended license dated September 28, 1989, has now been received.

5. Item 4b - The technologist cited was not actually drinking in the laboratory but was called into the laboratory from the office while he had the cup in his hand and sat it on a counter. However, it is realized that the presence of any eating utensil in the laboratory could present the possibility of personnel contamination. The posted laboratory procedures specifically states that no eating, drinking, smoking or applying cosmetics are to be done in the laboratory and this is reemphasized continually and in annual briefings. It has been made clear to the technologists that this is not to happen again.

6. Item 4c - See paragraph 3 above.

7. Item 4d - This violation was caused by the fact that the original survey meter being used by the Nuclear Medicine technologist malfunctioned and a different meter was substituted. The substituted meter had a range multiple that was confusing to the operator. During the daily surveys he compared the readings with background but failed to record the measured exposure rates. A different meter with a less confusing scale has now been furnished to Nuclear Medicine and the measured exposure rates will be recorded. These records will also be monitored periodically by the RSC and the RSO.

8. Item 5a - See paragraph 3 above.

9. Item 5b - This was an oversight by the RSO and will not happen in the future. The quarterly signature requirement has been placed on the RSO's computerized inspection schedule check list.

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10. In summary, full compliance with item 1 will be completed by Dec. 31, 1989. Full compliance of all other items was achieved on August 9, 1989.

Sincerely yours,

R.L. TURCOTTE
Director