Charleston Area Medical Center

Nuclear Medicine

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Nuclear Regulatory Commission
Washington, D. C. 20555

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Reply to a Notice of Violation

In regard to the Nuclear Regulatory Commission (NRC) inspection conducted on February 28, 1989 and pursuant to the provisions of 10 CFR 2.201, the Charleston Area Medical Center is forwarding this written response.

As related in violation 1, there have been occurrences of survey meters not being calibrated on a quarterly basis. Investigation has revealed that such occurrences were fostered by a lack of attention spawned by an overdependence on the facility health physics consultant. The initial correction has already been effected as half of the survey meters were calibrated in March, 1989 while the remaining survey meters have been sent for calibration. Full compliance will be achieved prior to May 1, 1989. Further such violations will be prevented by a newly initiated practice to be discussed later.

As related in violation 2, there have been incomplete dose calibrator accuracy calibration testing practices. These occurrences are the result of misleading consultant information and simple oversight. It is noted that the license application reference to "a Cobalt-60 source of approximately 10 millicuries..." can not be located. There is however a reference to a Cobalt-57 source of approximately 10 millicuries. There is not a clear understanding of this reference (a consultant procedural document) as the use of such a source is not advocated or supported by any NRC regulation which we can locate. Therefore this licensing inconsistency will be corrected by application for license renewal to be submitted on or about June 1, 1989.

The remaining immediate corrective actions include the necessary dose calibrator adjustments. Also, the use of all sources when performing these accuracy tests has been reinforced as the correct procedure. Thus, full compliance has been achieved except for the license modification previously referenced. Again, further violations will be prevented by a newly initiated practice.

The training needs related in violation 3 are being addressed. A video tape for inservice education has been acquired and the availability of additional tapes is being investigated. Another major problem with such refresher training is difficulty with efficient scheduling. The video tapes will allow scheduling of repeat sessions thus also helping

eliminate this scheduling dilemma. Full compliance is expected to be achieved by June 1, 1989.

It shall be attempted to prevent further violations of such refresher training activities, future occurrences of the two previously discussed violations, and future noncompliances with the radiation safety program in general by a new practice. This medical center continues to grow. It now has three campuses. So commencing in the second quarter of 1989, th Radiation Safety officer will make quarterly inspection visits to each campus! These visits will occur between (about midway) the quarterly health physics consultant survey visits. This practice will continue for one year and at such time will be reevaluated.

Thank you for your assistance and consideration. Should you have any questions or need additional information, please relate same.

Sincerely,

Ridgely G. Conant, RSO
Director, Department of Nuclear Medicine

cc: Regional Administrator, NRC, Region II
James J. Wente, Associate Administrator
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