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License No.: 35-07464-03 Docket No.: 30-02898/90-01

Oklahoma Medical Research Foundation ATTN: William G. Thurman, M.D. President 825 N.E. 13th Street Oklahoma City, Oklahoma 73104

Gentlemen:

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This refers to the routine, unannounced radiation safety inspection conducted by Ms. L. L. Kasner of this office on September 23, 1990, of the activities authorized by NRC Byproduct Material License No. 35-07464-03. The inspection findings were reviewed with the Oklahoma Medical Research Foundation (OMRF) radiation safety committee chairman (chairman) and radiation safety officer (RSO) 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.

Generally, adequate control had been established regarding the procurement, inventory, use, and disposit of licensed materials. Research laboratories were equipped with appropriate shielding and radiation detection instrumentation, and an adequate level of security had been provided for those areas where licensed materials were routinely stored. The staff members interviewed and observed during the inspection were noted to be conscientious in regard to fundamental radiation safety principles.

Management controls over licensed activities had been maintained by means of routine program audits directed by the RSO. This was further enhanced by the chairman's consistent followup on problems which were identified in the RSO's audit reports. Also notable was the fact that the chairman's review of the audit reports was timely and that his subsequent correspondence with individual researchers mandated prompt corrective action.

While the inspection did not reveal any significant weaknesses in the radiation safety program, and in fact, revealed a sound system of management controls, the inspector identified several items worthy of further review.

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Although access to the two irradiators had been restricted by means of locked entry and by the requirement to sign a log book documenting key access, the keys to these units were located in a secretarial area, and the individuals tasked with monitoring access to these units had no reference to determine which researchers had been authorized to use the irradiators. Recently, a key staff member responsible for the training and authorization of researchers using the irradiators had terminated her association with OMRF. Training records for the use of this equipment were missing; however, it was determined that training had been conducted by the former research supervisor. This issue was discussed with the chairman who was encouraged to ensure that each individual receiving access to this equipment received radiation safety training.

The inspector also reviewed a report from OMRF, dated August 14, 1990, regarding five vials of tritiated water (containing a total of 260 millicuries of hydrogen-3) which were unaccounted for. The RSO and the chairman concluded, after their investigation, that the material was most likely used by another researcher and was not accounted for on inventory records or that it had been misplaced in another storage area and had not yet been found. The inspector noted that extensive efforts had been taken or were planned to improve the inventory system. These included increasing the required inventory report frequency from semiannually to monthly, future independent physical inventory of all licensed material by the RSO's staff in addition to similar requirements for research staff, and placing the responsible researcher on probationary status pending a review period to ensure future compliance with inventory procedures. These corrective actions were clearly documented and had been reviewed with each staff member prior to the inspection.

A Notice of Violation could have been issued for this violation, inasmuch as it represents a failure to conduct an adequate physical inventory of licensed material. However, the violation had been promptly corrected, the corrective actions had been properly documented, and these actions appeared adequate to prevent future recurrence of the violation. Therefore, in accordance with Section V.G.1 of the NRC's Enforcement Policy, a Notice of Violation will not be issued. Your corrective actions will be reviewed during future inspections to ensure that they remain effective.

Please note that no response to this letter is required. Should you have any questions concerning this letter, we will be pleased to discuss them with you.

Sincerely,

A. B. BEACH

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

Oklahoma Radiation Control Program Director

CC:

Oklahoma Medical Research Foundation

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