SAINT AGNES MEDICAL CENTER
1900 SOUTH BROAD STREET, PHILADELPHIA, PENNSYLVANIA 19145 215/339-4100

February 23, 1989

Docket No. 030-03196
License No. 37-13651-01
EA 88-298

Director, Office of Enforcement
United States
Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406

Dear Sir:

Subject: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY
(NRC Inspection No. 30-03196/88/01)

ANSWER TO NOTICE OF VIOLATION

The mission of Saint Agnes Medical Center states that: "We provide compassionate and quality health care through a broad range of preventative, diagnostic, acute care and therapeutic services. We strive to identify and meet the health needs of the people we serve". The Nuclear Medicine section of the department of radiology has, in the past, and continues to provide the quality service which is reflected in this Mission Statement.

In view of the long history of this type of quality service and the presence of extenuating circumstances at the time of the violations, Saint Agnes Medical Center is requesting a mitigation of the proposed civil penalty in the amount of $2,500.

1) There was no willful act on the part of Saint Agnes Medical Center management to indicate that employees were permitted to neglect NRC requirements in order to maintain current workload. On the contrary, the Medical Center has gone to great lengths to ensure that all record keeping, surveys, instrument tests and other radiation safety requirements are fulfilled.

2) The technologist involved in these incidents is no longer an employee of Saint Agnes Medical Center.

3) A large part of the problem involved a lack of communication between the consultant and Saint Agnes Medical Center. While the Medical Center understands that it has the final responsibility, the failure of the consultant to convey findings of her inspections delayed our own corrective action.

4) The position of Radiology Administrator was vacant at the time of these incidents. Active recruitment for this position had been taking place from March 1988 with no suitable candidate found.

5) As part of its policy the Medical Center recruits and employs staff which it believes are competent and perform all necessary aspects of their jobs. In the Nuclear Medicine area, this would necessitate being technically able, as well as being aware of all regulatory responsibilities. The employee working in this area at the time of the incidents was a registered technologist and appeared to have a "handle" on what was going on in the department. At the time of these incidents, this technologist was working alone in the department while recruitment efforts continued.

6) At the time of the inspection (Nov. 2, 1988) Saint Agnes Medical Center was, and had been for several months, in full compliance with all NRC requirements.

7) A new department chairman had begun employment only two weeks before the incidents occurred.

Taking into account that problems were first identified and corrected by the Medical Center, that these problems were not willful on the part of the Medical Center, and that current performance of the department is consistent with conditions set forth in license 37-13651-01, it is our hope that you will view the above mentioned items as mitigating factors and consider the elimination or decrease of the civil penalty.

This in no way would alter our perception of the importance of this problem. The Medical Center is fully cognizant of the necessity to follow NRC guidelines and the resultant outcome should these guidelines be breached.

Sincerely,

Thomas P. Callaghan
Senior Vice President

TPC/ld

cc: Sister M. Clarence, OSF
Gerald Klein, M.D.