U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Enforcement Conference Report No. 030-10026/90-002

Docket No. 030-10026

License No. 31-02755-05 Priority 1 Category G Program Code 2110

Licensee: Veterans Administration Medical Center
113 Holland Avenue
Albany, New York 12208

Facility: Veterans Administration Medical Center

Enforcement Conference At: Region I, King of Prussia, Pennsylvania

Enforcement Conference Conducted: December 13, 1990

Prepared by: Christopher J. Eckert 12-20-90
Christopher J. Eckert, Health Physicist date

Approved by: Ronald R. Bellamy for Dec 20, 1990
Mohamed M. Shanbaky, Chief date
Nuclear Materials Safety Section A

Enforcement Conference Summary: Enforcement Conference held at King of Prussia Pennsylvania on December 13, 1990. The licensee representatives discussed the corrective actions taken and/or to be taken as a result of the November 20-21, 1990 inspection. NRC representatives discussed their concern regarding the apparent lack of adequate management oversight of the licensed program and violations identified during the inspection.

DETAILS

1. Persons Attending

Veterans Administration Medical Center

Fred Malphurs, Director
Lawrence H. Fiesh M.D., Chief of Staff
Andrew Kang M.D., Radiation Safety Officer
Mary-Ellen Piche, Quality Management Coordinator
John Dapolito, Consultant/Certified Health Physicist

Veterans Administration Central Office

Francis Herbig, Radiation Safety Officer, VA St. Louis
Diana Stockdale, Radiation Safety Officer, VA Philadelphia

Veterans Administration Office of the Inspector General

Roger Tillson
Timothy Bond
Judith M. Garland

Nuclear Regulatory Commission

Ronald Bellamy, Chief, Nuclear Materials Safety Branch
Karla Smith, Regional Counsel
Daniel J. Holody, Regional Enforcement Officer
Jean Gresick-Schugsta, Senior Health Physicist
Christopher J. Eckert, Health Physicist
Joseph DelMedico, Office of Enforcement

2. Conference Summary

On December 13, 1990, representatives of the Veterans Administration Medical Center, Veterans Administration Central Office, Veterans Administration Office of the Inspector General and Region I met at the Region I Office in King of Prussia to discuss the results of the November 20-21, 1990 inspection.

The violations identified during the November 20-21 inspection were presented and discussed. NRC representatives expressed their concern regarding the apparent lack of management oversight of the licensed program, the adequacy of the licensee's radiological safety training program, the apparent lack of technical program guidance provided by the Radiation Safety Officer (RSO) and twenty other apparent violations.

The licensee representatives acknowledged that the RSO did not ensure that appropriate radiation safety requirements were properly implemented, nor did facility management assure that he carried out his responsibilities. The licensee representatives also acknowledged all of the inspection findings except the failure to perform dose calibrator accuracy testing and described the actions which had been taken to bring

the program into compliance since the inspection. The licensee described their procedure for performing dose calibrator constancy checks and indicated that part of this procedure included the performance of a daily accuracy test. The inspector reviewed dose calibrator constancy records presented by the licensee and concluded that an accuracy test was performed as indicated by the licensee. Therefore, the NRC agreed that this apparent violation did not occur.

Based upon additional information presented at the enforcement conference by the licensee, NRC staff members reviewed the appropriateness of two other apparent violations of licensee procedures: (1) failure to survey hands, clothing, and shoes for radioactive contamination prior to leaving research laboratory areas and (2) failure of personnel frequenting radioactive material use and storage areas to wear required personnel dosimetry. NRC staff concluded that based upon the type and quantity of radionuclides used (< 1 millicurie of C-14, S-35 and H-3), these procedural deviations would not be cited.

During the conference the licensee committed to significant improvements to their licensed program which included recruiting a new full time RSO, and obtaining consultant services to support the existing RSO in the day-to-day implementation of the program until such time as a new RSO is hired, trained and added to the license as radiation safety officer. Furthermore, licensee representatives stated that as a result of the inspection, management had become significantly more aware of their responsibilities under a broad scope license and were committed to providing the support and personnel necessary to correct the apparent deficiencies and bring the program into full compliance with NRC regulations.

Enforcement options available to the NRC were reviewed.