



May 27, 2009

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Subject: **Reply to a Notice of Violation**

From: Providence Alaska Medical Center
Anchorage, Alaska
Docket No. 030-13426
License No. 50-17838-01

This is to respond to the letter on May 11, 2009: NRC Inspection Report 030-13426/09-001 and Notice of Violation from NRC Nuclear Materials Safety Branch A following the inspection conducted on April 23, 2009.

We gratefully acknowledge the finding of the two violations as pointed out in the letter.

The following is the summary of the two Severity Level IV violations and actions taken:

1. Failure to secure the keys to an HDR unit when left unattended:
 - (1) The reason for the violation:
We did not correctly interpret the regulation, specifically, "Secure ... the console keys" in 10 CFR 35.610(a)(1), a negligence to the regulations. The RSO and AMPs take full responsibility.
 - (2) The corrective steps that have been taken and the results achieved:
We now store the keys in secured rooms (locations not specified due to safety reasons) that have secure electronic locks with access only approved by the RSO. Hence the keys security is achieved.
 - (3) The corrective steps that will be taken to avoid further violations:
We studied NRC regulations carefully and reviewed our HDR treatment procedure for the corresponding modification for the keys security, to prevent recurrence. The modification was documented. A comprehensive review for HDR treatment safety was conducted by the RSO and AMPs as preventive measures against other hidden safety problems. Hence the radiation safety is more consolidated. See also "The further actions" below.
 - (4) The date when full compliance will be achieved:

IEO7
Res IV



We took the action for key security the same day of violation finding: April 23, 2009.

2. Failure to prevent dual operation of more than one radiation-producing device in a treatment room:
 - (1) The reason for the violation:

We did not strictly follow the regulation, specifically, 10 CFR 35.610(a)(3) to conduct a timely repair for the malfunctioned switch that was used to prevent dual operation, a negligence to the regulations. The RSO and AMPs take full responsibility.
 - (2) The corrective steps that have been taken and the results achieved:

The switch repair order was placed on April 24, the day after the inspection and the switch was repaired on April 28. A comprehensive test was conducted to ensure the device was working in specification. Hence the safety is achieved.
 - (3) The corrective steps that will be taken to avoid further violations:

This malfunctioning switch was detected to be faulty in our source exchange QA but was incorrectly deemed to not be an urgent matter. We reviewed our HDR treatment procedure for the corresponding modification by stressing that all repairs mandated by regulation will be given at the utmost urgency, to prevent recurrence. The modification was documented. A comprehensive review for HDR treatment safety was conducted by the RSO and AMPs as preventive measures against other hidden safety problems. Hence the radiation safety is more consolidated. See also "The further actions" below.
 - (4) The date when full compliance will be achieved:

We placed an order to repair the switch the day after the violation was found. The switch was fixed and functioning correctly on April 28, 2009.

The further actions:

1. An ad hoc RSC meeting with the key members was held for reviewing the inspection results on April 28, 2009.
2. The Notice of Violation was posted as instructed on May 27, 2009.
3. The NRC inspection with the violation results was addressed for awareness and education in the department meeting on May 27, 2009.
4. The relevant personnel were re-trained after the correction.
5. A summary will be presented in the next Quarterly Radiation Safety Committee meeting that is set for July 7, 2009.
6. The internal radiation safety audit for each department that was started before the NRC inspection is continually on going.



Should you have any questions regarding this submission, please contact me at (907)212-5691.

Sincerely,

A handwritten signature in black ink, appearing to read "Yongli Ning".

Yongli Ning, M.S., Chief Medical Physicist
Radiation Safety Officer
Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99519-6604
Tel: (907) 212-5691
Email: yning@provak.org

A handwritten signature in black ink, appearing to read "Wanda D. Katinszky".

Wanda D. Katinszky, RN, BSN, MSW
Director, Oncology Service Line
Providence Alaska Medical Center
3851 Piper Street, Ste. U239
Anchorage AK, 99508
Tel: (907) 212-4926
Email: wkatinsz@provak.org

A copy of this letter will be forwarded to Elmó Collims, the Regional Administrator, Region IV of US NRC as instructed.

Cc: John B. Halligan, M.D., Medical Director Radiation Oncology
Christopher Galloway, Clinical Manager Radiation Oncology
Wanda D. Katinszky, Director Oncology Service Line
Steven Katzenson, Chairman Radiation Safety Committee
Bruce Lamoureux, Administrator Providence Alaska Medical Center