UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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October 26, 1998

Lt. Colonel Don W. Jordan
Department of the Air Force
USAF Radioisotope Committee
HQ AFMOA/SGOR
110 Luke Avenue, Suite 400
Bolling AFB, D.C. 20332-7050

SUBJECT: NRC INSPECTION REPORT 030-28641/98-13

Dear Lt. Colonel Jordan:

On September 16-17, 1998, the NRC conducted an inspection at Wilford Hall, Lackland Air Force Base, San Antonio, Texas. The purpose of the inspection was to determine whether activities authorized by Air Force Permit No. TX-02682-01/00AFP were conducted safely and in accordance with NRC requirements. A telephonic exit briefing was subsequently conducted with Major Kristin Swenson of your staff on September 28, 1998.

Within the scope of this inspection no violations were identified; therefore, no response to this letter is required. However, one non-cited violation (NCV) was identified. The NCV involved two examples of failure to properly secure licensed materials. On December 22, 1997, and again on January 29, 1998, housekeeping personnel inadvertently removed radioactive waste containing iodine-125 (13 microcuries and 96 microcuries respectively) with bio-hazardous waste. Both of the events were promptly reported by Wilford Hall to the USAF Radioisotope Committee (RIC) and to the NRC. Following the second event, the Wilford Hall radiation staff implemented new procedures to prevent further recurrence. An NRC review concluded that the corrective actions were reasonable. Based on the small quantities of radioactive material involved, and that this violation was self-identified and corrected, it is being treated as a non-cited violation, consistent with Section VII.B.1 of the Enforcement Policy.

During the course of the inspection, the inspector noted a concern involving the failure to follow emergency procedures. On June 8, 1998, a specimen canister detection sensor on a blood irradiator (CIS Bio-International, Model Number IBL 437C, containing approximately 5,100 Curies of cesium-137) was not functioning properly. The blood bank staff contacted the Wilford Hall Medical Equipment Repair Center (MERC) to troubleshoot the device. MERC personnel determined that the device was still covered by its purchase warranty and notified the manufacturer. A manufacturer's representative telephonically guided the MERC staff through diagnostic troubleshooting and sensor adjustment procedures. Since these actions did not correct the problem, the representative visited Wilford Hall on June 9, 1998, and repaired a damaged wire on the unit. Blood bank personnel returned the irradiator to service immediately upon repair. Although the blood irradiator emergency procedures specifically require that the radiation safety officer (RSO) be immediately notified of any emergency, malfunction or other unusual occurrence involving the irradiator, the RSO was not informed of the event until after the device had been repaired and returned to service. The emergency procedures further require that the RSO perform an inspection and radiation protection survey prior to returning the

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irradiator to service. Since the RSO had not been informed of the event until June 11, 1998, the inspection and survey were not completed until after the irradiator had been returned to service. The inspection and survey that were conducted by the RSO after notification did not identify any safety concerns or unexpected radiation levels. Although the actions taken by the blood bank staff and MERC personnel did not appear to compromise safety, the failure to follow emergency procedures is of concern because of the potential adverse impact on health and safety to licensee personnel. We encourage you to review these procedures with appropriate staff to ensure that permit requirements are followed in the future.

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

Should you have any questions concerning this letter, please contact Anthony D. Gaines at (817) 860-8252 or Elmo E. Collins at (817) 860-8291.

Sincerely,

Lynda Howell

Ross A. Scarano, Director
Division of Nuclear Materials Safety

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