DEPARTMENT OF VETERANS AFFAIRS
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In Reply Refer To: 549/115

January 18, 1991

United States Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive
Arlington, TX 76011

Ref: License: 42-00220-06 and 42-00220-08
Dockets: 30-03256/90-01 and 30-00503-90-01

This letter is in response to the Notices of Violation dated December 24, 1990.

License 42-00220-06, Violation #1 - Failure to maintain logbooks

After our last inspection in August 1989, Research Service was reminded of the need to maintain logbooks and given detailed instructions. In addition, the revised Radiation Safety Handbook of April 1990 reflected the increased emphasis of logbooks. The RSO also spoke at a Research Service staff meeting to review changes in the handbook. Although most laboratories complied with the logbook requirements, Dr. Srere's laboratory simply failed to do so. In addition, the RSO failed to make timely inspections of laboratories to insure that the requirements were being met.

On August, 20, after our most recent inspection, the RSO visited Dr. Srere's laboratory to advise on keeping a logbook. By August 23 a complete inventory of radioactive material in Dr. Srere's laboratory had been accomplished, a logbook had been created, and workers had been instructed in using the logbook.

Also, very soon after the inspection, the Research Service Safety Subcommittee initiated quarterly inspections of each laboratory. In addition, each laboratory is required to maintain a specifically-formatted radiation safety notebook for ease in determining compliance. The RSO is also making semi-annual inspections of each laboratory. Full compliance has already been achieved.

License 42-00220-06, Violation #2 - Failure to measure thyroid burdens

Because 1-3 days elapses between dosage administration and thyroid checks, it is difficult to get the necessary personnel back to have their thyroids checked. The violation occurred mainly through a lack of diligence on the part of the RSO at insuring all checks were obtained. As a result of the violation, the RSO has initiated quarterly thyroid checks for Nuclear Medicine laboratory personnel (therapy dosages are administered in the laboratory). This has heightened awareness of the need for thyroid checks. Also, a policy will be instituted whereby personnel are scheduled for thyroid checks at the time of administration. The requirement for checks will also be stressed in training. Full compliance will be achieved in January 1991.

License 42-00220-08, Violation #1 - Failure to train new employee

At the time this employee was hired, we were in the process of changing therapy physicists. Dr. Huddleston remained as RSO and teletherapy physicist, but was less actively involved in day-to-day operations. As a consequence, training for the new employee was not accomplished. Immediately after the inspection, the present RSO gave the employee materials to read in order to provide the necessary training. The RSO is currently working with the therapy physicist to insure all radiation therapy personnel are trained in a timely manner. Full compliance will be achieved in February 1991.

JONATHAN H. GARDNER
Acting Medical Center Director