APPENDIX

ENFORCEMENT CONFERENCE SUMMARY

Licensee: Newman Memorial Hospital (NMH)
License: 35-16717-01
Docket/Report: 30-11681/90-02

On November 14, 1990, the radiation safety officer (RSO) and members of the licensee's administrative staff met with NRC staff members in the Region IV office to discuss the apparent violations identified during an inspection conducted at the licensee's facility in Shattuck, Oklahoma.

The NRC presentation focused on the continued lack of adequate management oversight of program activities as evidenced by certain violations identified during the October 1990 inspection which were similar to those observed during previous inspections conducted in January and May 1990. The staff reviewed the violations associated with the incident which prompted the inspection, and requested the licensee representatives to respond to concerns regarding the specific violations as well as the general issue of management control of program activities.

The licensee representatives responded, noting that they believed the violations to have occurred as described in NRC Inspection Report 30-11681/90-02. The RSO acknowledged NRC's concern regarding the amount of time that he was able to devote to the program due to his incumbent duties at another medical facility, although he noted that in his opinion, this had not been a factor in precipitating the incident involving the improper transfer of licensed material. The RSO attributed the incident to human error during an attempt to provide what a physician had considered a necessary medical examination.

The RSO acknowledged that as a result of his review of the circumstances related to this specific incident, as well as those associated with previously identified violations, he had determined that further procedure changes were necessary to ensure that these problems did not recur. The RSO reviewed those corrective measures which had been completed including: (1) disciplinary action for the individual involved and reinstruction of both the technical and the referring physician staff, (2) development of a revised procedure manual providing guidance to both the technical and physician staff in determining whether a routine nuclear medicine procedure was appropriate for a specific patient, (3) providing specific guidance for the referring physician staff regarding the criteria to be used in determining whether an emergency examination was necessary, and (4) the procedures to be followed in scheduling emergency examinations after normal working hours. He further noted that he had proposed limiting the nuclear medicine service to those periods when the technical director was available to perform these examinations.

The RSO also noted that he had advised hospital management that a second consulting physicist should be retained for the purpose of conducting an objective program audit to identify any additional items of noncompliance and

to assist him in developing corrective measures which would adequately address the more technical violations involving surveys, instrument checks, and personnel dosimetry.

The management representatives stated their support of the RSO's assessment and further discussed a resolution recently adopted by the hospital board of trustees. The hospital administrator noted that this resolution included the temporary suspension of licensed activities and a proposal to locate another individual qualified to serve as RSO and capable of devoting greater attention to the NMH radiation safety program. The administrator acknowledged that NMH did not intend to resume licensed activities until either another individual had been designated and approved to serve as RSO or, if NMH failed to locate such an individual, that each of the current RSO's concerns had been addressed and he was assured that NMH was fully in compliance with NRC requirements. He acknowledged that a letter would be forwarded to NRC describing the conditions of the resolution including the RSO's assessmert of the corrective actions necessary prior to resuming program activities, and that NRC would be notified when NMH had determined that the nuclear medicine service could resume operations.

The NRC staff stated in conclusion that a decision would be forthcoming regarding enforcement action.

Charles Z. Cain for

Linda Kasner, Health Physicist
Nuclear Materials Safeguards and
Inspection Section

ATTACHMENT

Enforcement Conference Attendance List

Newman Memorial Hospital

Newman Memorial Hospital

Gary W. Mitchell, Interim Administrator
Dr. D. Mitchell, Radiation Safety Officer
Charles B. Linton, Regional Director
Hospital Management Professionals, Inc.

Nuclear Regulatory Commission (Region IV Office)

A. B. Beach, Director, Division of Radiation Safety and Safeguards
C. L. Cain, Chief, Nuclear Materials and Safeguards Inspection Section
G. F. Sanborn, Enforcement Officer
L. L. Kasner, Nuclear Materials and Safeguards Inspection Section
V. H. Campbell, Nuclear Materials Licensing Section
S. Rajendran, Nuclear Materials Licensing Section
R. A. Leonardi, Nuclear Materials and Safeguards Inspection Section
A. B. Earnest, Nuclear Materials and Safeguards Inspection Section
G. L. Guerra, Jr., Nuclear Materials and Safeguards Inspection Section

Nuclear Regulatory Commission (NRC Headquarters)

R. J. DelMedico, Office of Enforcement
J. R. Schlueter, Nuclear Materials Safety and Safeguards