Official

AUG 30 1991

Docket No. 030-01350
License No. 10-01169-01
EA 91-103

Veterans Affairs Medical Center
ATTN: Mr. Glenn Alred, Jr.
Medical Center Director
1670 Clairmont Road
Decatur, GA 30033

Gentlemen:

SUBJECT: NOTICE OF VIOLATION
(NRC INSPECTION REPORT NO. 10-01169-01/91-01)

This refers to the Nuclear Regulatory Commission (NRC) inspection conducted by Mr. W. Loo on July 10-12, 1991, at the Veterans Affairs Medical Center in Decatur, Georgia. The report documenting this inspection was sent to you by letter dated July 31, 1991. As a result of this inspection, multiple failures to comply with NRC requirements were identified. An Enforcement Conference was held on August 7, 1991, with you and members of your staff in the NRC Region II Office to discuss the violations, their cause, and your corrective actions to preclude recurrence. A list of attendees at the Enforcement Conference is provided with this letter (Enclosure 2). Also, enclosed are your notes from the Enforcement Conference you sent us on August 11, 1991 (Enclosure 3).

The violations in the enclosed Notice of Violation (Enclosure 1) were identified by the NRC during the inspection referenced above and included failures to: perform required dose calibrator constancy checks, perform surveys with radiation survey instrument, perform annual radiation safety training, survey packages of radioactive materials received in research laboratories, perform complete audits and surveys of all research laboratories, calibrate survey meters, maintain records of daily contamination surveys, and maintain records of correction factors for survey instrument calibration.

The NRC is concerned with the results of this inspection, particularly in view of the number of violations that were identified and the fact that one of the violations was a recurrence of a previously cited violation. Collectively, the violations indicate a need for increased: management oversight of the radiation safety program, attention to detail by individuals using licensed material, day-to-day supervision and control by the Radiation Safety Officer (RSO) and the Radiation Safety Committee of licensed

IE07

activities, and surveillance of the program through comprehensive audits. The NRC is also concerned with the degree of authority granted by Medical Center management to the Radiation Safety Officer over licensed research activities.

The NRC considered aggregating the findings of this inspection at the Severity Level III level and proposing a monetary civil penalty. However, at the Enforcement Conference you provided information to indicate that in some cases, you had already identified and were in the process of correcting the violation at the time of the inspection. Also, you provided data to indicate, that you had recognized the lack of sufficient time that was afforded to the RSO to perform his duties. In addition, based on that data, you had taken steps to ensure that time was made available to the RSO prior to the NRC inspection. Based on discussions of the findings and additional information you provided during the Enforcement Conference, each of the violations in the enclosed Notice has been classified as a Severity Level IV or V violation. In addition, based on the information provided at the Enforcement Conference the NRC determined that the following apparent violations identified in NRC Inspection Report 10-01169-01/91-01 did not occur or should be considered licensee-identified:

- Failure of the Radiation Safety Committee to meet quarterly (Licensee-Identified because of the information provided at the Enforcement Conference).

- Failure to perform appropriate tests for accuracy and geometry dependence following adjustment or repair of the dose calibrator (Based on the information provided at the Enforcement Conference and discussions with NRC staff, it was determined that under the circumstances with regards to the minor repair of the dose calibrator, a constancy check was appropriate; however, if the repair had been more extensive then an accuracy, geometry dependence, and linearity test would have been appropriate).

- Failure to determine if dose calibrator linearity test results exceeded the predicted values by more than 10 percent (Based on information provided at the Enforcement Conference you demonstrated that a preliminary evaluation performed at the time of the test showed that the measured results did not exceed 10 percent of the predicted values).

- Failure to perform an evaluation when maximum daily disposal rate of liquid radioactive waste into a sanitary sewerage system was exceeded (Based on the information provided at the Enforcement Conference you demonstrated that disposals made by you into the sanitary sewerage system had been informally evaluated prior to the inspection and that they did not exceed regulatory limits).

- Failure to measure every six months the ventilation rates in areas of radioactive gas use (Based on information provided at the Enforcement Conference you stated that the ventilation rates had been performed but not documented).

At the Enforcement Conference you stated that the missed daily dose calibrator constancy checks (discussed in Section 3.b of the inspection report) had been licensee-identified. However, after you had identified these missed constancy checks, the violations still reoccurred on four (4) other occasions. Therefore, the NRC does not consider this as licensee-identified and the violation still stands as stated in the enclosed Notice.

Based on the findings of this inspection and discussions with you at the Enforcement Conference, the NRC expects you to take steps to see that materials are used safely and licensed activities performed in accordance with NRC requirements and/or conditions of your NRC radioactive materials license. During future inspections of your facility, these steps taken by you to prevent recurrence of these violations will be reviewed to ensure compliance to NRC regulations.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent to prevent recurrence. In addition, you should address actions you have taken or planned to strengthen management oversight of the radiation safety program, to improve the audit program for licensed activities and the authority and management support given to the Radiation Safety Officer to perform his responsibilities. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

AUG 30 1991

Veterans Affairs Medical Center 4

Should you have any questions concerning this letter, please contact us.

Sincerely,

Bruce S. Mallett Jr.

J. Philip Stohr, Director
Division of Radiation Safety
and Safeguards

Enclosures:
1. Notice of Violation
2. List of Enforcement Conference Attendees
3. Veterans Affairs Medical Center Meeting Notes

cc w/encls:
State of Georgia

V. A. Central Office
ATTN: Dr. M. Gross, Director
NMS (115)
810 Vermont Ave., N.W.
Washington, DC 20420

bcc w/encls:
Document Control Desk
G. Jenkins, EICS
J. Glenn, NMSS
J. Lieberman, OE

RII:DRSS	RII:DRSS	RII:DRSS	RII:DRSS	RII:EICS
WLoo (WTC)	CHosey	WCline	BMallett (BSM)	GJenkins
8/29/91	8/29/91	8/30/91	8/30/91	8/30/91