U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No. 89-01 EA-89-17

Licensee No. 04-17862-01

Licensee: Veterans Administration Medical Center
Jerry L. Pettis Memorial Veterans Hospital
11201 Benton Street
Loma Linda, California 92357

Facility Name: Same as above

Conference at: Same as above

Conference conducted: February 7, 1989

NRC Participants:

Robert J. Pate for — 2/16/89
R. A. Scarano, Director — Date Signed
Division of Radiation Safety and Safeguards

Robert J. Pate — 2/16/89
R. J. Pate, Chief — Date Signed
Nuclear Materials Safety and Safeguards Branch

A. D. Johnson — 2/16/89
A. D. Johnson, Regional Enforcement Officer — Date Signed

D. D. Skov — 2/14/89
D. D. Skov, Radiation Specialist — Date Signed

Approved By:

Robert J. Pate for — 2/16/89
R. A. Scarano, Director — Date Signed
Division of Radiation Safety and Safeguards

Summary:

Enforcement Conference on February 7, 1989 (Report No. 89-01)

The following matters were discussed:

1. The apparent violations identified during the last two inspections conducted on December 16-17, 1987 and December 19, 1988 to January 11, 1989.

2. NRC concerns.

3. Licensee management responsibilities.

4. NRC enforcement options.

The enforcement conference lasted approximately two hours, utilizing four NRC representatives.

Enforcement Conference

DETAILS

1. Enforcement Conference Participants

J. F. Hickman, Hospital Director
M. W. Murphy, Associate Director
I. N. Kuhn, Associate Chief of Staff for Education
D. G. Heustis, Acting Chief of Staff
J. R. Farley, Chairman, Radiation Safety Committee
T. R. Bennett, Radiation Safety Officer
R. A. Scarano, NRC Region V
R. J. Pate, NRC Region V
A. D. Johnson, NRC Region V
D. D. Skov, NRC Region V

2. Enforcement Conference

On February 7, 1989, an enforcement conference was held at the V. A. Medical Center in Loma Linda, California with the individuals listed above participating. Matters discussed during the enforcement conference related to the NRC inspections that were conducted on December 16-17, 1987, and December 19, 1988 to January 11, 1989. Activities involving the use of radioactive materials at this location are authorized by NRC License Number 04-17862-01. The enforcement conference was announced in a letter to the licensee dated January 27, 1989.

Mr. R. Scarano, NRC, began the meeting by stating that the purpose of the enforcement conference was to discuss the violations found during the NRC inspections in 1987 and 1988, provide the licensee the opportunity to offer additional facts concerning the violations identified by the NRC inspectors during the 1988 inspection, and to discuss NRC concerns and enforcement policy. Mr. Scarano briefly reviewed the licensee's enforcement history dating back to 1978, pointing out that the current meeting was the licensee's third enforcement conference within the last four years. Mr. Scarano reminded the licensee that enforcement action had not been taken by the NRC pending the completion of the investigation by the Region V Office of Investigation (OI). Licensee representatives asked some clarifying questions about investigations. Mr. Scarano stated that the results of the OI investigation would likely be issued sometime in the near future, at which time the licensee would be notified.

Mr. J. Hickman, licensee representative, introduced Dr. D. Heustis who was appointed as Acting Chief of Staff on January 30, 1989. Mr. Hickman added that the licensee's RSO, T. Bennett, would now report directly to Dr. Heustis in matters concerning radiation safety. Dr. D. Heustis, licensee representative, indicated that his experience with similar type inspections by the "CAP" (College of American Pathologists) of laboratory quality assurance and safety at the V.A. Hospital, gives him the background needed for adequate oversight of the licensed program to help avoid future noncompliance.

Mr. Hickman remarked that the licensee was also looking at the option of utilizing the services of a consultant to assist the licensee to improving the licensed program. Mr. Hickman commented that, at his invitation, three individuals who were knowledgeable in radiation safety practices at other V. A. hospitals had visited his facility following the last NRC inspection.

Mr. R. Pate, NRC, briefly summarized the violations identified during the earlier NRC inspection of December 16-17, 1987, and whether corrective actions had been taken by the licensee, as evaluated by the last NRC inspection on December 19, 1988 to January 11, 1989. The violations had previously been discussed in detail during the enforcement conference on March 1, 1988. Mr. Pate stated that the licensee had corrected only two of the four repetitive violations from the inspection of December, 1987.

Mr. Skov, NRC, discussed in detail each of the repetitive and other violations identified from the most recent NRC inspection (December 19, 1988 to January 11, 1989). One repetitive violation involved the failure by certain laboratory research personnel to attend required annual refresher training in radiation safety. Mr. J. Hickman responded that the projects authorizing use of licensed material had been suspended, the employees involved were prohibited from using licensed material, and radioactive materials in their laboratories had been confiscated. Mr. Hickman added that, following the last NRC inspection, the licensee independently identified two additional persons who also had not received the required training. Mr. T. Bennett stated that a training session was subsequently arranged for, and attended by, all laboratory and ancillary personnel who had previously lacked the required training.

The second repetitive violation concerned the failure to perform radiation level and smear surveys at the required frequency in certain laboratories. Mr. T. Bennett responded that effective February 1, 1989, weekly rather than monthly radiation surveys would be required in all research laboratories, and that the procedure for users reporting the survey results to the Radiation Safety Officer (RSO) had been changed to allow more timely followup by the RSO when appropriate. Mr. Bennett also commented that residual contamination from phosphorus-32 was still present in the animal room, which he was continuing to monitor. Dr. John Farley, licensee representative, commented that the phosphorus-32 animal research project had been suspended and would be reviewed again by the Radiation Safety Committee.

Mr. Bennett also stated that the licensee had taken action to correct the other violations documented in the NRC inspection report, including posting emergency instructions, and recording the results of radiation surveys in laboratories and of licensed material disposed as non-radioactive waste using the proper units required by 10 CFR Part 20. The licensee provided to the NRC representatives, copies of written procedures which described the corrective actions taken with regard to training, radiation surveys, and records of surveys.

Mr. R. Scarano asked the licensee for comments or additional information they may have regarding the findings of the NRC inspection as described in NRC Inspection Report No. 88-02. Mr. J. Hickman explained that the

licensee agreed in general with the inspection findings and that the violations as reported by the NRC were valid. T. Bennett discussed certain items in the report needing clarification or correction. Mr. Bennett stated that with regard to Section 6 of the report, documentation does exist to verify that laboratory personnel using licensed material had received initial training. However, Mr. Bennett added that receipt of the initial training was documented only for licensee personnel assigned to wear film badges. Regarding Section 10 of the NRC Report, Mr. Bennett pointed out that two days after the NRC inspection, the licensee posted a "Caution, Radioactive Material" sign in the In-patient Pharmacy where incoming radioactive material packages are received and stored. A written procedure for receipt of radioactive packages at the In-patient Pharmacy was provided to the NRC representatives.

Mr. R. Scarano expressed his concern that the licensee's management should have taken appropriate corrective action to the numerous and repetitive violations identified during past NRC inspections by utilizing mechanisms that should already exist to oversee the licensed program. Mr. Scarano stressed the critical importance of licensee internal audits in identifying potential violations of NRC requirements, proper communication of safety issues to the hospital's management, and prompt and effective followup corrective actions to any deficiencies identified. Mr. M. Murphy, licensee representative, replied that for tracking purposes, the status of deficiencies which are identified through internal audits of the radiation safety program would likely be included on the agenda of future meetings of the licensee's Radiation Safety Committee.

Dr. I. Kuhn and other licensee representatives discussed the problems the licensee faced in attempting to achieve compliance with the NRC requirement to evaluate and record the doses assigned to lost and missing film badges, which was the subject of two repetitive violations from past NRC inspections. The licensee representatives stated that their corrective actions had instead been incorrectly focused on reducing or eliminating the occurrence of lost or missing badges worn by licensee employees. Dr. Kuhn also expressed his concern that licensee efforts to resolve the problem regarding lost/missing badges had been misinterpreted in a way which indicated a potential willful violation of NRC requirements.

Mr. A. Johnson, NRC, briefly summarized the enforcement options available to the NRC, and discussed the new NRC enforcement policy with regard to mitigation and escalation of civil penalties.

3. Conclusion

Mr. R. Scarano told all participants that an early NRC reinspection of the licensed program would take place, and that the next inspection would focus on the effectiveness of the licensee's internal audit program. Mr. Scarano also informed the licensee that the enforcement actions to be taken by the NRC would be based on the combined findings of the NRC Region V OI investigation and the NRC inspections of 1987 and 1988.

Mr. J. Hickman emphasized that the licensee would continue their efforts to "make the (licensed) program work," and that he would not tolerate any repetition of the violations previously identified.