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November 26, 1990

Reply to Notice of Violation
Docket No. 030-12467
License No. 21-10578-02
EA 90-160

Director, Office of Enforcement
U.S. Nuclear Regulatory Commission
ATTENTION: Document Control Desk
Washington, D.C. 20555

Gentlemen:

We are in receipt of your letter dated October 29, 1990 titled "Notice of Violation and Proposed Imposition of Civil Penalty", (NRC Inspection Report No. 030-12467/90001). The Board of Directors, Administration, Nuclear Department at the Hospital have all had an opportunity to review and discuss the listed violations at their respective meetings. The following is our reply to Notice of Violation. Administration previously ruled on the Radiation Safety officer to review and ensure that all requirements were followed. We have altered our previous program to include spot checks by Administration to the area to ensure that the doors are kept properly closed, the logs are complete and constant communication is made with the Radiation Safety officer to review the departmental data.

Item: (1) We admit that a whole body or extremity dosimetry badge was not given to an individual working in the nuclear medicine department. The Radiology Administrator was responsible to provide badges to each person working in the department. A check-off list was developed that includes the receipt of a badge. The Radiation Safety officer will be checking to see that all new employees receive a badge and that each employee received their renewal badge. These records will also be reviewed at the Radiation Safety Committee meeting. This was instituted at the September 4, 1990 meeting. The reason that the badge was not given to the temporary employee was due to a misunderstanding by the Radiology Administrator. He felt that since a permanent technician was always below the listed levels of safety each month, that a person working only a fraction of the month didn't require a badge. The badge rule was made clear to the entire department immediately after the inspection took place and we were notified of the violation.

Item: (2) At the time of the inspection, it was noted that sealed dose calibrator reference sources and unit doses of radiopharmaceuticals, located in the hot lab were not under the immediate control of the licensee. The technician left the hot lab door open and the door to the department unlocked while she

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was developing a film. This was acted upon immediately. The technician was reminded that the door was to be kept properly closed the day the inspectors were here. This was checked by the Radiology Administrator and RSO on a continuous basis from that point. The licensee also installed automatic door closers to prevent the department from being left open when unattended by properly trained staff.

Item: (3) The inspectors spoke to the technician about a cup of water used by the above for drinking purposes with her medication. The technician admitted to the licensee that she drank water within the department when taking medication at her desk outside the hot lab. The technician was instructed that this is not allowed at any time. This was done immediately upon licensee being informed of same. Item three also mentions smoking within the area. This is heresay, as the inspectors or licensee did not see the temporary employee smoking in the area. The reason the problem occurred was because the technician falsely assumed that her desk (which is not in the hot lab or near where patients are injected) was a "safe" area. Smoke detectors were installed the week of October 1, 1990. Additional signs were put up regarding drinking and smoking in the area as well.

Item: (4) The surveys of the areas where radiopharmaceuticals are routinely prepared and administered were not performed at the end of the work day but were being done at the beginning of the workday. The technician was informed that this is contrary to the required practice at the time we were made aware of the violation. The RSO is now checking the log book of the surveys completed at the end of each day, thus ensuring that they are routinely completed at the end of the workday and not at the start of the next day. The RSO officer started this practice immediately after the violation was reported to the licensee. The reason this occurred was even though the logs were constantly checked, due to the nomenclature of the log it was impossible to determine the time that the check was completed. This has now been changed to reflect the proper work day time frame as required.

Item: (5) It is true that the RSO was not immediately notified by the technician that the dose calibrator constancy error exceeded the 10% level. However, the RSO was informed that same day and immediately discontinued its use until a replacement calibrator was obtained. We currently are using a daily check sheet that list a positive or negative 10% factor so it can be detected immediately. The technician did not use the sheet previously.

Item: (6) The records for the dose calibrator linearity were misplaced by the physicists. The tests were done. He was able to locate the two other tests, (copies have been previously supplied to the agency). The physicist stated that the test was

within the normal limits and was able to work out the findings based on the other information he had to confirm the results. The physicist was informed that he must provide us with copies immediately following the tests being done for our logs.
Item: (7) The proper maintaining of records in the log for unit doses of radiopharmaceuticals were not present. There were two items brought to our attention. The first had to do with the initiating of the record by the regular technician. She was informed of same and it was corrected the very day we were told of the violation. The second item pertained to the logging done by the temporary employee. All the data was put onto our work sheet but was not transferred to the log properly. The RSO is reviewing the worksheets daily to ensure proper maintaining of records at all times.

Item: (8) Records showing the receipt of licensed material were not kept for the period of July 19 - 31, 1990. The RSO was made aware of this and has since made sure that he has inspected daily to ensure that the logs indicate the receipt of all licensed material. Full compliance was achieved upon return of our regular technician and has remained current. This is checked on a daily basis by the RSO.

Item: (9) The radiation workers were not properly trained in radiation safety rules, procedures and conditions of the NRC license. The radiation safety officer has reviewed all rules, procedures and policies pertaining to safety when using licensed material. Signs have been placed as to constantly remind the workers of the rules. Inservices are being given to update and refresh the memory of the workers. These inservices began immediately upon notification of the violations.

The correcting of violations were all handled in an expeditious manner once we were informed that they existed. The radiation safety committee met while the investigation was still ongoing in an effort to correct the violations. A corrective plan was established and implemented prior to our official meeting, including putting one of the technicians on probation for disregard of set rules.

In our behalf I would like to say that we were continuously informed by the surveyors/inspectors throughout our discussions that their findings were not official and would not be formal until the official report. We did undertake to correct each item as we were so informed. I am including a copy of the corrective action plan that was instituted prior to the October 5, 1990 enforcement conference. Administration has requested to review all logs at our Radiation Safety Committee to ensure the RSO is adhering to his responsibilities. A series of checks and balances have been incorporated to prevent items from "slipping through the cracks" unnoticed.

Enclosed please find our check of $2,500.00 for penalty fees instituted. If you have any questions on the above data, please contact me.

Sincerely,

Jerry A. Frohlich

Jerry A. Frohlich
President

JAF/bjj

cc: Bert Davis,
Regional Administrator