DEC 17 1987

License: 35-11022-02
Docket: 30-09646

Baptist Medical Center
ATTN: Patrick Giordano
Vice President of Operations
3300 Northwest Expressway
Oklahoma City, Oklahoma 73112

Gentlemen:

Thank you for your letter of November 11, 1987, in response to our letter and the attached Notice of Violation dated November 2, 1987. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

Original Signed by:
R. J. EVERETT

William L. Fisher, Chief
Nuclear Materials and Emergency
Preparedness Branch

cc:
Oklahoma Radiation Control Program Director

bcc w/letter from licensee:
DMB - Original (IE-07)
R. Martin
R. Bangart
R. E. Hall
D. Powers
Inspector
RIV Files
NMEPB
RSTS Operator

RIV:NMIS	C:NMIS	C:NMEPB
LTRicketson;ap	RJEverett	WLFisher
12/15/87	12/16/87	12/16/87

IE07

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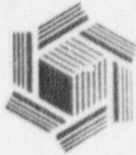
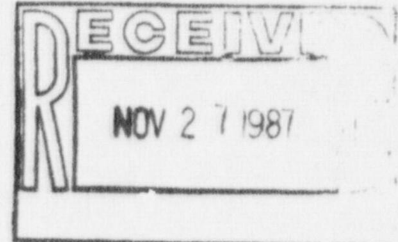
35-11022-02 DCD



BAPTIST MEDICAL CENTER OF OKLAHOMA



November 11, 1987

United States Nuclear
Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, TX 76011

RE: Response to Finding of NRC Inspection Report #30-09646187-01

This letter is in response to the "Notice of Violation" received from you in this office on November 2, 1987. In regard to violation 1., at the time of your inspection, no documentation could be produced as proof that individuals working in Radiation Therapy had been instructed in health protection problems associated with exposure to radioactive materials or radiation and in precautions or procedures to minimize exposure. To correct this violation, the Radiation Safety Officer has conducted three (3) one-hour inservice sessions. These sessions were initiated the week following the inspection and were continued the subsequent two weeks. The content of these inservices included an overview of the teletherapy license and the authorized users, the purpose and makeup of the Radiation Safety Committee, the ALARA program and the role the Radiation Safety Officer plays in the ALARA program. A copy of the Baptist Medical Center ALARA program was distributed and reviewed. Opportunity was also extended for questions from attendees and none were offered.

These efforts have resulted in reacquainting all of the Radiation Therapy staff with problems associated with exposure to radiation and in precautions and procedures to minimize exposure.

The steps taken to avoid further violation will include having the Radiation Safety Officer conduct at least two staff meetings on an annual basis addressing radiation safety issues. In addition, the Radiation Therapy Chief Technologist will be invited to attend the meetings of the Radiation Safety Committee.

Full compliance on this item was achieved as of November 1, 1987.

IE-07

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With respect to violation 2., documentation could not be produced to disprove this allegation. The corrective steps that were taken and results achieved have been described in the previous paragraph. The corrective steps taken to avoid further violations and the date of full compliance also are as described previously under violation 1.

In response to the details contained in pages 3 through 6 of your report, it is important to note that the Chief Technologist in Radiation Therapy planned and, in many cases, provided the majority of the inservice training for the personnel in the department. Unfortunately, she terminated her employment several months prior to your visit and was unavailable to help in providing answers to your questions during the inspection.

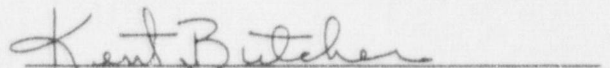
Also, the RSO has always considered personnel safety to be a high priority. He is constantly looking for ways to reduce exposure to patients and personnel in a manner consistent with the ALARA concept. The RSO takes high film badge readings seriously. He proceeded with diligence in investigating the possible causes of the readings which you questioned during your visit.

In regard to item 6. Misadministration, it is important to note that our records indicate that the technologist initiated the treatment and the chief technologist terminated the treatment immediately when the unit did not turn off at the prescribed time interval. This is opposite of the description provided in your report.

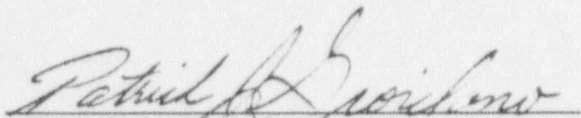
Finally, regarding item 8, Excessive Personnel Exposure, the Radiation Safety Officer indicated to you that he had been told by department personnel that the previous Radiation Safety Officer calibrated the teletherapy unit with the treatment room door open. The current Radiation Safety Officer did not observe this practice directly, therefore, it is important to note that his statement is probably not sufficient to substantiate this allegation.

Sincerely,

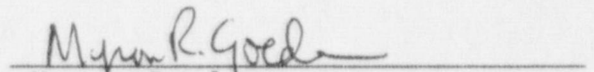
Stan Tatum
Executive Vice President and
Chief Operating Officer



Kent Butcher
Administrative Director
Department of Radiology



Patrick Giordano
Vice President



Myron Goede
Radiation Safety Officer