Medical Center

1055 Clermont Street
Denver CO 80220

Department of Veterans Affairs

October 5, 1989

In Reply Refer to:

RE: License #05-01401-02
Docket # 30-01234/89-01

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

Dear Mr. Fisher:

This letter is in response to the Notice of Violation and cover letter from your office dated 9/05/89 which were the result of the routine unannounced inspection conducted by Messrs. Van Scovill, Howard Rose, and Scott Grace on August 2-3, 1989. Our letter of May 20, 1988 following inspection in January, 1988, indicated that we had contracted with the Radiological Sciences Division, Department of Radiology, University of Colorado, to provide radiation safety assistance and appointed a Nuclear Medicine Technician as Radiation Safety Technologist. Our intent was that this would be a short term arrangement. Unfortunately, due to the shortage of experienced Health Physicists it took us much longer to recruit than anticipated. Additionally, during this time our Nuclear Medicine Technician staff declined from four to one. The foregoing is intended to be a general explanation of the reason for the violations. While it does not excuse us, especially from the two repeat violations, I hope it will be considered as mitigating somewhat our lapses.

We are confident that our successful recruitment of a Radiation Safety Officer in August will markedly improve the management control of our licensed activities. A letter requesting an amendment to our license to list our new Radiation Safety Officer as such has just gone to your Licensing Branch following approval of his appointment by the Radiation Safety Committee.

The Radiation Safety Officer is in the process of preparing written procedures documenting NRC requirements, to insure that if staffing problems arise in the future, the requirements of the radiation safety program will be clearly outlined and lapses will not occur. Specific responses to each violation follow.

a. Violation 1 - This violation was the result of a very heavy workload for the sole Nuclear Medicine Technician and the lack of a full time Radiation Safety Officer. When the Technician got backlogged with the patient load, package surveys were one of the things he did not keep up with. The lack of a full time Radiation Safety Officer allowed this condition to persist rather than be corrected as it should have been, even at the expense of not handling all the patients in need of treatment.

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Corrective action has included recruitment of a full time Radiation Safety Officer and instruction to the Technician regarding the importance of license conditions/agreements. The surveys are being done as required. In addition, to prevent a recurrence the Radiation Safety Officer is preparing a written procedure. The procedure will be implemented not later than October 31, 1989, on an interim basis pending approval by the Radiation Safety Committee at its next meeting, scheduled for November 30, 1989.

b. Violation 2 - In conducting its research activities, this Medical Center has historically relied on its principal investigators or users to instruct their lab personnel. The reason for this has been two-fold - the burden was placed on the researcher who was using the material; and it was felt the researcher was best acquainted with his own lab activities and so was best able to instruct in lab specific precautions. The Radiation Safety Officer also provided supplementary in-service training sessions as requested. This approach is the same that many Broad Scope Licensees have taken, but has resulted in inadequate documentation of training held.

To correct this violation the Radiation Safety Officer will assume responsibility for instruction under Section 19.12. In-service training covering the requirements of 19.12 will be held not later than October 31, 1989 with Research Service personnel. Additional in-service training sessions will be scheduled to provide instruction to personnel who work in or frequent other restricted areas not later than December 31, 1989.

To prevent recurrence, the RSO will also prepare an information sheet for distribution at orientation informing all new employees of general guidelines required under 10 CFR 19.12, and informing them that they will receive further training should they be assigned to a restricted area. Additionally, the information sheet will be sent to all Service Chiefs with a cover memorandum explaining the requirements. Instruction of personnel newly assigned to restricted areas will initially be done by supervisors, but will be supplemented by additional training given by the Radiation Safety Officer.

c. Violation 3 - This violation was the result of our contract Health Physicist's failure to comply with the survey requirement. We had reason to believe that he understood the requirements of 10 CFR 20 and assumed he was complying with those requirements. We fully understand, however, that the responsibility is and was ours. That this was a repeat violation is particularly troubling to us. The Radiation Safety Officer is conducting all such surveys now. The Radiation Safety Officer will additionally prepare a written procedure for decay-in-storage waste disposal and surveys, to prevent recurrence. The procedure will be submitted to the Radiation Safety Committee for review and approval at its next meeting, and will be implemented not later than November 30, 1989.

d. Violation 4 - This violation was caused by the Nuclear Medicine Technician's haste to prepare a camera for a study. In his haste he failed to attach a label to some containers. The Technician has been given instruction with respect to the labeling of radiopharmaceuticals, and is now labeling all containers which may be left unsecured and unattended (but in a restricted area).

Sincerely Yours,

Fred Salas
Medical Center Director