DEPARTMENT OF VETERANS AFFAIRS
Medical Center
1055 Clermont Street
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APR 2 6 1994

U.S. Nuclear Regulatory Commission, Region IV
Division of Radiation Safety and Safeguards
611 Ryan Plaza Drive, Suite 400
Arlington, Texas 76011-8064
ATTN: Mr. Samuel J. Collins, Director

In Reply Refer To: 554/115



RE: License 05-01401-02; Docket 030-01234

Dear Mr. Collins,

This letter is in response to your letter of March 29, 1994 and attached Notice of Violation.

Citation A, 10 CFR 35.70(a) That daily surveys of areas where radiopharmaceuticals are used were not performed.

1. We believe the reason for this violation is as follows. Doing daily surveys is not part of the routine of the Nuclear Medicine Technologists. For about three years the Radiation Safety Officer (RSO) has performed the daily surveys. This was done in part because of the work load on the Nuclear Medicine Technologists. Doing daily surveys had been made part of the Nuclear Medicine Technologist's evaluation criteria and a check sheet for off duty hour "call in" studies had also been created. However call in studies are infrequent and the check lists were not always used. Since the Technologists were not used to doing surveys during normal business days they apparently did not remember to do them on a weekend or holiday.

2. The following corrective action has been instituted. The Nuclear Medicine Technologists have been given the duty of performing the normal daily surveys every business day. The allowable exception to doing a survey on each day of use has been lowered from one per year to zero per year. At the time the current criterion was put into effect, it was thought by the Technologist's Supervisor that a zero tolerance rate would not be consistent with personnel policy.

3. The corrective action described in paragraph 2 immediately above should prevent a reoccurrence of the violation. In addition, periodically weekend and holiday studies will be compared with the survey log to insure that any omissions will be quickly noted and prompt action taken.

4. The Nuclear Medicine Technologists have been given the duty of doing daily surveys as of Wednesday, April 13, 1994 and the evaluation standard for surveys is being changed to zero effective Monday, April 25, 1994. As of the date of this letter we are in compliance.

(DMB IE-07) 1/0

(2)

Citation B, 10 CFR 35.50(b) That the dose calibrator was not tested for linearity to the highest dose administered to a patient.

1. This occurred because previous to this year the highest doses administered were 150 millicuries. This year two patients for which a higher 200 millicurie dose was prescribed were treated.

2. Up to the time of the inspection the old generator was eluted on a Tuesday, following it's last use for preparation of radiopharmaceuticals, yielding approximately 165 millicuries of technetium-99m. Starting with the linearity check occurring on the month following the inspection, the new generator is eluted and an amount of approximately 400 millicuries separated from that elution is used for the linearity test. (Note one generator is received each week, a new generator is prepared for use and first eluted late Monday morning or early Monday afternoon after it is received on Sunday. The "old" generator is normally eluted for the last time, for preparing radiopharmaceuticals, first thing on the Monday a week after being received. This procedure allows patients to be treated right away on Monday morning using the old generator. The new generator is checked and placed into the shield later in the day.)

3. The practice of using the new generator, on a Monday, will provide more than what ever the highest dose in use will be. This should prevent reoccurrence.

4. Having done a linearity test on March 14,1994 this facility is now in compliance with the regulation cited above.

Citation C, 10 CFR 20.1801 and 1802, that licensed material was not secured from unauthorized access.

1. This violation was identified in routine inspection activity by the station Radiation Safety Officer and a work order initiated to install a lock. Because the room was incorrectly identified as 9C100a instead of 9C100b the work was not performed.

2. A lock has been installed in the door to room 9C100b and those that store licensed material there have been instructed to keep the door locked.

3. The Radiation Safety Officer has checked the door on a random basis and will continue to do so in his normal inspection activity to insure it is locked.

4. This facility is in compliance with the regulations cited above.

If you have any questions please feel free to contact our Radiaton Safety Officer, Mr. Peter Vernig directly at (303) 399-8020 extension 2447.

Sincerely,

Thomas A. Trujillo
Medical Center Director