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NRC Proposes \$8,000 Civil Penalty for Connecticut Medical Center

The Nuclear Regulatory Commission has <u>proposed</u> an \$8,000 fine for a Connecticut hospital for violations involving the temporary loss of a radioactive source used to calibrate nuclear medicine dosage-measuring equipment.

The NRC received a report last year that a sealed radioactive source containing cesium-137 from St. Vincent Medical Center, in Bridgeport, Connecticut, had been found at a biohazardous waste vendor's facility in Woonsocket, Rhode Island, after it set off radiation monitors. The vendor notified the hospital on Oct. 27, 2021, that it had the source and placed it into storage. St. Vincent staff determined that the source had been inadvertently disposed of as biohazardous waste, and hospital personnel retrieved it and then properly disposed of it.

The NRC conducted an inspection in response to the event and identified several apparent violations. They were documented in an inspection report issued on Aug. 8, 2022. The medical center was offered, and accepted, an opportunity to discuss the issues with the NRC at a predecisional enforcement conference.

During the session, held on Sept. 15, 2022, at the agency's Region I Office in King of Prussia, Pennsylvania, St. Vincent representatives provided NRC staff with more information about the event and about planned and completed corrective actions to prevent recurrence of the apparent violations. Corrective actions include a review of nuclear medicine use and storage areas at the hospital, confirming a proper inventory of all unused sealed radioactive sources; actions to ensure the proper disposal of all unused sealed radioactive sources; and the enhancement of staff training on the handing of radioactive waste.

After considering all of the relevant information, including information presented at the conference, the NRC has determined the \$8,000 fine is appropriate based on the violations stemming from the event. The NRC also documented a number of less significant violations, related to the medical center's failure to maintain an effective radiation safety program and to implement an adequate radiation exposure monitoring program.

"While no employee or member of the public was harmed by the temporary loss of this sealed radioactive source, the NRC is concerned anytime there is breakdown in essential controls for such materials," said NRC Region I Administrator David Lew. "St. Vincent's has recognized what went wrong and taken steps to prevent another such event from occurring."