U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Enforcement Conference Report No. 030-12270/89-002

Docket No. 030-12270

License No. 06-17145-01 Priority 3 Category G Program Code 02120

Licensee: Bradley Memorial Hospital and Health Center
Merider Avenue
Southington, Connecticut 06489

Enforcement Conference Conducted: August 1, 1989

Prepared by: _____ 9/14/89
Richard B. Provencher, Health Physicist date
Nuclear Materials Safety Section B

Approved: _____ 9/15/89
Mohamed M. Shanbaky, Chief date
Nuclear Materials Safety Section A

Conference Summary: The findings documented in Inspection Report No. 030-12270/89-001 were discussed. The licensee described planned and completed corrective actions. The NRC's enforcement policy was reviewed.

DETAILS

1. Persons Participating

Licensee

Alan R. Melton M.D., Radiation Safety Officer
Clarence Silvia, Vice President
Michele Rispoli, Nuclear Medicine Technologist

U.S. Nuclear Regulatory Commission

Malcolm R. Knapp, Division Director, Division of Radiation Safety and Safeguards
John D. Kinneman, Acting Chief, Nuclear Materials Safety Branch
Keith Christopher, Enforcement Officer
Richard B. Provencher, Health Physicist, Nuclear Materials Safety Section B

2. Conference Summary

Each of the apparent violations identified in NRC Inspection Report No. 030-12270/89-001 was discussed. Particular emphasis was focused on the safety significance of the violations and the licensee's actions taken to correct identified problems and prevent recurrence. The licensee described corrective actions in letters dated June 16 and July 31, 1989. The licensee's response to the need for corrective actions was prompt. The licensee's completed actions included:

a. Hiring a new, qualified Chief Nuclear Medicine Technologist;

b. Training of all technologists in the license conditions and NRC requirements, including the new 10 CFR 35 requirements, by the Chief Nuclear Medicine Technologist, with support from a health physics consultant;

c. Improvement of the performance of dose calibrator constancy and molybdenum breakthrough tests and evaluations and procedures;

d. Assuring performance of the required personnel contamination surveys prior to leaving a restricted area, and establishment of area contamination trigger levels which require RSO notification;

e. Equipping all radiation survey instrumentation with dedicated check sources and labels, and performance of the required checks on each day of use of radioactive material;

f. Calibration of all required radiation survey instrumentation at least once every twelve months;

g. Performance of all required radiation safety record reviews and documentation by the RSO and the applicable technologists; posting of radioactive gas clearance times in areas of use; and maintenance of the area contamination wipe survey records as required.

The licensee provided additional information regarding the apparent violations concerning the failure to perform leak tests of sealed sources every six months (10 CFR 35.59(b)), and the failure to conduct a quarterly physical inventory of all sealed sources (10 CFR 35.59(g)). The licensee provided reports from their consultant health physicist dated January 28, 1989, and October 28, 1988, which demonstrated that the required leak tests and inventories had been conducted as required. The NRC staff stated that based on this information, which was not made available at the time of the inspection, the apparent violations are withdrawn.

Also, with regard to the apparent violation concerning the failure to initial the radiopharmaceutical dose record by the individual performing the evaluation (10 CFR 35.53(c)(5)), the licensee provided additional clarification. The RSO agreed that the radiopharmaceutical dose records reviewed by the inspector did not contain the "performer's" initials; however, other records maintained by the licensee, including the patient records, were required to be and were, in fact, initialled by the individual preparing and administering the radiopharmaceutical. Further, the RSO stated that the individual's identity was traceable in records maintained by the licensee. The NRC staff stated that based on this information, which was not made available at the time of the inspection, this apparent violation is withdrawn.

In addition, the NRC representatives stated their concern regarding the apparent degredation of management control as well as the unclear division of responsibility between the Radiation Safety Committee, the Radiation Safety Officer, the nuclear medicine technologists and the consultant health physicist.

NRC enforcement options were reviewed. The licensee stated their intent to be in full compliance with all applicable regulatory requirements.