DEPARTMENT OF VETERANS AFFAIRS
Edith Nourse Rogers
Memorial Veterans Hospital
200 Springs Road
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October 31, 1996

In Reply Refer To:

James M. Bondick
U.S. Nuclear Regulatory Commission, Region 1
475 Allendale Road
King of Prussia, PA 19046

Dear Mr. Bondick:

We appreciate the thorough review and constructive criticism of our Radiation Safety Program during your inspection visit of October 30, 1996. We will conduct an ongoing process to address items needing corrective action, but in addition, I would like to report to you responses we are already able to make in regard to these items. Four items you identified were: (1) failure of one of the 1995 Radiation Safety Committee minutes to include a review of Quarterly Inspection reports; (2) inadequate calibration of survey meters in 1996 (in contrast to previous years); (3) a 5-day delay between a radioiodination procedure in 1994 and thyroid monitoring; and (4) an extended period during which film badges were delayed in submission to Landauer - resulting in some of them being too old to read.

The lapse in film badge processing is an error that we acknowledge must be avoided in the future. It occurred during a several month period of Building 18 renovation, during which badges were kept in a remote storage building (along with many other items) and were overlooked. To prevent recurrence, J. Squicciarini has added the obligation to send out badges as a monthly recurring task in his Microsoft Schedule+ computer program. In addition, we will review the timeliness (as well as the content) of film badge results in our Quarterly RSC meetings.

The 5-day interval between radioiodination and monitoring was excessive, as you noted. I can report, however, that we identified that problem ourselves and addressed it in our December 1994 RSC meeting. In addition to increased alertness to the need for prompt monitoring, we took the specific action of posting a notice in the iodination room to ensure compliance. A copy of the relevant page from the minutes is attached. We believe that our action has adequately addressed the problem.

Regarding adequate calibration of survey meters, we find that it was done but that we failed to transfer the records properly. Neil Gaeta performed the calibration in February 1996 (see attached documentation), but the report was sent to Engineering Service and not forwarded to the Radiation Safety Office. We have notified Engineering Service of the need to forward copies of the calibration record promptly.

Regarding RSC review of Quarterly Inspection Reports, this is present in all of the RSC minutes from 1994-1996. The problem with the Sept. 26, 1995 minutes was simply that as printed out, this item was easy for a reader to overlook since the heading "Quarterly Inspection" appeared

at the bottom of p. 3 while the text, without any heading, was printed on p. 4. A copy of these pages is attached.

We hope these responses clarify some of the issues you addressed. We will continue to work to ensure our full compliance with NRC regulations in these and other areas and will be glad to respond further as the NRC deems necessary.

Sincerely,

Frederick L. Moolten, M.D.
Radiation Safety Officer

3. NEW BUSINESS

A. QUARTERLY INSPECTIONS

1. SURVEY INSPECTION

Conclusion: V. Evdokimoff reported that surveys for the last quarter resulted in the following: observation that some research staff are leaving their doors open when no one is present and that a person who performed iodination did not receive the required monitoring of thyroid within 72 hours.

Recommendation: There is a need to continue monitoring the policy of closing doors to laboratories when no one is present. There is also a need to establish a policy to ensure that iodination does not occur without advanced scheduling of thyroid monitor within 72 hours.

Action: Radiation Safety Office will continue to conduct random surveys of laboratories to ensure that doors are closed and notification will be placed on the iodination room to ensure that iodination does not occur without previously scheduling a thyroid monitor within 72 hours.

Evaluation: Monitoring will be continued by the Health Physics Consultant.

2. Misadministration

Conclusion: There were no misadministrations.

Recommendation: There was no need to make any recommendations.

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