



**Veterans  
Administration**

October 28, 1982

•License No. 02-12726-01

US Nuclear Regulatory Commission  
Region V  
Office of Inspection & Enforcement  
1450 Maria Lane, Suite 210  
Walnut Creek, CA 94596-5368

ATTN: G. G. Spencer, Director  
Division of Radiologic Safety  
and Safeguards Programs

Gentlemen:

Subject: Response to NRC Inspection, 9/10/82

The following corrective actions have been taken to bring into compliance those items of non-compliance presented in the Notice of Violation, 10/4/82:

A. At the time of inspection, no review of the training and experience of the licensee's Nuclear Medicine Technologist was performed by the Medical Isotope Committee. (Violation of duties and responsibilities of the Medical Isotopes Committee as described in Appendix B of NUREG-0338, Revision I, Item 7 of application).

Corrective Action:

The Radiation Safety/Radionuclide Committee (Medical Isotope Committee) met on 10/1/82.

1. The committee reviewed the responsibilities and duties of the Medical Isotopes Committee as stated in Appendix B, relating to Item #7, in the license application.
2. Dr. Mann and Dr. Gere (users under USNRC Material License 02-12726-01) attested to the capability of Robert Johnson, Nuclear Technologist.

Based on this testimony and reports of daily supervision of the activities performed by Robert Johnson in all operation of the Nuclear Medicine Service, and review of his experience and training, the Medical Isotope Committee concluded Robert Johnson is sufficiently qualified to perform the duties of Nuclear Medicine Technologist safely and in accordance with NRC Regulations, and the conditions of the license.



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Preventive Step:

1. At the beginning of each meeting of the Medical Isotope Committee, Appendix B, relating to Item 7 of the license application, will be reviewed.
2. Continuing evaluation of the qualifications of Robert Johnson, Nuclear Medicine Technologist. This will include:
  - a. Documentation of all training activities.
  - b. Listing all nuclear medicine procedures performed.
  - c. Specific instructions on each request for nuclear medicine procedure.
  - d. Daily checks on quality control and safe handling procedures.

Full Compliance: Ongoing

- B. Violation of 10CFR 35.43. Failure to report a diagnostic misadministration which occurred on 5/13/82 to the appropriate NRC Regional Office within ten days after the calendar quarter in which the diagnostic misadministration occurred.

Corrective Action:

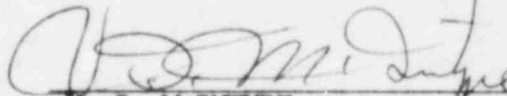
The diagnostic procedure misadministration which occurred on 5/13/82, was reported belatedly to Region V, USNRC. Written report sent on 9/29/82. (Within office of Radiation Safety Officer).

Preventive Step: Posting - For Information & Review: Regulatory Guide 10.1 (USNRC, Office of Nuclear Regulatory Research): Compilation of Reporting Requirements For Persons Subject to NRC Regulations.

Full Compliance: Achieved and ongoing.

"I certify that all information contained in this letter is true and correct to the best of my knowledge and belief"

10-29-82  
(Date)

  
V. I. McINTYRE  
Medical Center Director