U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 030-02101/94001(DRSS)

Docket No. 030-02101

License No. 21-11494-01

Licensee: Oakland General Hospital
27351 Dequindre Avenue
Madison Heights, MI 48071

Meeting Date: January 28, 1994

Meeting At: NRC Region III Office
Lisle, Illinois

Type of Meeting: Enforcement Conference

Inspection Conducted: Onsite December 20 and 21, 1993

Inspector: Evelyn R. Matson — Date: 1-31-94

Reviewed By: John A. Grobe, Chief, Nuclear Materials Safety Section 2 — Date: 2/1/94

Approved By: Roy J. Caniano, Chief, Nuclear Materials Safety Branch — Date: 2/1/94

Meeting Summary

Enforcement Conference on January 28, 1994 (Report No. 030-02101/94001(DRSS))
Areas Discussed: A review of the apparent violations and areas of concern 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. Persons Present at Conference

Oakland General Hospital

William Mott, Director of Clinical Services
Charles Feinman, D.O., Chairman, Department of Radiology/Therapy, and RSO

U.S. Nuclear Regulatory Commission, Region III

Roy J. Caniano, Chief, Nuclear Materials Safety Branch
Bruce A. Berson, Regional Counsel
Paul R. Pelke, Enforcement Specialist
Evelyn R. Matson, Radiation Specialist
Sally Merchant, Office of Nuclear Materials Safety and Safeguards

2. Enforcement Conference

An enforcement conference was held in the NRC Region III office on January 28, 1994. This conference was conducted as a result of the preliminary findings of the inspection conducted on December 20 and 21, 1993, in which apparent violations of NRC regulations were identified. Inspection findings are documented in Inspection Report No. 030-02101/93001(DRSS) transmitted to the licensee by letter dated January 20, 1994.

The purpose of this conference was to: (1) discuss the apparent violations, causes, and the licensee's corrective actions; (2) discuss several areas of concern; (3) determine if there were any escalating or mitigating circumstances; and (4) obtain any information which would help determine the appropriate enforcement action.

The licensee's representatives did not contest any of the apparent violations and were in agreement with the NRC's understanding of the areas of concern.

The licensee's representatives described the events which lead to the violations, including root causes and corrective actions taken. In summary, the corrective actions were: (1) a revised QMP was submitted to the Regional office on December 27, 1993, and a second revision on January 26, 1994; (2) the Radiation Safety Committee will be revised with regard to membership, activities, responsibilities, and reporting to upper level management; (3) recommendations regarding program quality from Arthur Porter, M.D., Director of Radiation Oncology Center, Harper Hospital, at Wayne State University were sought and will be implemented; and (4) the radiation therapy program will undergo an audit conducted by Dr. Porter's staff.

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