



RIVERSIDE HOSPITAL

A RIVERSIDE HEALTH GROUP MEMBER

United States
Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

December 1, 1992

License No. 34-13234-01

Att'n: Mr. John A Grobe
Nuclear Materials Safety Branch

Dear Mr. Grobe:

This letter is a reply to a notice of violation.

This letter refers to a special safety inspection conducted on August 31, 1992. At that time two areas of violation were noted.

The first violation involved insufficient training of ancillary personnel whose duties may require them to work in the vicinity of radioactive material. On January 18, 1992, two untrained housekeeping staff members were sent to retrieve waste containing radioactive material. The incident that occurred was out of the ordinary and corrective steps have been taken to prevent a recurrence.

- Action taken:
- A. Housekeeping personnel were instructed in rules designed to minimize potential radiation exposure/contamination.
 - B. Security personnel were also inserviced on rules for receiving incoming shipments of radioactive material, including possible contaminated waste.
 - C. The procedure for handling minor contamination for nursing personnel has been reevaluated and revised.
 - D. Beginning in January 1993, annual training/inservicing of all hospital personnel will be conducted.
 - E. A Bicron LFM-2 Radioactive Material Detection System has been installed and housekeeping have been instructed on it's use in an effort to eliminate the possibility of contaminated waste leaving the hospital premises.

The second incident involved improper disposal of contaminated material. A contaminated adult diaper (technetium-99m) was placed in routine trash pickup. It was detected at a nonradioactive landfill and was retrieved by trained personnel.

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- Action taken:
- A. Housekeeping and Security personnel were trained to recognise unusual occurrence.
 - B. Trained personnel were dispatched to retrieve the material (Health Physicist and Hospital Safety Director).
 - C. The Bicron System was installed subsequently to avoid further occurrences.
 - D. A holding area has been established for short term storage (48 hours) of rejected trash failing to pass through the monitoring device. The trash is rechecked no later than 48 hours after storage.

As noted in the report submitted by Inspector Toye Simmons, the trash in question is from the patient floors, not from the Nuclear Medicine Department. Contaminated items generated in the Nuclear Medicine Department are stored and monitored prior to disposal.

We feel that as of December 1, 1992, we are in full compliance.

Sincerely,

Jack Nichols, Vice President
Hospital Services