U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 030-02003/94002(DRSS)

License No. 21-01103-04

Licensee: Genesys Regional Medical Center
302 Kensington Avenue
Flint, MI

Meeting Conducted: February 3, 1994

Type of Meeting: Enforcement Conference

Inspector: Michael F. Weber — Date: 2/3/94
Michael F. Weber
Radiation Specialist

Reviewed By: John A. Grobe — Date: 2/3/94
John A. Grobe, Chief
Nuclear Materials Inspection
Section 2

Approved By: Roy J. Caniano — Date: 2/4/94
Roy J. Caniano, Chief
Nuclear Materials Safety
Branch

Meeting Summary

Enforcement Conference on February 3, 1994 (Report No. 030-02003/94002(DRSS))
Areas Discussed: This conference included a review of the apparent violations identified during the April 26 through May 4, 1993 inspection of St. Joseph Hospital (now d.b.a. Genesys Regional Medical Center, St. Joseph Campus) and the corrective actions taken or planned by the licensee. The enforcement options pertaining to the apparent violations were also discussed.

DETAILS

1. Conference Attendees

Genesys Regional Medical Center

Homer W. Read - Assistant to the President
Joseph W. Kyle - Vice President, Emergency Services/Diagnostic Center
C. V. Prasad, Ph.D. - Medical Physicist and Radiation Safety Officer
Mark Gentle - Director of Radiology
Thomas Kompuris - Consulting Medical Physicist

U.S. Nuclear Regulatory Commission, Region III

Roy J. Caniano - Chief, Nuclear Materials Safety Branch
Bruce A. Berson - Regional Counsel
Robert W. DeFayette - Director, Enforcement and Investigation Coordination Staff
John A. Grobe, Chief, Nuclear Materials Inspection Section 2
Michael F. Weber, Radiation Specialist/Enforcement and Investigation Coordination Staff
Angela Dauginas - Public Affairs Officer

2. Enforcement Conference Summary

An enforcement conference was held in the NRC Region III office on February 3, 1994, as a result of the preliminary findings of the inspection performed on April 26 through May 4, 1993, in which six apparent violations of NRC requirements were identified. These preliminary findings were documented in Inspection Report No. 030-02003/94001(DRSS) which was sent to the licensee on May 29, 1993.

The purposes of this conference were to: (1) discuss the apparent violations, the root causes, safety significance and the licensee's corrective actions; (2) determine if there were any escalating or mitigating circumstances; (3) provide the licensee an opportunity to point out any errors in our inspection report; and (4) obtain any information which would help determine the appropriate Enforcement Action.

The licensee representatives indicated that they were in agreement with the NRC's understanding of the facts pertaining to the apparent violations.

The licensee stated that the major cause of the apparent violations was a management oversight problem, that the Radiation Safety Officer and higher management were not providing sufficient attention to the program. The long term corrective actions were presented, which include management changes coupled with new policies and procedures which should dramatically increase the management oversight.

The meeting was closed by NRC representatives with a discussion of the NRC Enforcement Policy. The licensee was told that further Enforcement Actions were possible, and they would be notified in the near future of the final Enforcement Action.