

## MEMORANDUM

**DATE:** May 26, 1994

**TO:** United States Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

**FROM:** Barbara V. Howard, Ph.D.  
Radiation Safety Officer *BVH*

**SUBJECT:** REPLY TO NOTICE OF VIOLATION OF APRIL 28, 1994

The Following outlines our response to the violation outline in the memo of April 28.

A. Failure to report to the NRC within 24 hours of discovery of event.

1. Reason for violation. While we were aware of the requirement for a written report within 30 days, we were not properly cognizant of the regulations concerning oral notification of events.
2. Corrective steps. Dr. Howard, the Radiation Safety Officer and Dr. Michael Paidi, her assistant have reviewed the regulations concerning reporting of events.
3. Corrective steps. A thorough review of the regulations in 10 CFR 20.403(b)(1) will avoid further violations concerning reporting requirements for this.
4. Compliance with this was achieved in January 1994, as soon as we were made aware of our inaccurate knowledge of the regulations.

B. Failure to process film badges on a monthly basis.

1. Reason for violation. The film badges were not processed in the months of September and October because of excessive work load on the person responsible for processing.

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2. Corrective steps. Supervisors have made it clear to Dr. Paidi that the monthly processing of film badges must be done promptly and takes precedence over other duties.
  3. Corrective steps to avoid further violation. Supervisor is reviewing to assure that the monthly processing of film badges is occurring promptly.
  4. Full compliance was achieved in January 1994.
- C. Failure to convene the Radiation Safety Committee on a quarterly basis.
1. Reason for violation. The erroneous impression that there was no necessity for a meeting if there were no new projects or modifications of existing activity.
  2. Corrective steps. It has been made clear to the members of this committee that it is imperative that it meets on a quarterly basis. Meetings were held on January 11, 1994 and March 9, 1994.
  3. Steps to avoid further violations. Dr. Paidi has been charged by his supervisor that regular conduct of these meetings and the overall safety inspection that has been our practice to be performed on a quarterly basis in preparation for these meetings is an essential part of his job performance.
  4. Compliance achieved in January 1994.

We have taken the opportunity of this unfortunate event to thoroughly review our Radiation Safety Procedures and have added additional controls and documentation to improve our performance. In addition, in working with the Washington Hospital Center concerning this event, it has become apparent that the existence of two separate licenses and Radiation Safety Organizations is both inefficient and has the potential to create possibilities for individuals involved in both groups to "fall through the cracks". At its May 1994 meeting, the WHC Radiation Safety Committee voted to incorporate the activities of the Medlantic Research Institute under its license; this will include coverage of activities both at the George Hyman Research Building and the Clinical Research Center at 650 Pennsylvania Avenue. The administrative staffs at the Washington Hospital Center and the Medlantic Research Institute are supportive of this decision and we plan to implement this before the renewal date of the MRI license (August 1994). The Institute will continue to implement all existing Radiation Safety procedures and initiate any new ones that might be necessary to insure complete joint coverage.

Finally, we would like to thank all of the personnel at the Nuclear Regulatory Commission for their input and guidance through this situation.

cc: Regional Administrator  
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