



University of Hawaii at Manoa

Office of the Chancellor
Hawaii Hall 105 • 2500 Campus Road
Honolulu, Hawaii 96822

December 1, 1980

Mr. H. E. Book, Chief
U.S. Nuclear Regulatory Commission, Region V
Fuel Facility and Materials Safety Branch
1990 N. California Boulevard
Walnut Creek Plaza, Suite 202
Walnut Creek, California 94596

Re: Notice of Violation of NRC License No. 53-00017-23
University of Hawaii at Manoa

Dear Mr. Book:

The Notice of Violation and your letter dated November 13, 1980 were received by this office on November 17, 1980. We offer the following statements, explanations, and actions taken regarding the alleged infraction:

"Contrary to 10 CFR 20.101(a), a University employee received a whole body dose of 1.94 rem for the period May 1, 1980-May 31, 1980."

During the period May 1, 1980-May 31, 1980, our records show that Don Tolbert, Ph.D., CRP, received a film badge reading of 1940 millirem. This was reported by Nick Rinaldi, then UHM Radiation Safety Officer, in a letter to the director dated August 22, 1980.

Dr. Tolbert is an employee of the University working through the Cancer Center of Hawaii as director of an outreach program in radiological physics. In this capacity he provides radiological physics services to Kuakini Medical Center, St. Francis Hospital, Queen's Medical Center, all on the island of Oahu and at Hilo Hospital on the island of Hawaii. These services include calibrations on radiation therapy machines, leak tests on brachytherapy sources and instrument calibrations with sealed sources. In addition to his University position, Dr. Tolbert is employed as the Radiation Safety Officer (RSO)

and provides RSO services for the Queen's Medical Center. Film badge service is provided to him by the Queen's Medical Center. Further information on the same subject has been previously forwarded by Nick Rinaldi's letter dated August 22, 1980 and Dr. Tolbert's letter dated August 29, 1980.

The University will take immediate corrective steps to provide adequate monitoring capability for Dr. Tolbert. The University does not acknowledge responsibility for the alleged infraction as issued for the following reasons:

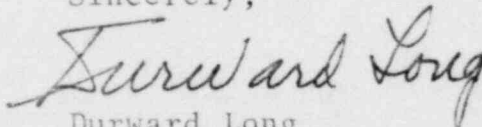
1. We acknowledge that Dr. Tolbert is a University employee and that his responsibilities include frequenting restricted areas under several other licenses under which the University has neither jurisdiction nor control of facilities. Further, we must point out that Dr. Tolbert has not and does not use, possess, or transfer any licensable materials belonging to the University or materials covered under its NRC license. Dr. Tolbert is not an "Authorized User" under the University's Radiation Health and Safety Program nor is he required, as part of his job responsibilities, to enter any University controlled laboratory classed as a restricted area. Thus we question that the University as the licensee, through its possession, use, or transfer of licensed material, has caused "any individual (Dr. Tolbert) in a restricted area" to receive an excessive occupational dose as referenced in the Notice of Violation.
2. Each of the therapy machines, brachytherapy sources or sealed sources serviced by Dr. Tolbert that require NRC licensing are licensed under the individual hospital or medical center. Thus any restricted area that Dr. Tolbert might enter in servicing these radiation units would fall under the jurisdiction and responsibility of the individual licensee and not the University of Hawaii.
3. Dr. Tolbert's employment with Queen's Medical Center as the Center's Radiation Safety Officer servicing multi restricted areas would lend itself much more favorably towards any excessive exposure than would Dr. Tolbert's employment with the University of Hawaii under its NRC license and licensing conditions.
4. In consideration of the above points, we would argue for a revocation of the alleged violation infraction towards the University of Hawaii and suggest that, if a violation indeed has occurred, any Notice of Violation should be placed against other NRC licensed institutions for which Dr. Tolbert provides services and have restricted areas under their jurisdiction and control.

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In the spirit of compliance and desiring to provide improved monitoring capability and safety protection to our employees, the University has taken action to notify Dr. Tolbert of his responsibilities as a University employee in regard to the University's licensing conditions and a copy of the Notice of Violation has been posted at his office. Further, arrangements will be made to provide a pocket dosimeter for gamma/X-ray detection in addition to the film badge service supplied by Queen's Medical Center. Dr. Tolbert will be instructed to wear the dosimeter and to maintain log readings prior to entering and again upon leaving each and every restricted area covered by any of his employment positions. Copies of the log sheets will be available to the University's Radiation Safety Officer upon request. Dr. Tolbert will be instructed to immediately notify the University's RSO of any unusual or higher than normally expected reading. The University's RSO will make an investigation concerning any incident and report such incident to the University's Radiation Safety Committee for further action if required.

The above procedures will be implemented immediately. A follow up report will be sent to you when full implementation has been achieved.

Sincerely,



Durward Long
Chancellor

cc: Clair Folsome, Chairman, Radiation Safety Committee
Don Tolbert, Cancer Center of Hawaii
Lawrence Piette, Executive Director, Cancer Center of Hawaii
Robert Hall, UHM Radiation Safety Officer
Bert Pumento, Acting Vice Chancellor for Administration