Licensee's admission of Example III.C.2. The issue of the Severity Level of the violation is addressed in the evaluation of the Licensee's response to Violations III.A and III.B. above.

Summary of Licensee's Response to Violation III.D.1

The Licensee denies Violation III.D.1, states that *the RSO* did not fail to discharge his duties, states that the RSO did not violate any regulation relating thereto, and notes that the NRC has not cited any such specific regulation and that the RSO had an ALARA program in place. The Licensee states that there is no requirement that the Licensee have any physical presence at any facility. In addition, the Licensee states that the RSO and a physicist were in communication with the Lehighton facility by telephone and fax.

#### NRC Evaluation of the Licensee Response to Violation III.D.1

The Licensee was required, pursuant to License Condition 17, to follow the commitments it made in the June 1, 1990, application to the NRC. Item 10.2 of the application required that Appendix G of Regulatory Guide 10.8 be followed which in turn required the RSO to be in "close contact" with all users and workers in order to develop ALARA procedures for working with radioactive materials. The Licensee specifically committed in its license application that the RSO would do this. The development of ALARA procedures is a continuing and evolving process and requires firsthand observations and audits of employee knowledge, work, and work conditions. The fact that some ALARA procedures may have been in place does not relieve the Licensee of full compliance with this requirement.

The mere fact that the RSO may have been in communication by telephone or facsimile does not disprove the violation. In order for that fact to be relevant at all, the Licensee would have to show that such communications were with all users and workers and were for the purpose of developing ALARA procedures, which the Licensee has not done. Clearly, communications concerning, for example, patient treatment parameters, would have no bearing at all.

The NRC determined, via interviews, that the Medical Director and authorized user at the Indiana, Pennsylvania and Lehighton, Pennsylvania facilities were not aware, at the time of the IIT and the NRC inspection in December 1992, who the RSO was. Additionally, the RSO had not visited the Lehighton facility in the past 6–9 months. Also, as determined during

the inspection of the Exton facility, the technologist and the medical physicist at the Exton facility both believed that the medical physicist was the RSO. Accordingly, it is appropriate to conclude that the RSO did not maintain close contact with all users and workers as required by License Condition 17. Therefore, the NRC concludes that Violation III.D.1 occurred as stated in the Notice.

## Summary of Licensee's Response to Violation III.D.2

The Licensee denies Violation III.D.2 and states that emergency procedures were available but not vertically posted because they kept falling down, and that it immediately posted the procedures following the inspection. The Licensee believes that, in any event, this constitutes a Severity Level V violation.

# NRC Evaluation of Licensee Response to Violation III.D.2

The Licensee stated that the emergency procedures kept falling down. The inspection report states that the procedures were available but not posted at the time of the inspection, and that this was corrected before the inspectors left the facility. During the inspection, the medical physicist obtained a copy of a set of emergency procedures which was incomplete (contained blanks), and the Licensee had to fill in the blanks with Licensee specific information, and post the procedures conspicuously near the control console so that appropriate staff would have access to the procedures. The Licensee specific information had not been entered on the emergency procedures prior to the inspection. Therefore, even the emergency procedures that were available, but not posted, were incomplete.

At the time that the Licensee established its HDR brachytherapy program, the blanks in the emergency procedures should have been filled in with Licensee specific information and the procedures should have been conspicuously and durably posted near the control console so that appropriate staff would have immediate access to it. This was not done. There, the NRC concludes that Violation III.D.2 occurred as stated in the Notice. The issue of the Severity Level of the violation is addressed in the evaluation of the Licensee's response to Violations III.A and III.B, above.

# Summary of Licensee's Response to Violation III.D.3

The Licensee denies Violation III.D.3 and states that Exton personnel always did hand calculations and always

checked the source travel time error and accuracy of the timing device by using the clock on the wall and their wrist watches. The Licensee believes that, in any event, Violation III.D.3 would constitute a Severity Level V violation.

## NRC Evaluation of Licensee Response to Violation III.D.3

The Licensee's unsupported general assertion that the calculations and checks for timing device accuracy and travel time error were in fact performed does not demonstrate that the violation did not occur. During the inspection, the NRC found evidence that the checks of the source travel time error and accuracy of the timing device were not done. Specifically, as noted in Section 7 of NRC Inspection Report 30-31765/ 92-001, issued on December 23, 1992, the record of the HDR calibration performed at Exton indicated that the source output was checked but that the source travel time error and accuracy of the timing device were not checked. Therefore, the NRC concludes that the violation occurred as stated in the Notice. The issue of the Severity Level of the violation is addressed in the evaluation of the Licensee's response to Violations III.A and III.B, above.

#### Summary of Licensee's Response to Violation III.D.4

The Licensee denies Violation III.D.4 and states its belief that Omnitron personnel performed surveys for the benefit of the Licensee. The Licensee believes that, in any event, Violation III.D.4 would constitute a Severity Level IV violation.

## NRC Evaluation of Licensee Response to Violation III.D.4

The Licensee's response provides no facts or records to support the Licensee's assertion that the surveys in question were ever performed by Omnitron. While Omnitron personnel may have performed some surveys in connection with their work during source exchanges, the Licensee provides no evidence that any such surveys included all adjacent areas as well as control areas. Therefore, the NRC concludes that Violation III.D.4 occurred as stated in the Notice. The issue of the Severity Level of the violation is addressed in the evaluation of the Licensee's response to Violations III.A and III.B, above.

## Summary of Licensee's Response to Violation III.D.5

The Licensee admits the violation but believes that it would constitute a Severity Level IV violation.