U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 030-02643/93002(DRSS)

Docket No. 030-02643

License No. 34-00341-06

EA No. 93-288

Licensee: Miami Valley Hospital
1 Wyoming Street
Dayton, OH 45409

Meeting Conducted: December 9, 1993 at the Region III office

Type of Meeting: Enforcement Conference

Inspection Conducted: October 25-27, 1993

Inspector: Kevin G. Null — 12/23/93
Kevin G. Null
Radiation Safety Specialist
Date

Reviewed by: W. J. Holt for — 12/29/93
B. J. Holt, Chief
Nuclear Materials Inspection
Section 1
Date

Approved by: Roy J. Caniano — 12/29/93
Roy J. Caniano, Chief
Nuclear Materials Safety Branch
Date

Meeting Summary

Enforcement Conference on December 9, 1993 (Report No. 030-02643/93002(DRSS))
Areas Discussed: A review of the apparent violations identified during the inspection, and corrective actions taken or planned by the licensee. The enforcement options pertaining to the apparent violations were also discussed with the licensee.

DETAILS

1. Conference Attendees

Miami Valley Hospital

Bill Thornton - Chief Operating Officer
Mark Shaker - Vice President, Hospital Operations
Jose Quinones, M.D. - Medical Director, Nuclear Medicine
Don Ruegsegger - Medical Physicist, Radiation Safety Officer
Paul Early - Medical Consultant (NMA) for the licensee

U.S. Nuclear Regulatory Commission

Roy J. Caniano - Chief, Nuclear Materials Safety Branch
Bruce Berson - Region III Counsel
Charles Weil - Enforcement and Investigation Coordination Staff
B.J. Holt - Chief, Nuclear Materials Inspection Section 1
Kevin G. Null - Radiation Specialist

2. Enforcement Conference

An open Enforcement Conference was held in the Region III office with representatives of the NRC Region III office and Miami Valley Hospital on December 9, 1993. This conference was conducted in response to the preliminary findings of the inspection conducted on October 25-27, 1993, in which apparent violations of NRC requirements were identified. The inspection findings are documented in Inspection Report No. 030-02643/93001(DRSS) transmitted to the licensee by letter dated December 2, 1993.

The purpose of this conference was to (1) discuss the apparent violations, their cause, and the licensee's corrective actions; (2) provide the licensee the opportunity to point out any errors in the inspection report; and (3) discuss any additional information which would help determine the appropriate enforcement action.

The licensee's representatives agreed with the facts as presented in Inspection Report No. 030-02643/93001(DRSS) and the apparent violations with the exception of Item no. 1 under the heading entitled, Corrective Actions. The correct date of the memorandum referenced in Item No. 1 is September 10, 1993, not September 16, 1993 as documented in Section 4 of the report.

The licensee described the events which led to the apparent violations, including root causes and corrective actions planned. They indicated that the root causes of the violation pertaining to the use of radioactive material at an unauthorized location were (1) concern for the patient who appeared to be too ill to come to the hospital for the

treatment; and (2) failure to consult with the RSO prior to removing the material from hospital property. Licensee representatives indicated that they will not use material at locations other than those authorized on their license. Rather, if a similar situation arises in the future, they will request an emergency amendment to the license.

Also discussed during the conference were concerns the NRC has pertaining to the apparent lack of communication between the nuclear medicine staff and the RSO, and the radiation safety training of key individuals.

In addition, the NRC presented apparent violations concerning a falsification of a survey record by a staff nuclear medicine technologist. In response, the licensee representatives presented written statements made by the technologist. The statements, however, generated additional concerns relative to potential falsification of other records by the technologist and other staff members, and the integrity of these individuals. The NRC requested that the licensee investigate the statements and provide the NRC with a written response within 10 days of the date of the conference. The NRC received the hospital's response in a letter dated December 21, 1993, and is continuing to review this matter.

At the conclusion of the meeting, the licensee's representatives were informed that they would be notified in the near future of the final enforcement action.