UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV

Walnut Creek Field Office
1450 Maria Lane
Walnut Creek, California 94596-5368

APR 21 1994

Docket No. 030-01208
License No. 02-06186-01

Department of Veterans Affairs
Medical Center
South Sixth Avenue
Tucson, Arizona 85723

Attention: Dr. Jayendra Shah, M.D.
Acting Medical Center Director

SUBJECT: NOTICE OF VIOLATION

This refers to the inspection conducted by Mr. David D. Skov of this office on March 21-22, 1994. The inspection included a review of activities authorized for your facility in Tucson, Arizona. The initial inspection findings were discussed with you and other members of your staff on March 23, 1994. Subsequent discussions relative to the inspection were also held with you and other medical staff during a telephone conference call on April 1, 1994, and with the Radiation Safety Officer on April 11, 1994.

The inspection was an examination of the activities conducted under your license as they relate to radiation safety and to compliance with the Commission rules and regulations and the conditions of the license. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, independent measurements, and observations of activities in progress. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements.

Based on the results of this inspection, certain of your activities appeared to be in violation of NRC requirements, as specified in the enclosed Notice of Violation (Notice). One of the violations involved the failure of your Radiation Safety Committee (RSC) to review the qualifications of two physicians to ensure that they meet 10 CFR Part 35 Subpart J training and experience requirements, and to designate the physicians as authorized users prior to their use, or supervision of use, of licensed material in nuclear medicine, as required by License Condition 12.B. Other significant violations included: (1) the use of sulfur-35 in a research laboratory which was not authorized under a permit issued by your RSC, as required by License Condition 23.D.; (2) the use of licensed material by a technologist who had not received initial radiation safety training, as required by License Condition 23.D.; and (3) the failure to check the ventilation rates every six months in a nuclear medicine laboratory using radioactive gas, as required by 10 CFR 35.205(e).

Three additional violations were also identified during the inspection involving failures to: (1) document all information as required by License Condition 21.C., for surveys of radioactive waste held for decay-in-storage including the survey instrument used, the background dose rate, and the dose rate measured at the surface of each waste container; (2) establish trigger levels for notifying the Radiation Safety Officer when radiation levels and removable contamination levels

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are exceeded, as required by 35.70(d),(e); (3) include a plan of each area surveyed, the instrument used to make the survey, and the trigger level in records of daily radiation surveys in the Nuclear Medicine Department, as required by 35.70(h). However, these violations are not being cited because the enforcement discretion criteria specified in Section VII.B of the Enforcement Policy (10 CFR Part 2, Appendix C) were satisfied.

In addition to the need for corrective action regarding the specific violations in the Notice, we are concerned about the implementation of your management control system that permitted the violations to occur. These violations indicate a lack of attention to NRC and license requirements, and the need for additional management oversight to ensure full compliance with NRC requirements.

We also have a concern about the effectiveness of daily radiation surveys conducted by nuclear medicine technologists in radiopharmaceutical elution, preparation and administration areas. During the inspection, the procedure used by a nuclear medicine technologist to conduct surveys of two radiopharmaceutical administration areas (Scan Rooms A104 and A104A), was not adequate to detect the presence of surface contamination. This was demonstrated during a survey on March 21, 1994, when the technologist failed to detect significantly high fixed and removable radioactive contamination levels on an injection table and an imaging table. During the telephone conference call on April 1, 1994, you indicated that following the inspection, nuclear medicine personnel had been retrained on the proper survey procedures. The adequacy of this program area will be evaluated again during our next inspection.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. Your response should document the specific actions taken and any additional actions you plan to prevent recurrence of these violations. Also, specifically describe the administrative controls that will be established to improve the management oversight of your licensed program to prevent violations of NRC requirements. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

Dwight D Chamberlain

for Samuel J. Collins, Director
Division of Radiation Safety
and Safeguards

Enclosure:
Notice of Violation

bcc w/enclosure and IFS Form:
Docket File
Inspection File
Y. Elko, RIV Arlington (original IFS)

bcc w/Enclosure:
J. Callan, RIV Arlington
S. Collins, RIV Arlington
G. Sanborn, RIV Arlington
K. Perkins, WCFO
R. Huey, WCFO
G. Cook, WCFO
State of Arizona

bcc w/o enclosure:
M. Smith, WCFO

Department of Veterans Affairs
ATTN: Francis K. Herbig, Director
Health Physics Programs (115HP)
915 North Grand Blvd.
St. Louis, MO 63106

Department of Veterans Affairs
Veterans Health Services & Research Administration
Western Region
ATTN: Edwin M. Liedholdt, Jr., Ph.D
Radiation Safety Program Manager
301 Howard Street, Suite 700
San Francisco, CA 94105-2241

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(YES) / NO]	(YES) / NO]	YES / NO]	(YES) / NO]	(YES) / NO]