John L. McClellan
Memorial Veterans' Hospital
4300 West 7th Street
Little Rock AR 72205

Veterans
Administration

DEC 06 1990

In Reply Refer To: 115/LR

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington D.C. 20555

Subject: NRC Inspection Letter dated 11/8/90

1. This is in response to the NRC inspection letter dated November 8, 1990, Docket No. 30-01212/90-01.

2. Please refer to the attachment which addresses the points contained in the Notice of Violation as an appendix to that letter.

ROBERT T. PATTON
Medical Center Director

cc: USNRC
Region IV

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NMSS LIC30
03-01082-01 PDC

IE07

REPLY TO A NOTICE OF VIOLATION

Veterans Administration Medical Center
Little Rock, Arkansas

Docket No. 30-01212/90-01
License No. 03-01082-01

Item A.1.

1) Reason for violation: Although researchers had previously been notified of this requirement, including the distribution to them of Information Notice 89-35, it appears that all of them were not fully aware of the requirement. Additionally, some of the labs remained unlocked at time when housekeeping personnel were in the area.

2) Corrective steps taken : A memo has been distributed to all affected personnel reemphasizing the important nature of this issue. Additionally, all housekeeping is now done during the day shift (0730-1600).

3) Corrective steps taken to avoid future violations: Increased surveillance by VA staff and emphasis of this point at orientations and annual refresher training.

4) Date when full compliance will be achieved: 31 December 1990.

Item A.2.

1) Reason for violation: Lack of awareness of affected staff members to document verbal training instructions and reliance on proximity of experienced individuals to monitor activities.

2) Corrective steps taken: All keys and access to the irradiator will be limited to only a few trained experienced individuals. Infrequent users will not be allowed to operate irradiator. A sign and instructions to this effect have been posted on the irradiator.

3) Corrective steps taken to avoid future violations: Monthly followup will be made by the radiation safety staff.

4) Date when full compliance will be achieved: Immediate.

Item B.1.

1) Reason for violation: Human error - oversight. Please note that this incident had been fully documented, investigated and corrective action taken prior to the inspection. A report was given to the inspector during her visit.

2) Corrective steps taken: Noted above.

3) Corrective steps taken to avoid future violations: A reminder note is posted in the misadministration file regarding the requirements.

4) Date when full compliance will be achieved: Immediate.