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JUN 14 1994

Veterans Administration
Lakeside Medical Center
ATTN: Joseph L. Moore, Director
333 East Huron Street
Chicago, IL 60611

License No. 12-02642-06
Docket No. 030-01435

Dear Mr. Moore:

This refers to the special inspection conducted by Mr. Robert Hays of this office on Wednesday March 2, 1994, and to the discussions with your Radiation Safety Officer, Dr. Zimmer, members of your Radiation Safety Committee, and to subsequent telephone conversations between Dr. Zimmer, the authorized user, the research assistants and Mr. Hays on March 9, 15, and 18, 1994 to discuss the actions taken regarding your notification in a letter dated October 22, 1993, of an incident involving the discovery of unauthorized transfers of licensed radioactive material to VA Lakeside Medical Center by an authorized user.

The unauthorized transfer of licensed material is an apparent violation of NRC requirements and condition No. 28 of your license which requires that licensed material be possessed and used in accordance with statements, representations and procedures contained in the application dated February 29, 1988, and letters dated December 10, 1991 and June 28, 1993. Page 102 of the application entitled "Material Acquistion" states the Radiation Safety Officer or his delegate will approve all requests to order or otherwise acquire radioactive materials to ensure that the material may be possessed by authority of licenses and that activity limits will not be exceeded.

Normally this violation would be categorized as a Severity Level IV violation, however, because the violation was self-identified and immediate corrective actions taken, the violation is not being cited based upon 10 CFR 2, Appendix C, VII., Exercise of Discretion.

After a review of the facts and corrective actions taken by your Radiation Safety Staff and Radiation Safety Committee, it appears that those corrective actions are adequate.

Additional information provided during the meeting indicated that the root cause of this incident was a misunderstanding occurring between the Northwestern Memorial Hospital Radiation Safety Office and the authorized user's research assistant regarding the authorized user's permit and use of radioactive material for research purposes. The investigation performed by the Radiation Safety Committee and the Radiation Safety Officer, determined there was no willful or deliberate misconduct on part of the authorized user. This fact was also substantiated during subsequent telephone conversations on March 9, 15, and 18, 1994, between the NRC, the authorized user and the research assistants.

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The NRC considers this matter closed and we have no further questions at this time. However, the NRC will review during future inspections the continuing effectiveness of the implemented corrective actions.

The NRC expects its medical institution licensees through its RSO and Radiation Safety Committee to assure that all requirements of the NRC license are met and that potential violations are identified and expeditiously corrected. This is particularly important for those medical institutions which use licensed material for research as well as medical diagnosis and therapy, and in which licensed material is used by or under the supervision of individuals designated by the licensee's Radiation Safety Committee.

We will gladly discuss any questions you have concerning this matter.

Sincerely,

Original Signed by John D. Jones

John D. Jones, Acting Chief
Nuclear Material Inspection
Section 2

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Hays/bt
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