



U.S. NUCLEAR REGULATORY COMMISSION OFFICE OF PUBLIC AFFAIRS -- REGION I

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NRC PROPOSES \$3,000 FINE AGAINST HOWARD UNIVERSITY HOSPITAL

The Nuclear Regulatory Commission has cited Howard University Hospital for two violations of NRC requirements. The staff has proposed a \$3,000 fine.

The NRC conducted an inspection at the Washington, D.C., hospital on April 17 and 19 to review the circumstances surrounding the loss of four seeds containing iridium-192. On April 4, a patient was undergoing treatment for a cancerous tumor. During the treatment, one of eleven ribbons containing iridium-192 seeds was lost. The hospital was unable to determine exactly how the ribbon was lost, but concluded it was likely flushed into the sewer system because subsequent surveys of the hospital laundry and other areas within the hospital didn't identify any radioactive material. The ribbon might also have been placed in the laundry bag along with the patient's soiled gown and removed from the patient's room without being surveyed. However, this is less likely since the source was not found.

There is no indication the radioactive material was intentionally removed from the patient's room or the hospital. Because it is likely the material was flushed into the sewer system, the seeds do not pose a significant threat to public health and safety. This fact, along with the relatively low radiological activity and short half-life of the material combine to effectively preclude use of the seeds in a malevolent act.

The NRC has cited Howard University Hospital for two violations: failure to control radioactive material; and failure to make, or cause to be made, surveys to evaluate the radiological conditions that could be present.

In a letter to the hospital, Region I Administrator Hubert J. Miller said, "The safety significance of these violations was minimized by the fact that the source, whether discarded in the sewer or the laundry, is unlikely to come in close contact with any individual."

These violations are of concern to the NRC, Miller said, because failure to control the radioactive material resulted in the loss of a source and such sources can result in "substantial unintended radiation dose to an individual if placed in close contact with the skin."

The hospital has 30 days to respond to the notice of violation.

