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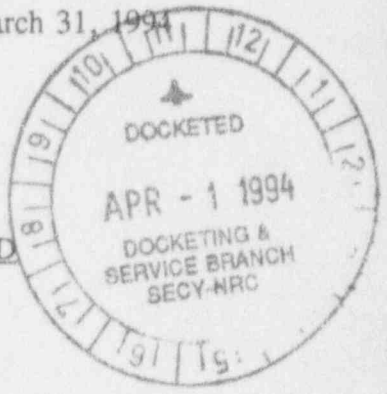
March 31, 1994



UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of	)	
	)	
INDIANA REGIONAL CANCER CENTER INDIANA, PENNSYLVANIA	)	Docket No. 030-30485-EA
	)	
	)	
(Byproduct Material License No. 37-28179-01)	)	EA No. 93-284
	)	
	)	

NRC STAFF'S RESPONSE TO
MOTION TO ELIMINATE BASIS FOR SUSPENSION

INTRODUCTION

Pursuant to the Atomic Safety and Licensing Board's (Board) "Order (Prehearing Conference Order)," (Order), dated February 1, 1994, the staff of the Nuclear Regulatory Commission (Staff) hereby responds to the Indiana Regional Cancer Center's (Licensee or IRCC) and Dr. James E. Bauer's "Motion to Eliminate Basis for Suspension," dated February 28, 1994 (Licensee's Motion). For the reasons set forth below, the Board should deny the Licensee's Motion.

BACKGROUND

The IRCC is the holder of Byproduct License No. 37-28179-01 (strontium-90 license) issued by the Nuclear Regulatory Commission pursuant to 10 C.F.R. Parts 30 and

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35. The strontium-90 license authorizes the Licensee to use a strontium-90 source for the treatment of superficial eye conditions at the Licensee's facility in Indiana, Pennsylvania.

On November 16, 1993, the Staff issued an Order Modifying and Suspending License (Effective immediately)" (Order Modifying and Suspending License). 58 Fed. Reg. 61932 (November 23, 1993). The Order Modifying and Suspending License suspended the strontium-90 license until further order. Order Modifying and Suspending License at 5; 58 Fed. Reg. 61933. In addition, the Order Modifying and Suspending License modified the strontium-90 license to prohibit James E. Bauer, the RSO and only authorized user named on the strontium-90 license, from engaging in activities under the strontium-90 license. *Id.* One of the bases for the Order Modifying and Suspending License was an incident in November 1992 at the IRCC involving a patient treatment using a High Dose Rate (HDR) Afterloader that resulted in a patient being exposed to significant levels of radiation, and numerous other members of the general public being exposed to unnecessary radiation. In that event, Dr. Bauer failed to cause an adequate survey to be made which could have prevented the exposures. *Id.* at 3; 58 Fed. Reg. 61932.

On February 1, 1994, the Board issued its Order. In its Order, the Board provided that "the parties shall have up to and including Monday, February 28, 1994, within which to file a dispositive motion relative to any of the issues specified in the parties' January 18, 1994 joint prehearing report." *Id.* at 1. On February 28, 1994, the Staff filed "NRC Staff Motion for Summary Disposition and Motion for Dismissal"

(Staff's Motion), in which it moved the Board to grant summary disposition, in its favor, on the issue of whether Dr. Bauer's alleged conduct under License No. 37-28540-01 (HDR License), which is subject to pending litigation, can as a matter of law, be a basis for the suspension of License No. 37-281709-01 (Strontium-90 License). Staff's Motion at 11. On February 28, 1994, the Licensee and Dr. Bauer filed their Motion in which they moved the Board to "eliminate as a basis for the suspension of License No. 37-28179-01 (Strontium-90 license) the conduct of James E. Bauer, M.D., under License No. 37-28540-01 (HDR License), which is subject to pending litigation." Licensee's Motion at 1.[1]

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[1] In their Motion, under a section entitled "factual and procedural posture," the Licensee and Dr. Bauer assert that "neither OSC nor Dr. Bauer were cited for failure to follow a license condition with respect to said survey." Licensee's Motion at 2. The Staff fails to understand the relevance of this assertion to the above-captioned proceeding, but feels, nonetheless, obligated, in an effort to clarify the record, to explain the violation of HDR license condition 17 described in the Order Suspending License (Effective Immediately) issued to Oncology Services Corporation (OSC) on January 20, 1993. 58 Fed. Reg. 6825 (February 2, 1993). Although it is correct that neither OSC nor Dr. Bauer were "cited for failure to follow HDR license condition 17 with respect to said survey," the Order Suspending License discussed a violation of HDR license condition 17 for the failure of the OSC's personnel to enter the treatment room with either an audible dosimeter or survey meter. *Id.* In addition, the Order Suspending License described a violation of 10 C.F.R. § 20.201(b). 58 Fed. Reg. at 6825-26. The December 30, 1993 letter from Mr. James Lieberman, Director, Office of Enforcement, to Ms. Marcy L. Colkitt, Esq., referenced by the Licensee and Dr. Bauer, explained that the violation regarding the failure of Dr. Bauer to cause an adequate survey in the Order Modifying and Suspending License issued to the IRCC constituted a violation of 10 C.F.R. § 20.201(b). This letter did not address the violation of license condition 17 described in Order Suspending License issued to OSC.

The Licensee and Dr. Bauer further assert, in their "factual and procedural posture," that the "inspection found absolutely no radiation safety violations." Licensee's Motion at 2 (emphasis in the original). The inspection report described apparent violations of license condition 9 and of 10 C.F.R §§ 30.3 and 30.9. All three apparent violations raise potential safety concerns.

DISCUSSION

A. The Staff's Reliance on Dr. Bauer's Conduct During the November 1992 Incident As a Basis for Suspending the Strontium-90 License is Constitutional

The Staff's reliance on Dr. Bauer's conduct during the November 1992 incident as a basis for suspending the strontium-90 license is not unconstitutional.[2] The Licensee and Dr. Bauer argue that the reliance by the Staff on Dr. Bauer's conduct under the license issued to OSC (License No. 37-28540-01, HDR license) as a basis for suspending the strontium-90 License, violates the due process clause of the fifth amendment of the U.S. Constitution. Licensee's Motion at 4. In support of their argument, the License and Dr. Bauer assert that since allegations of conduct under the HDR license remain the

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Inspection Report No. 030-30485/93-01 at 4. A copy of this report is attached hereto as Attachment 1.

Also contained under the section entitled "factual and procedural posture," is the Licensee's and Dr. Bauer's assertion that " [T]he NRC has attempted to penalize licensee IRCC for the alleged conduct of a separate licensee!" and that the Staff was "forced to rely on Dr. Bauer's alleged failure to do a survey one year earlier, in November 1992." Licensee's Motion at 2-3 (emphasis in the original). The action taken in the Order Modifying and Suspending License was based on three facts, one of which was Dr. Bauer's conduct under the HDR license. *See* Order Modifying and Suspending License at 3-4; 58 Fed. Reg. 61932-33. Whether the action taken by the Staff in the Order Modifying and Suspending License was justified based on those facts is an issue which may be litigated at a hearing. Also, as discussed below and in the Staff's Motion, the Staff's reliance on Dr. Bauer's conduct in November 1992 as one basis for the Order Modifying and Suspending is appropriate. *See* Staff's Motion at 7-10. In addition, the Staff does not agree that it was "forced to rely" on Dr. Bauer's failure to perform a survey in November 1992 in order to support the Order Modifying and Suspending License.

[2] A large portion of the Licensee's and Dr. Bauer's argument relates to whether due process standards apply to the suspension and modification of the strontium-90 license. *See* Licensee's Motion at 4-8. The Staff does not dispute that certain due process guarantees are applicable to this proceeding. These guarantees, as discussed below, have been afforded to both the Licensee and Dr. Bauer.

subject of pending litigation, they are unadjudicated and unproven and, thus, constitute "hearsay" statements. *See id.* at 4, 5-6. It is their contention that the due process clause prohibits the reliance on such "hearsay" statements and "alleged conduct" as a basis for the suspension of a license. *See id.* at 5-6.

The Licensee's and Dr. Bauer's argument is without merit. Since both the Licensee and Dr. Bauer were given the opportunity to request a hearing on the suspension of the strontium-90 license, and have, in fact, done so, they will have the opportunity to challenge the bases of the Order Modifying and Suspending License, including the allegation regarding Dr. Bauer's conduct during the November 1992 incident under the HDR license. Thus, the Licensee and Dr. Bauer have not been deprived of their due process rights. *See Metropolitan Edison Co.* (Three Mile Island Nuclear Station, Unit 1), CLI-85-2, 21 NRC 282, 316 (1985) ("The Due Process Clause of the Fifth Amendment prohibits a federal agency from depriving an individual of 'liberty' or 'property' interests without providing that individual an opportunity for a hearing."). The Staff's reliance on the "alleged" conduct of Dr. Bauer under the HDR license on November 16, 1992 is not, therefore, unconstitutional.

Further, as discussed in more detail in the Staff's Motion, the Commission has broad authority to take any action necessary to protect the public health and safety. *See Oncology Services Corp.*, LBP-94-2, 39 NRC ___, slip op. at 9 (January 24, 1994), *citing Siegel v. AEC*, 400 F.2d 778, 783 (D.C. Cir. 1968), Staff's Motion at 7. This authority includes the consideration of any and all facts deemed to be sufficient grounds to issue an

order. *See* 10 C.F.R. § 2.202. In addition, section 2.202 of the Commission's regulations provides that if the public health, safety, or interest requires it, the Staff may make an order immediately effective, before the assertions in such an order are challenged at a hearing. Section 2.202 further provides a mechanism whereby a licensee or an individual may challenge an immediately effective order on the basis, *inter alia*, that the order was based on mere suspicion, unfounded allegations, or error. 10 C.F.R. § 2.202(c)(2)(i). Neither the Licensee nor Dr. Bauer has sought to challenge the immediate effectiveness of the Order Modifying and Suspending License on any basis.[3]

Further, the Licensee's and Dr. Bauer's "hearsay" argument fails to support their assertion that their due process rights were violated. The Licensee and Dr. Bauer have apparently confused an evidentiary issue, *i.e.*, "hearsay," with the issue of whether the Staff may rely on conduct in taking enforcement action which is subject to pending litigation. Hearsay, as defined by the Federal Rules of Evidence, is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted. Fed. R. Evid. 801(c). Since the Staff has yet to introduce evidence regarding Dr. Bauer's conduct under the HDR license, the assertion

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[3] The Licensee's and Dr. Bauer's assertion that OSC has been denied its fifth amendment right to due process is unfounded. *See* Licensee's Motion at 5. OSC and the Staff are currently in the process of engaging in prehearing discovery, at the end of which OSC will be afforded a hearing. In any event, since the OSC proceeding and above-captioned proceeding are separate, the License's and Dr. Bauer's assertion regarding OSC's due process rights has no relevance to the IRCC proceeding.

in the Order Modifying and Suspending License in this regard cannot be considered hearsay. The Licensee and Dr. Bauer are free to object at the evidentiary hearing, to the introduction of specific evidence supporting this allegation, if appropriate. The Licensee's and Dr. Bauer's discussion of hearsay and evidentiary standards is not relevant to the issue of the Staff's legal authority to rely upon Dr. Bauer's past conduct as one basis for the Order Modifying and Suspending License at issue in this proceeding. Their "hearsay" argument does not support their claim that their due process rights were violated.[4]

The Licensee and Dr. Bauer also assert, in furtherance of their due process argument, that since the "hearsay" statements regarding Dr. Bauer's conduct under the HDR license have not been adjudicated before any tribunal, these statements do not possess a "minimal indicium of reliability." Licensee's Motion at 6. According to the Licensee and Dr. Bauer, due process requires that hearsay information contain a "minimal indicium of reliability."[5] *Id.* at 6. The Licensee's and Dr. Bauer's assertion concerning

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[4] The Licensee and Dr. Bauer also provide a discussion of the level of judicial review of an administrative agency's actions. Licensee's Motion at 7-8. This discussion has no relevance to the issue of whether the Staff may rely, as a basis for enforcement action, on conduct which is the subject of pending litigation and provides no support for any of the Licensee's or Dr. Bauer's due process arguments.

[5] The Licensee and Dr. Bauer rely on *U.S. v. Beaulieu* (893 F.2d 1177 (10th Cir. 1990)) to support their assertion that due process requires that hearsay information contain "some minimal indicium of reliability." *See* Licensee's Motion at 6. The Licensee's and Dr. Bauer's reliance is misplaced. *Beaulieu*, involved the issue of whether a trial court when conducting a sentencing hearing may rely on hearsay information. *Beaulieu*, 893 F.2d at 1178-79. The Court of Appeals determined that the trial court did not violate any constitutional, procedural or statutory rules when it relied on such hearsay information. *Id.* at 1179. Here, since a hearing has yet to be held, the issue of whether the Board may properly consider hearsay evidence is

the reliability of the allegation regarding Dr. Bauer's conduct under the HDR license is unsupported. The mere fact that certain assertions in a suspension order have not been adjudicated does not indicate that those assertions are not reliable. As a general matter, any fact described in a suspension order is not likely to have been previously adjudicated before a tribunal.[6] As discussed above, the Staff may rely on whatever facts in its possession, in the Staff's view, warrant a suspension of a license. The Licensee's and Dr. Bauer's due process rights, however, have not been violated since the facts relied upon in the Order Modifying and Suspending License, and the action taken therein based on those facts, may be challenged at a hearing.[7]

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premature. The Licensee's and Dr. Bauer's reliance on *United States v. Sunrhodes* (831 F.2d 1537 (10th Cir. 1990)) and *United States v. Fulbright* (804 F.2d 847 (5th Cir. 1986)) is, for similar reasons, misplaced.

[6] It should be noted that the other bases for the Order Suspending and Modifying License, also have not, yet, been adjudicated before a tribunal, however, neither the Licensee nor Dr. Bauer appear to have any due process concerns regarding those allegations.

[7] In addition, as stated above, the Licensee and Dr. Bauer could have challenged the Staff's reliance on any of the factual assertions in the Order Modifying and Suspending License on the basis that they were based on mere allegations. *See* 10 C.F.R. § 2.202(c)(2). Neither the Licensee nor Dr. Bauer has made this challenge.

B. The Staff's Reliance on the Dr. Bauer's Conduct During the November 1992 Incident is both Relevant and Material

The Staff's reliance on the November 16, 1992 incident is both relevant and material to this proceeding. The Licensee and Dr. Bauer assert that the allegations pertaining to Dr. Bauer's conduct under the HDR license do not relate "in any substantive way to the allegations which underlie the suspension of the IRCC strontium-90 license."[8] Licensee's Motion at 9. Because Dr. Bauer's conduct under the HDR license does pertain to the suspension of the Licensee's license, the Licensee's and Dr. Bauer's argument is without merit.

As discussed in the Staff's Motion, the Staff is not limited to citing conduct related to a given license, but may consider all facts in its possession which support the Staff's conclusion that the suspension of that license is warranted. *See* Staff's Motion at 7-10. In this proceeding, the Order Modifying and Suspending License provided that Dr. Bauer's conduct during the November 16, 1992 incident under the HDR license cast doubt on his ability to follow the Commission's regulations and to conduct licensed

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[8] The Licensee and Dr. Bauer also argue that since the allegations regarding Dr. Bauer's conduct under the HDR license would be inadmissible evidence under the Administrative Procedure Act, then that conduct should not serve as a basis for the suspension of the Licensee's license. Licensee's Motion at 9. The Licensee's and Dr. Bauer's argument lacks merit. The Staff, as well as any other party, may introduce in a hearing any evidence which is relevant, material, and reliable. 10 C.F.R. § 2.243(c). Since the Order Modifying and Suspending License did cite, as one basis, Dr. Bauer's conduct under the HDR license, any evidence which is relevant and material, as well as reliable, regarding Dr. Bauer's conduct may be introduced in a hearing. If, at the time of the hearing, the Licensee or Dr. Bauer wishes to object to the introduction of specific evidence, they may do so.

activities under the strontium-90 license in a manner which ensures that the public health and safety will be protected. Order Modifying and Suspending License at 4; 58 Fed. Reg. at 61933. Thus, Dr. Bauer's conduct during the November 1992 incident is relevant and material to the suspension of the Licensee's license since that conduct casts doubt on Dr. Bauer's ability to perform his duties as the Radiation Safety Officer (RSO) and authorized user under the Licensee's license.

Furthermore, a license may be suspended for any reason which would have warranted the refusal to grant a license initially. Atomic Energy Act of 1954, as amended, § 186, 42 U.S.C. § 2236. The Staff may refuse to grant a license if it finds that the applicant is not equipped and committed to observe the safety standards established by the Commission for the protection of the public health and safety. 10 C.F.R. § 35.18(c). Thus, when considering a license application, the Staff may consider any action of the applicant and/or other individuals named on the license application which bear on the ability of the applicant or individuals to conduct licensed activities safely and in accordance with the Commission's regulations. *Hamlin Testing Laboratories, Inc.*, 2 A.E.C. 423, 428 (1964), *aff'd* 351 F.2d 62 (6th Cir. 1966). *See also Randall C. Orem, D.O.*, CLI-93-14, 37 NRC 423, 431 (1993) (Dissenting Views of Commissioner Curtiss). This consideration may include an individual's conduct under a different license. Since Dr. Bauer's activities as an authorized user under the HDR license cast doubt on whether he is equipped and committed to observe the safety standards established by the Commission for the protection of the public health and safety,

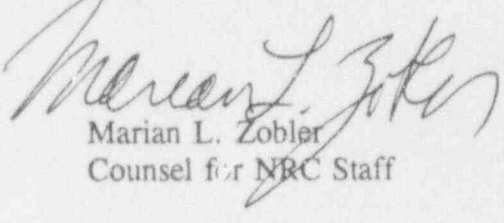
Dr. Bauer's conduct under the HDR license is relevant and material to the suspension of any license which lists Dr. Bauer. Because Dr. Bauer was the RSO and only authorized user listed on the Licensee's license, his conduct under the HDR license is relevant and material to the suspension of the Licensee's license.

In summary, the Licensee's and Dr. Bauer's assertions that their due process rights were violated is without merit. The Licensee's and Dr. Bauer's argument regarding hearsay information is premature, unsupported, and irrelevant to the issue of whether the Staff may legally rely on Dr. Bauer's conduct under the HDR license which is the subject of pending litigation as a basis for the Order Modifying and Suspending License. Further, Dr. Bauer's conduct under the HDR license is relevant and material to the suspension of the Licensee's license since it reflects on the ability of the Licensee's RSO and only authorized user to adhere to the Commission's regulations. The Licensee's Motion should, therefore, be denied.

CONCLUSION

For the reasons set forth above, the Licensee's Motion should be denied.

Respectfully submitted,



Marian L. Zobler
Counsel for NRC Staff

Dated at Rockville, Maryland
this 31st day of March, 1994

U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 030-30485/93-001 License No. 37-28179-01

EA No. 93-284

Docket No. 030-30485 Priority 4 Category G2

Licensee: Indiana Regional Cancer Treatment Center
877 Hospital Road
Indiana, PA 15701

Facility Name: Indiana Regional Cancer Treatment Center

Inspection At: 877 Hospital Road
Indiana, PA 15701

Inspection Conducted: November 11, 1993

Inspectors: Penny Nessen 12-2-93
Penny Nessen, Health Physicist Date
Medical Inspection Section

Steve Shaffer 12/2/93
Steve Shaffer, Health Physicist Date
Industrial Applications Section

Approved by: Jenny M. Johansen 12/2/93
Jenny M. Johansen, Chief Date
Medical Inspection Section

Inspection Summary: Unannounced safety inspection conducted on November 11, 1993 (Inspection Report No. 030-30485/93-001).

Areas Inspected: Scope of licensee program; organization; training; facilities and equipment; use of material; personnel radiation protection; waste disposal; misadministrations; and quality management program.

Results: Two apparent violations were identified: 1) use of byproduct material not authorized by a specific license issued pursuant to 10 CFR Parts 30 and 35 (Section 2); and 2) failure to provide complete and accurate information pursuant to 10 CFR 30.9 (Section 2).

DETAILS

1. Persons Contacted

*James E. Bauer, M.D., Medical Director and Radiation Safety Officer
*Marcy Colkitt, Counsel
Pat Korywchak, Nurse
Charlene Santes, Secretary
Mitch Jarosz, Consultant

*Present at Exit Conference on November 11, 1993

2. Scope

The licensee currently has an NRC license that authorizes treatment of superficial eye conditions with a strontium-90 medical eye applicator. The licensee stated that 6 to 7 patients are treated per year with the strontium-90 source.

The Radiation Safety Officer (RSO) and only authorized user was asked by the inspectors about the treatment modalities for which the source was used. The RSO stated that he used the source for treatment of pterygium, an eye condition. The inspectors asked the RSO if he used the sou ce for any other treatment modality. The RSO stated again that the source had been used for treatment of pterygium. When asked to provide the last six patients' files for review, the RSO provided a patient file that showed treatment for pterygium in June and July of 1993.

The inspectors then asked the secretary for and received a patient scheduling log for the year. Upon review of the log, the inspectors determined that two patients had been treated recently (September, October, and up to November 11, 1993). Upon review of the files, the patients were found to have been treated with the strontium-90 source for skin lesions, a treatment modality not authorized by the license. The first patient was treated from September 20, 1993 to October 25, 1993, for a skin lesion on the tip of the nose with a total dose of 4500 centigray delivered over 6 fractions of 750 centigray each. The second patient was treated from October 21, 1993 to November 11, 1993 (immediately prior to the inspection) for a skin lesion on the nose and a skin lesion on the face with four fractions delivered of 750 centigray each. The second patient was prescribed to have two additional treatments of 750 centigray each to complete the treatment.

10 CFR 30.3 requires, in part, that except for persons exempted, no person shall use byproduct material except as authorized by a specific or general license issued pursuant to Title 10, Chapter 1, Code of Federal Regulations.

Condition 9 of License No. 37-28179-01 issued pursuant to Parts 30 and 35 limits the authorized use of the strontium 90 medical eye applicator to the treatment of superficial eye conditions.

Use of byproduct material, except as authorized by License Condition 9, is an apparent violation of 10 CFR 30.3 and Condition 9 of License No. 37-28179-01.

10 CFR 30.9 requires, in part that information provided to the Commission by a licensee be complete and accurate in all material respects.

Failure of the RSO to provide complete and accurate information to the inspectors when questioned about the use of the strontium-90 source is an apparent violation of 10 CFR 30.9.

3. Organization

Dr James E. Bauer is the Medical Director, the RSO, and the sole authorized user for this license. Dr. Bauer uses the services of a consultant to perform sealed source leak tests, sealed source inventories, sealed source storage surveys, and radiation safety training. Dr. Bauer also uses the services of Ms. Marcy Colkitt for legal counsel related to this license.

4. Training

The consultant provided training in November of 1993 on the Quality Management Program as it relates to any therapy treatment, including strontium-90. The RSO stated that he provided the nurse additional training on radiation safety as it applied to the use of the strontium-90 source.

5. Facilities and Equipment

a. Facilities

The licensee is licensed for use in a specific room located at 877 Hospital Road. The strontium-90 source was locked in a cabinet within this room. The storage area containing the strontium-90 source was posted as required.

b. Equipment

The licensee had available two Victoreen 410 meters with a range of 0.1 milli-Roentgen per hour to 1 Roentgen per hour. Both meters were calibrated as required. The inspectors also verified that licensee staff had been trained on how to perform check source readings to ensure operability of the meters.

6. Use of Materials

The inspectors reviewed the quarterly ambient surveys performed around the source storage area and the leak tests and inventories performed of the source.

a. Area Ambient Surveys

The inspector noted that the licensee performs ambient dose rate surveys around the source storage location approximately quarterly. When a transition was made by the licensee in 1993 to a new consultant the surveys were performed late, however the licensee identified the oversight and performed subsequent surveys as required. Records are maintained of the surveys as required. Because the surveys were peformed within 30 days after the calendar quarter ended and the licensee identified and corrected this oversight, this violation is not being cited.

b. Sealed Source Leak Test and Inventory

The inspector noted that all sealed source leak tests and inventories of the strontium-90 sealed source were conducted as required. As discussed above, during the transition to a new consultant the leak test and inventory were performed late, however subsequent leak tests and inventories have been performed on schedule. Records are maintained of the leak tests and inventories as required. Because the leak tests and inventories were peformed within 30 days after the required frequency ended and the licensee identified and corrected this oversight, this violation is not being cited.

7. Personnel Radiation Protection

The inspector noted, on the day of the inspection, that personnel had available the required personnel dosimetry. Records of personnel exposure were reviewed from January 5, 1993 to September 4, 1993. Records were not reviewed for the period from the last inspection, January 1989, to December 1992 since these records were reviewed previously during the investigation in December 1992 of an event at the Center. The licensee uses vendor dosimeters which are exchanged monthly. The

licensee's RSO reviewed and investigated one exposure that occurred in June of 1993 where the nurse received 100 millirem whole body dose from a beta source. The nurse was retrained on radiation hazards associated with the strontium-90 source and instructed that when assisting the RSO during treatments, maximum distance should be observed as far away from the source as possible.

8. Waste Disposal

The licensee has not disposed of any strontium-90 sources since the previous inspection conducted in 1989.

9. Misadministrations

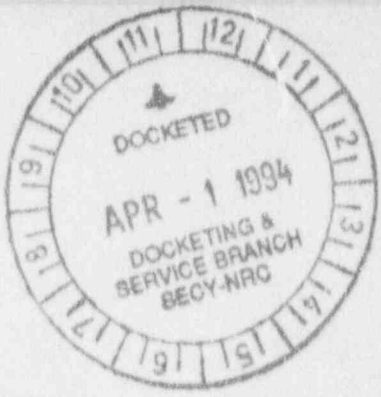
The licensee's RSO stated that no misadministrations had occurred with the strontium-90 source.

10. Quality Management Program

The inspector determined that the licensee had implemented the quality management program that was submitted to the NRC for Oncology Services Corporation's license. The inspector also determined that the licensee had followed the quality management program when performing the strontium-90 treatments.

11. Exit Interview

The inspector met with the licensee's representatives designated in Section 1 of this report at the conclusion of the inspection. The inspector summarized the scope and findings of the inspection.



UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of	)	
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INDIANA REGIONAL CANCER CENTER INDIANA, PENNSYLVANIA	)	Docket No. 030-30485-EA
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	)	
(Byproduct Material License No. 37-28179-01)	)	EA No. 93-284

CERTIFICATE OF SERVICE

I hereby certify that copies of "NRC STAFF'S RESPONSE TO MOTION TO ELIMINATE BASIS FOR SUSPENSION" in the above-captioned proceeding have been served on the following through deposit in the Nuclear Regulatory Commission's internal mail system, or by express mail as indicated by an asterisk, this 31st day of March, 1994:

G. Paul Bollwerk, III, Chairman
Administrative Judge
Atomic Safety and Licensing Board
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dr. Charles N. Kelber
Administrative Judge
Atomic Safety and Licensing Board
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dr. Peter S. Lam
Administrative Judge
Atomic Safety and Licensing Board
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Washington, D.C. 20555

Iles Cooper, Esq.*
Counsel for Indiana Regional
Cancer Center and
James E. Bauer, M.D.
Williamson, Friedberg & Jones
One Norwegian Plaza
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Washington, D.C. 20555
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Adjudicatory File (2)
Atomic Safety and Licensing Board
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Office of Commission Appellate
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U.S. Nuclear Regulatory Commission
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