APPENDIX A

NOTICE OF VIOLATION

Veterans Administration Medical Center

Docket: 030-17159
License: 05-08400-02

As a result of the inspection conducted on July 6 and 9, 1981, and in accordance with the attached Interim Enforcement Policy, 45 FR 66754 (October 7, 1980), the following violations were identified:

1. License Condition 15 states that licensed material shall be used in accordance with statements, representations, and procedures contained in your application received November 23, 1979.

   a. Item 12 of the license application states that two members from the staff of the St. Louis VA Nuclear Medicine Service will visit the Grand Junction facility for purposes of training and audit at regular 6-8 week intervals.

      Contrary to this requirement, and excepting the visit made on March 31, 1981, no other such visits have been made by members of the St. Louis staff since the issuance of the license on December 28, 1979.

   b. Items 11 and 21B of the license application describes the Gamma Scanning Room and its positive exhaust system capable of moving in excess of 200 cu. ft./min of air to the exterior of the building. This exhaust capability is provided to insure that concentrations of xenon-133 gas will remain below the regulatory limits during xenon ventilation studies.

      Contrary to this requirement, the Gamma Scanning Room that has been in use since the issuance of the license on December 28, 1979, was found not to be as described in the license application, and was not provided with a positive ventilation system capable of exhausting air at a rate in excess of 200 cu. ft./min.

   c. Item 10 of the license application commits the licensee to perform quarterly linearity tests of the dose calibrator according to procedures contained in Appendix D of Regulatory Guide 10.8.

      Contrary to this requirement, quarterly linearity tests have not been performed since issuance of the license on December 28, 1979.

   d. Item 17 of the license application requires laboratory areas to be surveyed weekly with a GM survey meter.

      Contrary to this requirement, weekly area surveys were not performed during the period from October 27, 1980 to February 2, 1981.

   This is a Severity Level IV violation (Supplement VII.D.1).

2. 10 CFR 20.201(b) requires each licensee to make or cause to be made surveys as may be necessary for him to comply with all sections of Part 20. 10 CFR 20.201(a), in part, defines survey to mean an evaluation of the radiation hazards incident to the use, or presence of radioactive materials under a specific set of conditions.

   Contrary to this requirement, no such surveys or evaluations were made since the license was issued on December 28, 1979, necessary for the licensee to insure compliance with 10 CFR 20.106(a) "Radioactivity in effluents to unrestricted areas " Such an evaluation was necessary for the set of conditions that existed during xenon ventilation studies.

   This is a Severity Level IV violation (Supplement IV.D.1).

3. 10 CFR 20.203(e)(1), "Caution signs, labels, signals and controls," requires that rooms or areas in which byproduct material is used or stored in an amount exceeding ten times the quantity of such material specified in Appendix C of 10 CFR 20 be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words: "Caution-Radioactive Material."

   Contrary to this requirement, the area where spent technetium generators and other radiopharmaceutical wastes are held for decay, was not posted "Caution-Radioactive Material."

   This is a Severity Level VI violation (Supplement VII.F).

4. 10 CFR 35.14 f(2) requires, in part, that licensees who possess and use calibration and reference sources in amounts not exceeding 3 millicuries, shall conduct a quarterly physical inventory to account for all sources received and possessed.

   Contrary to this requirement, no quarterly inventories have been performed of the four sealed calibration sources since the issuance of the license on December 28, 1979.

   This is a Severity Level VI violation (Supplement VII.F).

Pursuant to the provisions of 10 CFR 2.201, Veterans Administration Medical Center (Grand Junction) is hereby required to submit to this office within 30 days of the date of this Notice, a written statement or explanation in reply, including: (1) the corrective steps which have been taken and the results achieved; (2) the corrective steps which will be taken to avoid further violations; and (3) the date when full compliance will be achieved. Under the authority of Section 182 of the Atomic Energy Act of 1954, as amended, this response shall be submitted under oath or affirmation. Consideration may be given to extending your response time for good cause shown. The responses directed by this Notice are 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.

Dated JUL 31 1981

Glen D. Brown

Glen D. Brown, Chief
Technical Inspection Branch

APPENDIX B

SUMMARY OF ENFORCEMENT TELECONFERENCE BETWEEN NRC-REGION IV AND GRAND JUNCTION VETERANS ADMINISTRATION MEDICAL CENTER ON JULY 24, 1981

An enforcement teleconference was held on July 24, 1981, between representatives of the VA Medical Center in Grand Junction and the NRC staff at the Region IV office in Arlington, Texas. The following individuals participated in, or were present for this meeting:

VA Medical Center - Grand Junction, Colorado

W. Freer, Director
R. Pacini, M.D., Chief of Medicine
R. Harmon, Nuclear Medicine Technician

VA Medical Center - St. Louis, Missouri

J. W. Fletcher, M.D. - authorized user/supervisor (Grand Junction license)

NRC Region IV

J. T. Collins, Deputy Director, Region IV
J. E. Gagliardo, Director, Investigation and Enforcement Staff
R. J. Everett, Chief, Materials Radiation Protection Section
D. B. Spitzberg, Radiation Specialist

The purpose of the meeting was to discuss radiation safety, and licensee compliance with the conditions of their license. The NRC representatives expressed their concern regarding the violations identified during the inspection of July 6 and 9, 1981, that indicated weaknesses in the licensee's management of the Nuclear Medical Program. Also discussed was the extent to which supervision of the use of licensed material met the conditions of the license and the guidelines of Regulatory Guide 10.8.

The licensee's representatives expressed their mutual concern for these matters, and described steps that have been taken or will be taken to correct them.