

Veterans
Administration

License No. 31-00845-01

June 7, 1985

U.S. Nuclear Regulatory Commission
Region I
634 Park Avenue
King of Prussia, Pennsylvania 19406SUBJ: Docket No. 030-02619
Inspection No. 030-02619/85-01

In reply to your letter of 5/9/85 we submit the required information below:

A. Medical Isotopes Committee Meetings.

1. The Committee met three times in 1981, three times in 1982, four times in 1983 and two times in 1984. The minutes of the meetings were not all available in an organized folder at the time of the inspection, and we regret this inconvenience. The Committee has met twice in 1985, 1/24 and 5/16, so that we are in compliance as to the frequency of meetings. Corrective steps which will be taken to avoid further violations of this item include:

The Radiation Safety Officer (RSO) will submit four proposed dates for the meeting at quarterly intervals and be responsible that Nuclear Medicine Service secretary reminds the members of the Committee of the meetings one week prior. The secretary will be present at the meetings to record and transcribe the minutes of the meetings and the RSO will be responsible for the distribution of the minutes within 10 working days of the Committee meeting. We are in full compliance as to the required number of meetings this year and we will be in full compliance as to the administrative details by 7/1/85. If you so wish, we will be glad to send you copies of all previous Medical Isotope Committee Meetings since 1981 as your Inspector, Mr. C.T. Oberg, may not have had an opportunity to review some of them.

2. Proper instruction of individuals before assuming duties with radioactive materials: The individual described received a film badge from the RSO who was told that she had previously worked with radionuclide materials in a laboratory at the State University Hospital, but he did not personally interview this technician. The technician also apparently missed the class held for Research Service workers during the past six months. The corrective steps which have been taken include: Personal interview and instruction for this individual technician by the RSO commensurate with the technician's duties in regard to radionuclide materials. Corrective steps which will be taken to avoid further violation:

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(a) No individual will be issued a film badge until that individual has been interviewed by the RSO in order to determine his/her level of experience. The RSO will then match the individual's level of experience to the proposed duties and determine whether the individual requires more training in the safe use of radionuclide materials. This determination will be reported to the Medical Isotopes Committee at its next scheduled meeting.

(b) The Chief of the Research Service has agreed to supply the RSO with a list of all new Research Service employees who work on the premises so that even individuals who do not require a film badge can be interviewed by the RSO, who will keep a file on each Research Service employee as to their level of experience regarding radionuclide materials. This will also serve as an opportunity to educate individuals about posted areas. This system will be in effect by 7/1/85.

(c) The RSO will retrospectively create a file for all current Research Service workers which indicates their level of experience, training, and current usage of radionuclide materials to see if their knowledge and training matches their work situation.

(d) The RSO will review this file for all Research Service workers annually in the month of September and report on the results of his review to the Medical Isotopes Committee. Full compliance will be achieved when the RSO presents his first such review at the Medical Isotopes Committee Meeting of September 1985.

3. (a) Frequency of wipe tests and surveys. (b) Verification that the method for performing wipe tests is sufficiently sensitive to detect 200 dpm per 100 cm² for the contamination involved. Corrective steps that have been taken include:

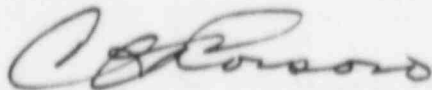
A survey of the laboratory described in the Research Service, and no significant contamination was present. The instruments used to measure wipe test samples have now been calibrated to determine disintegration rates or microcuries by the RSO. In addition, we have started a systematic survey of all laboratories that use radionuclide materials in the Research Service on a monthly basis. This survey is conducted by a registered Nuclear Medicine Technologist who works for the Chief of the Research Service. The monthly survey and wipe test reports, the first of which was accomplished at the end of May 1985, are to be reviewed by the RSO and reported to the Medical Isotopes Committee at its next quarterly meeting. We feel these steps will avoid further violations. In addition, all Research Service Investigators will be informed that they must do surveys and wipe tests at the conclusion of each experiment or at the end of the day when they work with radionuclide materials in amounts of 200 microcuries or more per experiment. This will accomplish the requirement of weekly wipe tests in accordance with I of Regulatory Guide 10.8, Rev. 1, October 1980. From the data presented to the RSO, he will be able to determine if each investigator is complying with the requirements of either weekly or monthly surveys and wipe tests. Full compliance will be achieved by 7/1/85. In addition, the RSO, the Chief of the Research Service and his technologist will develop a format that educates and assists the individual researchers in converting their counting data to disintegrations per minute or microcuries for the results of wipe tests.

B. Wipe tests on sealed sources: The most recent tests were run in March 1985 and these tests will continue to be done by the RSO every six months in March and September of each year as long as the sources are in our possession. The results of the sealed source wipe tests are maintained in units of microcuries. We are in full compliance at the present time regarding this item. The results of the sealed source wipe tests will be reported to the Medical Isotopes Committee by the RSO in the meetings immediately following the tests which usually will be March and September of the year.

C. Bioassay results of measurements of thyroid burdens are now maintained in microcurie units and we are in full compliance on this item.

D. Posting a notice describing the location of the NRC License, License conditions and documents incorporated into the license: We are now in compliance; there are "three by five" cards with this information located in the Research Service areas and the Nuclear Medicine hot lab.

E. Diagnostic misadministration quarterly reports: We previously have been instructed that all communications between the VAMC, Syracuse, NY, and the Nuclear Regulatory Commission had to be sent to the VA Central Office Nuclear Medicine Service Chief who would then forward the material to the NRC. We have sent such reports as required since the first quarter of 1981. For your information, our records indicate negative reports for the last quarter of 1980, first and second quarter of 1981, last quarter of 1982, the second and third quarters of 1983, the second and third quarters of 1984 and the first quarter of 1985. There was one diagnostic misadministration in the first quarter of 1981, one in the fourth quarter of 1981, one in the first quarter of 1982, one in the second quarter of 1982, one in the third quarter of 1982, one in the first quarter of 1983, one in the third quarter of 1983, one in the first quarter of 1984, and one in the last quarter of 1984. All of these consisted of a standard, usual dose for a test other than the test procedure which was specified. None of these instances involved giving a dose larger than the usual dose. There were no therapeutic misadministrations throughout the entire time covered. We have requested Nuclear Medicine Service VA Central Office that they forward the misadministration reports to your Regional Office, however, we will be glad to forward copies of these reports to you directly if you so desire. It should be noted that this is a total of nine diagnostic misadministrations over a period of 4½ years during which time we have administered approximately 8,000 doses of radionuclide for patient studies.



C. H. CORSARO
Medical Center Director