Hillcrest
Medical Center

REPLY TO A NOTICE OF VIOLATION

September 24, 1992

U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011-8064

Dear Sir:

This letter is a reply to the said violation of activities authorized by the NRC License #35-092060-03, as reported by Mr. Mark Shaffer during his inspection of our facility on August 26 and 27, 1992.

We acknowledge the violation 10 CFR 20.202 (a) (1) that states we did not supply appropriate personnel monitoring equipment to our Radiation Safety Officer. The reason for this violation is that the Radiation Safety Officer wanted to wear one badge to record his total dose, as he visits several institutions. Therefore, he had his own badge, but not one issued from our institution. The corrective steps taken was a film badge was ordered and supplied. (Badge #38, customer #101641 from Siemens Medical) on September 2, 1992. Corrective steps to avoid further violation will be that all personnel will be supplied appropriate monitoring equipment and required to use such equipment. Full compliance was achieved on September 2, 1992.

We acknowledge the violation 10 CFR 35.50 (b) (1) that states we did not check the dose calibrator for constancy on several weekend days. The reason for this violation was due to an oversight of the technical staff on weekend call back situations. Corrective steps taken was an inservice to personnel involved where they were instructed to do constancy checks for each day of usage. Corrective steps to avoid further violation will be that the Chief Technologist will verify on a continuing basis that these checks are done, and a sign has been posted on the dose calibrator and at the door exiting the hot lab asking "Have you done calibrator quality control and air surveys?" Full compliance was achieved on September 8, 1992.

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We acknowledge the violation 10 CFR 35.50 (b) (3) that states we failed to properly perform our dose calibrator linearity test on two occasions. The reason for this violation was an oversight by the technical personnel on June 24, 1991. Subsequently, this person was terminated for repeated non-conformity to regulations. The violation on December 26, 1991 was due to a newly hired person that was unaware the range was 10 microcuries. Corrective steps taken was a meeting with the consulting physicist who noted the deficiency and instructed the technologist to the proper range. Corrective steps to avoid future violations will be that all linearity tests will cover the range of it's use between the highest dosage administered to a patient and 10 microcuries. Full compliance was met in January, 1992.

We acknowledge the violation 10 CFR 35.70 (a) that states we failed to survey (on several occasions) with a radiation detection instrument at the end of the day areas where radiopharmaceuticals were prepared. The reason for this violation was an oversight by the technologist on weekend call back. Corrective steps taken was all technical personnel involved in day to day and call back for the department were inserviced and instructed to perform surveys each day there is a usage of a radiopharmaceutical. Corrective steps to avoid further violations will be that the Chief Technologist will verify on a continuing basis that these surveys are done, and a sign has been posted on the dose calibrator and at the door exiting the hot lab asking "Have you done calibrator quality control and air surveys?" Full compliance was accomplished on September 8, 1992.

Should you have any questions concerning these violations, please contact me as I will be pleased to discuss them with you.

Sincerely,

Terry Eichor, Administrative Director
Radiologic Sciences

cc: U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Don Lorack
Chief Operating Officer

Dave Anderson
Radiation Safety Officer

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