THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

OFFICE OF RADIATION SAFETY MC-3930
Tel. (203) 679-2250

October 27, 1993

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

RE: Reply to a Notice of Violation
License No: 06-13022-02
Docket No: 030-01295
Inspection No: 93-001

Dear Sirs:

The University of Connecticut Health Center (UCHC) is responding to a "Notice of Violation" letter dated September 29, 1993, in which two violations were identified as a result of a routine inspection conducted August 30 and 31, and September 1, 1993. Reference is also made in this Notice of Violation letter to a Nuclear Medicine Technologist extremity exposure of 17.02 Rem which occurred in August of 1993. This dose is in error as the estimated exposure recorded was 14.12 Rem. This correspondence addresses each violation in turn and corrective actions taken since these violations were identified.

VIOLATION A: Nuclear Medicine Technologist Not Wearing a Finger Ring Monitor

REASON FOR VIOLATION

The University of Connecticut Health Center admits that a Technologist did not wear a finger ring monitor during preparation and assay of radiopharmaceuticals on August 31, 1993, but denies the Technologist was not wearing a finger ring during elution of the generator. Records present in the department and a corroborating statement from the Lead Technologist indicate that the generator was eluted prior to the time the NRC inspection team was present. We submit this information in order to ensure the record is accurate, even though we are admitting to the violation. Interviews with the technologist have indicated that he was aware of the finger ring requirement, but that he simply forgot to don the dosimeter after washing his hands. In addition, he stated he was somewhat distracted due to the fact he was under direct observation by the NRC.

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CORRECTIVE STEPS TAKEN TO DATE

September 2, 1993: The violation was presented by the NRC Inspection Team to UCHC Management and Committee members on September 1, 1993, at 3:00 PM. Management, the Radiation Safety Officer, and selected Committee members met with the Technologist at 8:00 AM on September 2, 1993. During this meeting, the results of the inspection and the alleged violations were discussed with the Technologist. In addition, the possible ramifications of the alleged violations were discussed, as well as the importance of adhering to all UCHC licensing conditions. The Technologist was informed that the alleged violation would be discussed by the Radiation Safety Committee, and that the Committee would take corrective actions. The Technologist stated that he would be very cognizant of the finger ring requirement in the future.

October 7, 1993: The Radiation Safety Officer met with the Technologist on October 7, 1993, to discuss the violation. The possible ramifications and the absolute need to adhere to radiation safety requirements, especially wearing extremity dosimetry at all times while working with radioactive materials, were discussed. The Technologist was also informed that the Committee would meet to discuss corrective actions.

October 11, 1993: The Radiation Safety Committee met on October 11, 1993, at 8:30 AM to discuss corrective actions which should be taken as a result of the Notice of Violation letter. The Committee was of the opinion that since the Technologist had been involved in a previous violation which led to an enforcement conference, and that other incidents had been noted since that conference, significant corrective action must be taken. The Committee decided to require the Technologist to appear before the Committee on October 20, 1993, to discuss these events prior to making any final decisions on corrective action(s).

October 18, 1993: The Radiation Safety Officer again met with the Technologist to inform him of the Committee's requirement for his attendance at a special meeting to be held on October 20, 1993. Again, radiation safety requirements were discussed and a copy of an NRC Enforcement Action taken against the Department of Veterans Affairs Medical Center, Birmingham, Alabama (a copy attached), which appeared in the Monday, September 27, 1993, (pg 50371) Federal Register, was provided to the Technologist for his ongoing education concerning the gravity of the situation.

October 20, 1993: The Technologist appeared before the Committee to provide information regarding the violation and other incidents which had occurred in the past. The Technologist stated that he had changed his work habits to ensure a finger ring will be worn at all times while working with radioactive materials. These changes in work habits were:

1. Putting on the finger ring when he arrives in the Department and not removing it until the end of the day or when leaving the department.

2. Washing his hands with the ring on.

After deliberation by Committee members, it was decided to suspend the Technologist's authorization to work with radioactive materials from Monday, October 25, 1993, through November 5, 1993. In addition, the Committee instituted a two week surveillance period by select members of Nuclear Medicine Faculty, the Radiation Safety Office, and the Committee. During this period, spot checks will be performed to ensure the Technologist does indeed wear a finger ring while working with radioactive materials. This surveillance period will begin Monday, November 8, 1993, and extend through Friday, November 19, 1993. This surveillance period is intended to reinforce the Technologist's awareness of all licensing requirements. The Committee further required that any NRC reportable incident attributable to the Technologist or observation of work with radioactive materials without wearing a finger ring or protective gloves during the surveillance period would result in immediate suspension of radioactive materials work privileges until the Committee meets to discuss further action. The Committee also voted that after the surveillance period any NRC reportable incident in which the Technologist is involved would result in immediate suspension of work privileges until such time the Committee could meet to discuss corrective action. A letter was drafted from the Committee Chairman to the Technologist explaining the corrective actions and hand delivered by the Radiation Safety Officer on October 21, 1993, at 4:50 PM. A copy of this letter is attached.

October 25, 1993: Hospital Management decided to suspend the Technologist from work at the UCHC, without pay, from 12:00 Noon on October 25, 1993, through November 5, 1993.

CORRECTIVE STEPS THAT WILL BE TAKEN

Corrective steps to be taken in the future will depend on the individual's work habits and Committee mandated actions should future violations occurr. Corrective steps in progress or that will be taken include:

1. Suspension from work with radioactive materials from Monday, October 25, 1993, through Friday, November 5, 1993, inclusive. Hospital Management has decided that this suspension will be without pay.

2. Surveillance of the Technologist's work habits for the period November 8, 1993, through November 19, 1993, by selected Nuclear Medicine Faculty members, Radiation Safety Office staff members, and/or members of the Committee. Such surveillance will involve spot checks to ensure the Technologist is wearing a finger ring and protective gloves while working with radioactive materials. This is intended to be an educational reinforcement of the licensing requirements. Any violation noted during this period will result in immediate suspension of radioactive materials work privileges until the Radiation Safety Committee meets to decide upon further action.

3. Immediate suspension of the Technologist's privileges to work with radioactive materials at the UCHC should an NRC reportable violation occur in the future directly attributable to the Technologist. This suspension would be in effect until the Radiation Safety Committee meets to decide upon further action.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The suspension period will extend from Monday, October 25, 1993, and end Friday, November 5, 1993, inclusive.

The surveillance period will extend from November 8, 1993, through November 19, 1993, inclusive.

It is expected that full compliance will be achieved by November 19, 1993. Should an additional reportable future violation occur, attributable to the Technologist, such violation will be identified in Radiation Safety Committee minutes with the date when corrective action was taken.

VIOLATION B: Food Items In Thyroid Uptake Room.

REASON FOR VIOLATION

The UCHC admits that said items were present in the Nuclear Medicine "Swing Room". This area has historically been used as an "on again" "off again" breakroom. The use of the "Caution-Radiation Area" sign was to inform individuals when the room was not to be used as a breakroom. The violation occurred as a result of the failure to follow protocol.

CORRECTIVE STEPS TAKEN TO DATE

The alleged violation was identified during the NRC closeout meeting with Management on September 1, 1993, at 3:00 PM. Management, the Radiation Safety Officer, and selected Committee members met at 8:00 AM on September 2, 1993, to discuss the alleged violation. Individuals present agreed to move all work with radioactive materials out of the "swing room" into another room, CG167. This was accomplished by September 3, 1993. Room CG167 is now a radioactive materials use area and is labeled as such. The "Swing Room" is now a breakrocm only, with no radioactive materials permitted.

CORRECTIVE STEPS THAT WILL BE TAKEN

The UCHC is of the opinion that the corrective step taken by September 3, 1993, was sufficient to correct the violation. It is anticipated that in the early part of 1994, the Nuclear Medicine Department will move into new and spacious quarters which will be conducive to a safer and less congested radioactive materials use environment. This new area does have a designated breakroom that will be used by staff for consumption of food and beverage.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on September 3, 1993.

Sincerely,

Leonard P. Paplauskas
Assistant Vice President for Research

LPP:ep

cc: Dr. A. Lurie
Mr. K. McCarthy
State of Connecticut
Mr. W. Pickett
Mr. K. Price
USNRC
Region I
Regional Administrator

measurements over three consecutive breeding seasons, interannual variation in feeding ecology and reproductive performance will be assessed to determine composition.

Location

Palmer Station, Antarctic Peninsula, Hero Bay, East Antarctica.

Dates: October 1, 1993–March 1, 1996.

Thomas F. Forhan,
Permit Officer, Office of Polar Programs.

[FR Doc. 93-23517 Filed 9-24-93; 8:45 am]

BILLING CODE 7555-01-M

NUCLEAR REGULATORY COMMISSION

Cleveland Electric Illuminating Co., et al. Perry Nuclear Power Plant; Issuance of Supplemental Director's Decision Under 10 CFR 2.206

[Docket No. 50-440]

Notice is hereby given that the Director, Office of Nuclear Reactor Regulation (NRR), has issued a supplemental decision concerning a petition of September 29, 1992, submitted by Steven C. LaTourette on behalf of the Lake County Board of County Commissioners (petitioners). The petition requested that the U.S. Nuclear Regulatory Commission (NRC) take action, so that (1) a public hearing is held before the construction of an onsite, low-level radioactive waste storage facility at the Perry Nuclear Power Plant and (2) the construction of the storage facility is suspended until (a) the NRC or the licensee produces an environmental impact statement on the [illegible] of onsite storage of low-level radioactive waste and (b) the NRC promulgates regulations for the storage of low-level radioactive wastes at nuclear power plant sites.

The Director, NRR, denied the petition in Director's Decision DD-93-05 dated March 28, 1993. On April 21, 1993, the petitioners requested that the Commission review and reverse that decision. Although the regulations of 10 CFR 2.206 provide that no petition or other request for Commission review of a director's decision under that section will be entertained by the Commission, the Director, NRR, subsequently elected to issue a supplement to the original decision, to clarify the bases upon which that decision was reached.

The Director, NRR, has confirmed the previous denial of the request. The reasons for this decision are explained in the "Supplemental Director's Decision Under 10 CFR 2.206" [DD-93-15], which is available for public inspection in the Commission's Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC 20555, and at the Local Public Document Room at the Perry Public Library, 3753 Main Street, Perry, Ohio 44081.

A copy of the supplemental decision has been filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR 2.206(c). The decision, as supplemented, will constitute the final action of the Commission, unless the Commission, on its own motion, institutes review of the decision, as supplemented, within 25 days of issuance of the supplemental decision.

Dated at Rockville, Maryland, this 21st day of September 1993.

For the Nuclear Regulatory Commission.

Thomas E. Murley,
Director, Office of Nuclear Reactor Regulation.

[FR Doc. 93-23554 Filed 9-24-93; 8:45 am]

BILLING CODE 7590-01-M

[Docket No. 030-01204; License No. 01-00643-02 EA 93-174]

Department of Veterans Affairs Medical Center, Birmingham, Alabama, Confirmatory Order Modifying License (Effective Immediately) and Demand for Information

I

The Veterans Administration Medical Center (Licensee), Birmingham, Alabama is the holder of Byproduct Material License No. 01-00643-02 (License), issued by the U.S. Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR part [illegible] 35. The Licensee is authorized to possess and use byproduct material for diagnostic and therapeutic nuclear medicine procedures, and for research and development purposes. This is a broad scope license and use of licensed material on humans is permitted by or under the supervision of a physician authorized by the Radiation Safety Committee, subject to the training and experience requirements in 10 CFR 35, subpart J. The License was most recently amended on April 10, 1992, and was due to expire on July 31, 1992. The License is currently under timely renewal.

II

On September 13, 1991, an allegation was received by the NRC relating to possible diagnostic misadministrations which occurred in July 1991 at the Licensee's facility. The alleger indicated that a nuclear medicine technologist (technologist) at the Licensee's facility may have administered diagnostic radiopharmaceutical dosages to patients in excess of the dosages prescribed. Additionally, the alleger stated that the technologist may have falsified records to conceal his actions. An investigation was conducted by the NRC Office of Investigation (OI) concerning the failure of the technologist to follow regulatory/or license requirements which may have led to misadministrations and the follow up of these concerns by managers at the Licensee's facility (i.e., Chief Technologist, Radiation Safety Officer, and Chairman of the Radiation Safety Committee). A synopsis of the investigation report was sent to the Licensee by letter dated January 7, 1993. As a result of the investigation, violations of NRC requirements were identified. These violations are identified as described in the Notice of Violation and Proposed Imposition of Civil Penalty issued concurrently with this Confirmatory order and Demand for Information.

The violations and the circumstances surrounding them are of very significant concern to the NRC because of the length of time the Licensee allowed the records violations to continue and the ineffectiveness of the Radiation Safety Officer (RSO) and Radiation Safety Committee (RSC) in ensuring that the radiation safety requirements were being followed and deviations corrected. The technologist failed to properly record patient dosages over almost a two-year period, even after receiving counseling from management. Further, the technologist's supervisor (Chief Technologist), the Chairman of the RSC (also serving as Chief of the Nuclear Medicine Services and an authorized user), the RSO and the RSC all had substantial information indicating the failure of the technologist to follow requirements and the implications associated with that failure, and yet, actions to correct the problem were not effective. The NRC staff concludes that the violations are of very significant concern and that VAMC management actions were ineffective and were unacceptable in that despite its knowledge that violations of NRC regulations were ongoing, no lasting or effective corrective action was taken.

The Licensee possesses a broad scope license which places a significant responsibility on the RSC, as well as the RSO, to ensure that licensed activities are conducted safely and in accordance with NRC requirements. Through a broad scope license, the NRC allows great latitude in the management of the radiation safety program, and, in return for that latitude, the NRC expects an unusually high degree of responsibility

For Your Information, from Ken Price.

by the Licensee to assure that all requirements of the NRC license are met, and to identify and promptly correct potential violations of NRC requirements. The licensee's failure to maintain sufficient control over the administration of radiopharmaceuticals to patients and to ensure accurate recordkeeping of licensed activities raises significant questions regarding the adequacy of its oversight of activities at its facility, as well as the ability of the Licensee to assure that activities at the facility under its broad scope license are conducted safely and in accordance with Commission requirements. The Licensee had continued to allow the recordkeeping violations in this case even though the NRC (1) took enforcement action for recordkeeping violations as a result of previous NRC inspections in March 1991 and May 1992, including recurring recordkeeping violations identified in the May 1992 inspection, (2) held a management meeting with VAMC management representatives on April 26, 1991, to discuss the results of the recordkeeping issues from the March 1991 inspection, and (3) issued a letter dated June 16, 1992, as a result of the May 1992 inspection, to VAMC expressing NRC concerns regarding the Licensee's recordkeeping system, need for increased management attention, and recurring violations. The NRC recognizes that attempts were made by VAMC management to correct the violations. These attempts were ineffective and the recordkeeping violations recurred. Accordingly, without additional requirements, there is inadequate assurance that licensed activities will be adequately controlled by the Licensee's facilities.

III

During an enforcement conference on February 16, 1993, the Licensee presented a corrective action plan, including the removal of the technologist from activities requiring the use of radioactive materials after receipt of NRC's January 7, 1993 letter. The Licensee indicated that the technologist would not be allowed to use or supervise the use of radioactive materials at the Licensee's facilities. Additionally, the Licensee committed to: (1) Requiring that the RSO now report directly to the Chief of Staff, who reports to the Medical Center Director, (2) designating of a new Chairman of the RSC, and (3) initiating audits of the radiation safety program by someone independent of the VAMC. In view of the concerns set forth in Section II of this Order, I have agreed with VAMC that additional actions are needed to increase and improve management attention to licensed activities and that the Licensee's commitments, as described in Section IV, are necessary to assure that licensed activities are conducted so as to assure radiological safety and in accordance with NRC requirements. Specifically, I have determined that the public health and safety require that License No. 01-00643-02 be modified to confirm the Licensee's commitments. The Licensee consented to the issuance of this Confirmatory Order during a June 29, 1993 telephone conversation between yourself and Mr. Raymond J. Reevey, VAMC, and Dr. Bruce S. Mallett of the NRC Region II staff. Pursuant to 10 CFR 2.202, based on the significance of the violations described above and on the licensee's consent to the Order, I have also determined that the public health and safety require that this Order be immediately effective.

IV

Accordingly, pursuant to sections 81, 161b, 161i, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR part 30, It is Hereby Ordered, Effective Immediately, That License No. 10-00643-02 is Modified as Follows:

A. The Licensee shall provide written notice to the Regional Administrator, NRC Region II at least one week prior to Mr. Carl E. Chappell's reinvolvement in licensed activities authorized under License No. 01-00643-02, including a statement from the Licensee explaining the basis for concluding that, in light of Mr. Chappell's prior conduct described in the attached Notice, he can be expected to maintain complete and accurate records in accordance with regulatory requirements and otherwise comply with NRC requirements (this condition expires five years from its effective date).

B. The Licensee shall retain an expert, independent of the Licensee's staff, to perform an audit of the Licensee's radiation safety program and provide recommendations for a performance improvement program based on the audit findings and the specific concerns and violations described in the letter transmitting this Order and the attached Notice of Violation and Proposed Imposition of Civil Penalty enclosed with that letter. Within 60 days from the date of this Order, the Licensee shall submit to the Regional Administrator, NRC Region II, for approval, the credentials of one or more experts (Consultant) with experience in the management and implementation of a broad scope radiation program, including activities similar to those authorized under the Licensee's program, qualified to perform an audit of the Licensee's radiation safety program.

C. Within 30 days of NRC approval of the consultant selection as described above, the Licensee shall submit to the Regional Administrator, NRC Region II, for approval, an audit plan. In developing the audit plan, the Licensee or Consultant shall review the documents submitted to NRC in support of the license renewal applications and consider incorporation, within the scope of the audit, of any proposed changes in the Licensee's program. The Consultant must notify the Licensee at any time during the program review if it identifies violations of the VAMC license and NRC requirements. The audit of the Licensee's radiation safety program shall include, but not be limited to, a review of the following:

1. Organizational and management structures, to include assigned responsibilities and authorities of individuals responsible for the management of the radiation safety program.

2. The radiation safety program, to include oversight functions by management, including but not limited to ensuring records are accurate, complete, filed and maintained; and that the RSO fully investigates incidents.

3. The scope, methods, and frequency of the Licensee's program for surveillance and audits performed.

D. The Licensee shall provide written quarterly audit reports to the NRC Region II office for a period of one year and semiannual reports for a period of two years thereafter.

The Regional Administrator, NRC Region II, may, in writing, relax or rescind any of the above conditions upon demonstration by the Licensee of good cause.

V

Any person adversely affected by this Confirmatory Order, other than the Licensee, may request a hearing within 20 days of its issuance. Any request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Chief, Docketing and Service Section, Washington, DC 20555. Copies also shall be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, to the Assistant General Counsel for Hearings and Enforcement at the same address, to the Regional Administrator, NRC Region II, 101 Marietta Street, NW., suite 2900, Atlanta, Georgia 30323, and to the

Licensee. If such a person requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.714(d).

If a hearing is requested by the Licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Confirmatory Order should be sustained.

Pursuant to 10 CFR 2.202(c)(2)(i) any person adversely affected by this Order other than the Licensee, may, in addition to demanding a hearing, at the time the answer is filed or sooner, move the presiding officer to set aside the immediate effectiveness of the Order on the ground that the Order, including the need for immediate effectiveness, is not based on adequate evidence but on mere suspicion, unfounded allegations, or error.

In the absence of any request for hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. An Answer or a Request for Hearing Shall not Stay the Immediate Effectiveness of This Order.

VI

In addition to issuance of this Confirmatory Order modifying License No. 01-00643-02, the Commission requires further information from the Licensee in order to determine whether the Commission can have reasonable assurance that in the future the Licensee will conduct its activities in accordance with the Commission's requirements.

Accordingly, pursuant to sections 161c, 161o, 182, and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's requirements in 10 CFR 2.204 and 10 CFR 30.32(b), in order for the Commission to determine whether your license should be further modified, suspended or revoked, or other enforcement action taken to ensure compliance with NRC regulatory requirements, the Licensee is required to submit to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, within 30 days of the date of this Order and Demand for Information, in writing and under oath or affirmation:

A. Written assurance that the proposed new RSO, the former Chairman of the RSC (listed as an authorized user on the license), and the Chief Technologist fully understand their responsibilities and their obligation to comply with NRC requirements, including license conditions;

B. Written assurance that the reporting relationship of the RSO and RSC are to the Medical Center Chief of Staff and independent of any organization they audit for radiation safety purposes;

C. A statement describing the Licensee's procedures that have been established to ensure that the former Chairman of the RSC (listed as an authorized user on the license) and the Chief Technologist will comply with Commission regulations and the conditions of the license;

D. The results of the Licensee's review of the July 22, 1991, incidents which demonstrate that patients administered diagnostic doses by the technologist on that date did not receive excessive or inadequate doses;

E. A statement as to why the NRC should not modify the license to limit the scope of the VAMC program to a specific license of limited scope until the Licensee demonstrates that it can sustain the required level of management oversight and properly manage a broad scope program; and

F. A statement as to why the NRC should have reasonable assurance that the VAMC will take prompt and lasting corrective action when a violation of NRC requirements is identified.

Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address, and to the Regional Administrator, NRC Region II, 101 Marietta Street, N.W., Suite 2900, Atlanta, GA 30323.

After reviewing your response, the NRC will determine whether further action is necessary to ensure compliance with regulatory requirements.

For the Nuclear Regulatory Commission.

Dated at Rockville, Maryland this 13th day of September 1993.

Hugh L. Thompson, Jr.,

Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operations Support.

[FR Doc. 93-23555 Filed 9-24-93; 8:45 am]

BILLING CODE 7590-01-M

OFFICE OF POLICY DEVELOPMENT

President's Council on Sustainable Development; Meeting

AGENCY: Office of Policy Development.

ACTION: Noticing the second meeting of the President's Council on Sustainable Development.

Time and Date: 8-5, Monday, October 18, 1993.

Place: Auditorium—U.S. Department of Commerce, 14th & Constitution Avenue, NW., Washington, DC.

Status: Open to Public.

Matters to be Considered: The President's Council on Sustainable Development is a partnership of industry, labor, government and environmental organizations, not-for-profit groups, and civil rights organizations. The Council will hear reports from interim task forces, and establish short and long term priorities for developing recommendations to the President for a U.S. Sustainable Development strategy.

Contact: Keith Laughlin—The White House Office on Environmental Policy, (202) 456-6224.

Keith Laughlin,

Associate Director.

[FR Doc. 93-23599 Filed 9-24-93; 8:45 am]

BILLING CODE 3127-01-M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-32930; File No. SR-NASD-92-46]

Self-Regulatory Organizations; Filing of Proposed Rule Change by National Association of Securities Dealers, Inc. Relating to Conflicts of Interest in the Distribution of Securities

September 21, 1993.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"), 15 U.S.C. 78s(b)(1), notice is hereby given that on August 3, 1993, the National Association of Securities Dealers, Inc. ("NASD" or "Association") filed with the Securities and Exchange Commission ("SEC" or "Commission")[1] the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the NASD. The Commission is publishing this notice to

[1] The NASD filed the proposed rule change with the Commission on November 12, 1992. The NASD has filed three amendments to the proposed rule change. Amendment No. 1, filed on January [illegible], reported the results of a member vote on the proposed rule change: 1675 voting in favor, 231 opposed, and 42 not voting or unsigned. Amendment No. 2, filed on May 19, 1993, amended the text of the rule change to reflect the language of the proposed rule change pending in File No. SR-NASD-89-35. See *infra* note 2. Amendment No. 3, filed on August 3, 1993, amended the rule change to clarify that the term "preferred equity" under the rule change would not include debt securities. In addition, the amendment clarified the NASD's position under Section 2(a) of Schedule E to the NASD By-Laws that the term "common equity" includes warrants or rights that are exercisable within the 60-day period following the offering. The amendment also clarified the proposed rule language with respect to securities that are rated by a nationally recognized statistical rating organization in one of its four highest generic rating categories.

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

OFFICE OF RADIATION SAFETY MC-3930
Tel. (203) 679-2250

October 21, 1993

TO: Mr. John McDonough
Staff Nuclear Medicine Technologist

FROM: Alan Lurie, D.D.S., Ph.D.
Chairman, Radiation Safety Committee

SUBJECT: Corrective Actions For Radiation Safety Violations, Including Violation A Identified in Nuclear Regulatory Commission Notice of Violation Letter Dated September 29, 1993

The Radiation Safety Committee held an emergency meeting on October 20, 1993, to discuss multiple Radiation Safety violations, including Violation A identified in a Nuclear Regulatory Commission "Notice of Violation" letter dated September 29, 1993. As you are aware, the NRC violation was identified during an NRC Routine Inspection conducted at the Health Center and it's satellite facilities on August 30, 31, and September 1, 1993. Following that inspection, the NRC cited you for "...performing elution of the generator and preparation and assay of the radiopharmaceuticals in your Nuclear Medicine Hot Lab.. not wearing a ring badge." The Radiation Safety Committee heard your contention that you were wearing the said finger monitoring device while eluting the generator but not during the preparation and assay of radiopharmaceuticals. The University of Connecticut Health Center must admit to the violation. The Committee would like to thank you for appearing at the meeting to provide information concerning this and other violations.

After much deliberation, with due consideration of the gravity and potential consequences of this violation, and of the information presented to the Committee during the October 20 meeting, the Committee decided to institute corrective actions. The Committee voted that the following actions be taken to insure the safety of you and others, and to ensure that future violations will be avoided:

1. Suspension of your authorization to handle and/or use radioactive materials at the University of Connecticut Health Center for a period of two weeks, beginning Monday, October 25 extending to Friday, November 5, 1993, inclusive.

2. Beginning Monday, November 8, 1993 and continuing through Friday, November 19, 1993 your activities involving radioactive materials will be under surveillance by Faculty of the Department of Nuclear Medicine, the Office of Radiation Safety, and occasionally by Radiation Safety Committee members.

3. If during the surveillance period any designated individual observes you not wearing a finger ring while working with radioactive materials and/or not wearing protective gloves while working with radioactive materials or injected patients, your authorization to use radioactive materials at the University of Connecticut Health Center will be suspended by the Chairman of the Committee. In addition if you are directly responsible for an incident which is reportable to the Nuclear Regulatory Commission during this period your authorization to use radioactive materials will be suspended. Any such suspension will be effective until an emergency meeting of the Radiation Safety Committee can be convened to decide upon further definitive action.

4. If, after the surveillance period, you are directly involved or otherwise responsible for an incident reportable to the Nuclear Regulatory Commission, the Chairman of the Radiation Safety Committee will immediately suspend your authorization to use radioactive materials at the University of Connecticut Health Center. An emergency Radiation Safety Committee meeting will then be convened to decide upon appropriate actions up to and including permanent suspension of your privileges to work with radioactive materials.

The Committee has an institutional and regulatory responsibility for insuring the safe and compliant use of radioactive materials, and for maintaining the authorization for individuals to conduct science and patient care involving radioactive materials throughout the Health Center. It is the sincere wish of the entire Committee that these corrective actions will result in your increased level of safety and that future incidents and/or violations will be avoided.

AL:ep

cc: Mr. P. Davern
Mr. L. Paplauskas
Mr. J. Patrylak
Mr. K. Price
Dr. R. Spencer