



SCHOOL OF MEDICINE

UNIFORMED SERVICES UNIVERSITY  
OF THE  
HEALTH SCIENCES

SCHOOL OF MEDICINE  
4301 JONES BRIDGE ROAD  
BETHESDA, MARYLAND 20814

25 July 1985



TEACHING HOSPITALS  
WALTER REED ARMY MEDICAL CENTER  
NAVAL HOSPITAL, BETHESDA  
MALCOLM GROW AIR FORCE MEDICAL CENTER  
WILFORD HALL AIR FORCE MEDICAL CENTER

Nuclear Materials Safety Section A  
Division of Radiation Safety and Safeguards  
U. S. Nuclear Regulatory Commission  
Region I  
631 Park Avenue  
King of Prussia, Pennsylvania 19406

Gentlemen:

In reply to license violations noted in Inspection Report No. 85-01 (Re: License #19-23344-01), and as requested in a letter dated 03 July 1985 signed by John D. Kinneman, the following actions have been taken to rectify License Violations and verify items of understanding found by, and discussed with, Mr. F. Costello during his routine safety inspection conducted on 24 January 1985.

Finding: Item A - Control of Radioactive Materials - violation of  
10 CFR 20.207

Corrective Actions and Results

Isotope security is emphasized during all training sessions. Monthly University laboratory surveys by the Department of Environmental Health and Occupational Safety (EHOS) personnel include a review of isotope security. These actions have resulted in heightened user awareness for the necessity of isotope security and the consequences of not following established safeguards.

Steps to Avoid Further Violations

At its next regularly scheduled meeting, the Radiation Safety Committee will review existing isotope control procedures and institute corrective actions where required to ensure that the regulations of 10 CFR 20.207 are not violated by persons authorized to use radioactive materials under the USUHS By-Products Materials License. All long-term actions directed by the Radiation Safety Committee will be implemented no later than 01 January 1986.

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Finding: Item B - Radiation Extremity Exposure -  
Violation of 10 CFR 20.101

Comments: There is an error in the reported time periods in Item B. Our records indicate the dosimetry device in question had been lost for the period 15 May to 18 May 1984, vice the reported period of 15 May to 08 June 1984. The second period 18 July to 10 September 1984 agrees with our records.

Corrective Actions and Results

Dose estimates for the two periods for which the extremity dosimeter was lost have been made. The following procedures for the review and audit of personnel exposures have been implemented.

Monthly - The USUHS Dosimetry Program Manager reviews all results returned from the film processing activity. All exposures in excess of the USUHS ALARA limits and all persons who fail to return a dosimetry device or who have lost a dosimetry device are noted. The Radiation Safety Officer (RSO) reviews the dosimetry results and assigns exposures as necessary. The exposures assigned are based on an interview of the radiation worker, past work/exposure history, exposure received by co-workers and types/quantities of isotopes handled during the exposure period.

Quarterly - All occupational exposure records are updated and reviewed for completeness.

Semiannually - The RSO performs a dosimetry record review.

Annually - As a portion of the Annual Program audit, the Radiation Safety Committee will review exposure records and dose estimation procedures. No further action is required to achieve full compliance with 10 CFR 20.101.

The following information is provided as requested:

Phosphorus-32 spill on 20 November 1984

(1) Although the spill was not formally discussed by the RSC until its meeting on 03 May 1985, the following RSC members were consulted during the cleanup: Kenneth E. Kinnamon, D.V.M., Ph.D. (Chairman), CDR Jerry A. Thomas, (Vice Chairman), CPT Mark A. Coombs (Radiation Safety Officer), Lt Col Richard M. Riccardi, and Dr. John Hay.

(2) A formal report on the contamination incident (enclosed) was completed by the RSO on 20 February 1985.

(3) The Principal Investigators responsible for the contaminated work area submitted revised laboratory procedures on 03 July 1985.

(4) Future spills resulting in widespread facility contamination will be formally documented following the spill and will be submitted for RSC review at its next regularly scheduled meeting.

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Three items of understanding were discussed at the time of the audit. They follow:

1. Iodination Effluent Monitoring

Effluent monitoring practices following iodination procedures have been reviewed and revised. As suggested by Mr. F. Costello, sampling times have been extended to ensure that post-iodination releases are adequately monitored.

2. Phosphorus-32 Vial Handling Devices

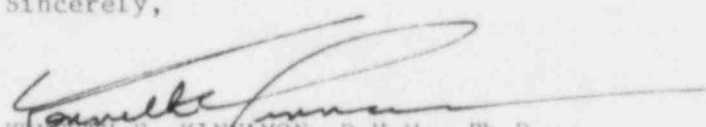
All researchers working with millicurie quantities of  $^{32}\text{P}$  have been issued appropriate vial and test tube handling devices.

3. Nickel-63 Foils

All high pressure liquid chromatography and gas chromatograph units which could use  $^{63}\text{Ni}$  foils have been identified.

The professionalism of Mr. F. Costello during his review of our facility made the inspection an enjoyable experience for all members of our staff. His informal comments were appreciated and I feel that our Radiation Safety Program is better as a result of his inspection.

Sincerely,

  
KENNETH E. KINNAMON, D.V.M., Ph.D.  
Associate Dean for Operations

Enclosure