THE
GENERAL HOSPITAL CENTER AT PASSAIC
350 Boulevard • Passaic, New Jersey 07055 • (201) 365-4300

Robert J. Jablonski
Chairman
Board of Governors

Daniel L. Marcantuono
President and
Chief Executive Officer

January 2, 1991

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Docket No. 030-08130
License No. 29-01040-03
EA 90-198

Subject: Reply to a Notice of Violation
NRC Inspection Report No. 90-001

Gentlemen:

Pursuant to the provisions of 10 CFR 2.201, The General Hospital Center at Passaic is hereby submitting a written statement to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting the Notice of Violation.

Please find enclosed our statement marked, "Reply to a Notice of Violation."

Sincerely,

C. Thomas D'Esmond

C. Thomas D'Esmond
Senior Vice President For Operations

Enclosure: Reply to a Notice of Violation

cc: Mr. Thomas T. Martin, Regional Administrator, Region I
Arthur Weisel, MD, Radiation Safety Officer
Radiation Safety Committee

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Mr. Thomas T. Martin
Regional Administrator
United States Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Docket No. 030-08130
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Subject: Reply to a Notice of Violation
NRC Inspection Report No. 90-001

Dear Mr. Martin:

Pursuant to the provisions of 10 CFR 2.201, The General Hospital Center at Passaic is hereby submitting a written statement to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting the Notice of Violation.

Please find enclosed our statement marked, "Reply to a Notice of Violation." If you have any questions, please do not hesitate to contact me.

Sincerely,

C. Thomas D'Esmond

C. Thomas D'Esmond
Senior Vice President For Operations

Enclosure: Reply to a Notice of Violation

cc: U.S.N.R.C., Document Control Desk, Washington, D.C.
Arthur Weisel, MD, Radiation Safety Officer
Radiation Safety Committee

CTD/dms

REPLY TO A NOTICE OF VIOLATION

The General Hospital Center at Passaic
350 Boulevard
Passaic, New Jersey 07055

Docket No. 030-08130
License No. 29-01040-03
EA 90-198

Pursuant to the provisions of 10 CFR 2.201, The General Hospital Center at Passaic hereby submits its written statement marked, "Reply to a Notice of Violation" for alleged violations A, B and C.

A. Falsification of a Record.

1. We admit to the alleged violation.

2. The reason for the violation was that the Nuclear Medicine Technologist (NMT) stated that he was not wearing his film badge and therefore he did not want to enter the "hot" lab and perform the radiation survey. Since no one had told him about a radiation contamination he assumed that entering the results similar to the background would be acceptable.

3. Corrective steps taken included:

a. Hospital disciplinary action report was filed on June 18, 1990.

b. Acknowledgement by the NMT that recording a survey result without actually performing the survey was a violation of hospital policy, NRC policy, and was unacceptable performance and subject to disciplinary action including suspension and/or termination.

Results achieved: Subsequent unannounced monthly audits, beginning July 18, 1990, performed by our Health Physicist have not detected any further falsification of records.

4. Corrective steps taken to avoid further violations: Meetings were held with the Nuclear Medicine Staff to inform them that any future falsification of record keeping requirements would result in further disciplinary action including suspension and/or dismissal.

5. Full compliance was achieved on July 18, 1990.

B. Model Spill Procedure

1. We admit to the alleged violation.

2. The reason for the violation was a lack of effective communication between the technologists of the Nuclear Medicine Staff. After the spill was

detected, the busy workload prevented the immediate decontamination. The NMT who discovered the spill reported it to his supervisor, the Assistant Chief NMT (ACNMT) but no action was taken at that time. The NMT's were aware of the appropriate spill protocol but no action was taken and the Radiation Safety Officer (RSO) was not informed.

3. Corrective steps taken included:

a. Inservice education was conducted on June 15 and 18, 1990 for the Nuclear Medicine Staff by our Health Physicist on the Model Spill Procedures described in NRC Appendix J, NRC Regulatory Guide 10.8, Revision 2.

b. Hospital disciplinary actions were issued on June 18, 1990 to all Nuclear Medicine Technologists, who were present the day the spill was detected, citing their failure to decontaminate the area according to the spill protocol.

c. In July 1990, the "hot" lab was modified to include additional shielded storage for radioactive waste and the NMT's were instructed to no longer leave any waste on the "hot" lab floor.

d. On June 25, 1990, an Assistant Chief NMT who was not present when the spill occurred and not involved in the incident was promoted to Chief NMT and assumed the duties of the ACNMT who was present when the spill occurred.

Results achieved: Timely decontamination of minor radiation spills that occurred on June 25, July 24, August 16, October 4, and November 11, 1990; immediate Radiation Safety Officer notification as well as appropriate administrative personnel; and timely completion of the spill forms.

4. Corrective steps taken to avoid further violations:

a. Counselling the Nuclear Medicine Staff that any future recurrences will result in additional disciplinary actions including suspension and/or termination. This counselling occurred on June 18, 1990.

b. In July 1990, the "hot" lab was modified to include additional shielded storage for radioactive waste and NMT's were instructed to no longer leave any waste on the "hot" lab floor.

c. On June 25, 1990, an Assistant Chief NMT who was not present when the spill occurred and not involved in the incident was promoted to Chief NMT and assumed the duties of the ACNMT who was present when the spill occurred. In addition, this promotion improved the supervision in the Nuclear Medicine Section.

d. On July 18, 1990, bi-weekly Nuclear Medicine Staff meetings were established to improve the working relationships between the NMT's and to enhance

intradepartmental communications and education.

e. On July 18, 1990, management implemented unannounced monthly audits by the Health Physicist of all the record-keeping functions. In addition, the Radiation Safety Officer increased his oversight activities by reviewing the results of these audits with the Health Physicist and the Nuclear Medicine Staff.

5. Full compliance was achieved on July 18, 1990.

C. Missing Survey on June 14, 1990.

1. We admit to the alleged violation.

2. The reason the violation occurred was that the Nuclear Medicine Technologist (NMT) falsified the entry in the survey log book. The NMT stated that he was not wearing his film badge and therefore he did not want to enter the "hot" lab and perform the required radiation survey. Since no one had informed him about any radiation contamination, he assumed that entering the results similar to background would be acceptable.

3. Corrective steps taken included

a. Hospital disciplinary action report was filed on June 18, 1990.

b. Acknowledgement by the NMT that recording a survey result without actually performing the survey was a violation of hospital policy, NRC policy, and was unacceptable performance and subject to disciplinary action including suspension and/or termination.

c. On June 25, 1990 the Health Physicist presented an inservice program to the Nuclear Medicine Staff on daily survey protocol.

d. Beginning July 18, 1990, the Health Physicist initiated unannounced monthly recording-keeping audits which closely monitored the work performed by the NMT's.

Results achieved: Unannounced monthly record-keeping audits performed by Health Physicist have revealed that the Nuclear Medicine Staff have performed their daily surveys each and every day that radiopharmaceuticals were used except on Saturday, November 25, 1990. The NMT responsible for the missing survey on this date was not the same NMT who was responsible for the missing survey on June 24, 1990. The NMT was immediately counselled and disciplined and the Nuclear Medicine Staff was immediately re-advised of the importance and necessity of daily surveys as well as the notice of violation from the State of New Jersey that the Department had received as a result of a missing survey and the pending notice of violation from the Nuclear Regulatory Commission.

4. Corrective steps taken to avoid further violations:

a. On June 18, 1990, a meeting was held with the Nuclear Medicine Staff at which they were advised that any further reoccurrences of this violation would result in disciplinary action including suspension and/or dismissal.

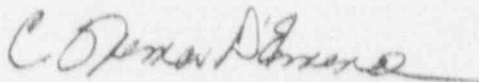
b. On June 25, 1990, an Assistant Chief NMT who was not present when the spill occurred and not involved in the incident was promoted to Chief NMT and assumed the duties of the ACNMT who was present when the spill occurred. In addition, this promotion improved the supervision in the Nuclear Medicine Section.

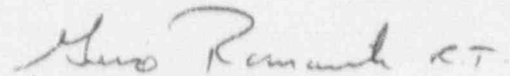
c. On June 15, 1990, the Health Physicist conducted an inservice program on the daily survey protocol.

d. On July 18, 1990, management implemented unannounced monthly audits by the Health Physicist of all record-keeping functions. In addition, the Radiation Safety Officer has increased his oversight activities by reviewing the results of these audits with the Health Physicist and the Nuclear Medicine Staff.

5. Full compliance was achieved on July 18, 1990.

This "Reply to a Notice of Violation" is dated January 2, 1991 and is submitted by:





C. Thomas D'Esmond
Senior Vice President For Operations

Gino Romanik, RT
Assistant Technical Director

cc: Thomas J. LaRocca, MD
Health Physicist
Bio-Med Associates

Arthur Weisel, MD
Radiation Safety Officer