SAINT AGNES MEDICAL CENTER
1900 SOUTH BROAD STREET, PHILADELPHIA, PENNSYLVANIA 19145 215/339-4100

December 16, 1993

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

RESPONSE TO NOTICE OF VIOLATION

RE: Material License 37-13651-01
Inspection Number 030-03196/93/001

Gentlemen:

The following information summarizes corrective measures implemented by Saint Agnes Medical Center relating to the deficiencies identified during a recent regulatory inspection. The responses alphabetically correspond to the issues identified in the report dated November 24, 1993.

A. Radiation Safety Training of Nuclear Medicine Personnel:

1. As discussed on October 19, 1993 (date of inspection), required training of nuclear medicine personnel was not completed in accordance with 10 CFR 19.12 and current license conditions. This oversight is partially the result of the recent hiring of a nuclear medicine technologist.

2. Corrective action relating to this matter includes, though not limited to, radiation safety inservicing, review of current license conditions and review of pertinent parts to 10 CFR 35. Nuclear medicine personnel have been instructed to review various regulatory documents and publications as well as the report received from our medical physics consultant. Radiation safety inservicing shall be conducted by the Radiation Safety Officer and/or our medical physics consultant.

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3. Monitoring of radiation safety training activities shall be conducted by the Radiation Safety Officer and Radiation Safety Committee. In addition to conducting radiation safety inservicing, nuclear medicine personnel shall actively participate with the radiation safety audits conducted by our medical physics consultant and review each report. This action will enable personnel to keep abreast of license conditions, regulatory guidelines and alerts as well as evaluate the current status of regulatory compliance.

4. Information regarding radiation safety training requirements has been discussed with nuclear medicine personnel. A complete and thorough review is to be completed during our next radiation safety audit conducted by our medical physics consultant (scheduled for December 22, 1993). Documentation shall be placed on file regarding this radiation safety inservicing in accordance with current license conditions and applicable regulations. Therefore full compliance will be achieved as of December 22, 1993.

B. Radiation Safety Officer Review of Leak Test/Inventory Records:

1. Inadvertently, records of sealed source leak testing and inventory during December 1992 and August 1993 were not signed by the Radiation Safety Officer. Information regarding these required procedures is included within the report generated by our medical physics consultant.

2. Corrective action implemented includes a thorough review of the sales source leak test and inventory results. The radiation Safety Officer's signature shall be affixed to the reports provided by our medical physics consultant.

3. Records of sealed source leak testing and inventory shall be reviewed and signed at required frequencies. The Radiation Safety Committee and medical physics consultant shall monitor this matter on quarterly intervals.

4. Full compliance has been achieved as of October 19, 1993. Records of sealed source inventory and leak testing have been signed by our Radiation Safety Officer.

Lastly, dosimetry information shall be forwarded to the Region 1 office as discussed on October 19, 1993. There appears to have been concern with the extremity exposures received by nuclear medicine personnel. The lead glass inserts of some of our syringe shields were missing. Increased hand exposure was possible because of the missing glass inserts.

Replacement inserts have been received and subsequently installed. It is anticipated that lower extremity exposures shall result upon correcting this matter. A sampling of dosimetry information shall be fowarded, separate from this correspondence, in order compare the extremity exposures received by nuclear medicine personnel before and after the glass insert replacement.

I trust that the described corrective actions meet to your satisfaction. In the event additional information is required, please contact Neil Proshan, M.D., Radiation Safety Officer, at (215) 339-4797. I thank you in advance for your assistance and guidance provided to St. Agnes Medical Center with respect to our Radiation Safety Program.

Sincerely,

Sister Margaret Sullivan, OSF

Sister Margaret Sullivan
Vice President

cc: USNRC, Region I