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UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

MAR 1 4 1994

Docket No. 030-12775
License No. 13-17449-01
EA 93-250

Morgan County Memorial Hospital
ATTN: S. Dean Melton
Administrator
2209 John R. Wooden Drive
Martinsville, Indiana 46151

Dear Mr. Melton:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES - $9,750, AND DEMAND FOR INFORMATION (NRC INSPECTION REPORT NO. 030-12775/93001)

This refers to the inspection conducted on September 28, 1993 of activities authorized by NRC Byproduct Material License No. 13-17449-01 at Morgan County Memorial Hospital, Martinsville, Indiana. During the inspection, violations of NRC requirements were identified. The report documenting the inspection was mailed to you on October 18, 1993. The violations, their causes, and your corrective actions were discussed with you and other members of your staff during an Enforcement Conference on October 26, 1993. The results of the Enforcement Conference were documented in Report No. 030-12775/93002, which was mailed to you on November 16, 1993. The violations are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice).

A civil penalty is proposed for the three violations involving a nuclear medicine technologist's deliberate failure, over a period of approximately two and a half years, to perform radiation surveys in accordance with NRC regulatory requirements and his deliberate falsification of NRC-required survey records to indicate that the surveys were being performed as required. The significance of these violations is increased because it involved deliberate misconduct and also because it went undetected and uncorrected by the Radiation Safety Officer and licensee management for such an extended period of time. NRC has also taken separate enforcement action against the technologist. A copy of that action is provided as Enclosure 2.

A civil penalty was also assessed for drinking and storing beverages in areas where radioactive materials were used or

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stored. This violation involved careless disregard on the part of the same technologist who was involved in the deliberate violations discussed above. This technologist was involved in a previous violation involving storage of food in the hot laboratory that was identified during an April 3, 1991 inspection. At the enforcement conference, the technologist indicated that, as a result of the previous inspection, he was aware of the prohibition against storage or consumption of food and beverages in areas where radioactive materials are used or stored. During the inspection, the technologist stated that he had not considered the patient imaging area of the nuclear medicine department to be an area of use or storage of radioactive materials. However, given the backdrop of the 1991 inspection, this individual should have made the effort to clarify the issue, which could have been accomplished easily by raising it with his management, the Radiation Safety Officer, or a representative of your consulting health physics service. At a minimum, this failure on the part of the technologist constitutes careless disregard as the term is used in the "Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C.

In accordance with the Enforcement Policy, the violations involving falsification of records and failure to perform surveys has been classified as a Severity Level II problem and the violation involving drinking and storage of beverages in a prohibited area has been classified at Severity Level III.

The root causes of the violations for which civil penalties have been assessed were deliberate misconduct by your nuclear medicine technician and a failure by management, including the Radiation Safety Officer, to instill in the employees a proper respect for the radiation safety program and its requirements. Furthermore, management failed to oversee licensed activities to assure rigorous compliance. Concerning the violation for failure to perform surveys, the nuclear medicine technician stated that he knew the regulations but chose to ignore them because of their (perceived) minimal safety significance and to save time because of his other duties. The NRC considers the deliberate disregard of its safety regulations to be a serious matter which will not be tolerated.

The NRC recognizes that you took corrective actions immediately after the event, including issuing a letter of reprimand to the technologist, and increasing management oversight of the survey process. These actions were documented in your September 28 and October 27, 1993, letters to Mr. Roy Caniano and were discussed at the Enforcement Conference on October 26, 1993. Notwithstanding these corrective actions, the NRC is concerned that you have not addressed a significant contributing factor to

each of the violations. Specifically, you have not addressed management or the Radiation Safety Officer's lack of oversight of the radiation safety program. The Radiation Safety Officer is critical to the proper functioning of a radiation safety program and is a key person in the organization to ensure compliance with NRC requirements. Management, including the Radiation Safety Officer, must take an active role in managing the radiation safety program and in ensuring that necessary resources are available and that deficiencies are identified and corrected when they occur.

To emphasize the serious nature of willful violations of NRC requirements, the need to instill in your employees a proper respect for the radiation safety program and its requirements, and the need for you to increase and maintain oversight of the radiation safety program, I am issuing the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice) in the amount of $9,750 for the violations described above and in the Notice.

The base value of a civil penalty at a medical institution is $4,000 at Severity Level II and $2,500 at Severity Level III. The civil penalty adjustment factors in the Enforcement Policy were considered. Both civil penalties were escalated 50% because the NRC identified the violations. For the reasons discussed above, neither escalation nor mitigation was considered appropriate based on your corrective actions for both violations. The violations represent a substantial decline in performance since the last NRC inspection; therefore, notwithstanding good prior performance, mitigation of the civil penalties based on this factor is not warranted. Although the survey violation involved multiple examples, that fact was taken into consideration in establishing the Severity Level. The other adjustment factors in the Policy were considered and no further adjustments were deemed appropriate. Therefore, based on the above, the base civil penalty has been increased by 50% for each violation.

A violation for failure to follow procedures for safely opening packages containing licensed material has been categorized at Severity Level IV. A civil penalty was not assessed for this violation.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. In addition, given the willful nature of the technologist's actions, it is appropriate that NRC monitor the

procedure that you have instituted to ensure that his surveys are observed by either the Department Head or designee.

In order to monitor your improvement in the radiation safety program oversight and the procedure instituted to oversee the technologist's surveys, and in order to determine whether your license should be modified or other further enforcement action taken, you are hereby required, pursuant to sections 161c, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended and the Commissions requirements in 10 CFR 2.204 and 10 CFR 30.32(b), to submit to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington D.C. 20555, the following information, in writing, under oath or affirmation:

1. A description of the actions taken or planned to improve oversight of licensed activities by the Radiation Safety Officer and licensee management.

2. Your basis for having confidence in the integrity of the technologist relating to his performance in NRC-licensed activities, and your basis for having confidence that, in the future, he will not commit willful violations of NRC requirements.

3. Written notice to NRC of any change in your procedure for observing the technologist's performance of daily and weekly surveys as described in Section 3.1 and Attachment E of your letter dated October 27, 1993, including any decision to discontinue the observations; and

4. In the event that the observations are discontinued, your basis for having confidence that the technologist will conduct surveys and maintain related records in a forthright and candid manner and in accordance with the requirements of 10 CFR 30.9.

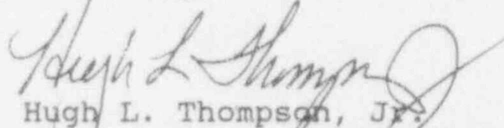
The responses to Items 1 and 2 above shall be submitted within 30 days of the date of this Demand for Information. The responses to Items 3 and 4 shall be submitted within 10 business days of any change in the observation procedure or decision to discontinue the observations.

After reviewing your response to this Notice and Demand for Information and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your responses will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Public Law No. 96-511.

Sincerely,



Hugh L. Thompson, Jr.
Deputy Executive Director
for Nuclear Materials Safety,
Safeguards and Operations Support

Enclosures:
1. Notice of Violation and Proposed Imposition of Civil Penalty
2. Order Issued to Morgan County Memorial Hospital Employee

cc: Mr. William K. Headley