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November 1, 1996

EA 96-445

Mr. Donald Babb, CEO
Citizens Memorial Hospital
1500 N. Oakland - No. Hwy 83
Bolivar, MO 65613

SUBJECT: NRC INSPECTION REPORT NO. 030-18261/96001(DNMS) AND INVESTIGATION REPORT NO. 3-96-017

Dear Mr. Babb:

This refers to the inspection conducted on April 10-11, 1996, with continuing NRC review through June 27, 1996, at Citizens Memorial Hospital, Bolivar, Missouri. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the findings were discussed with you and those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

This also refers to an investigation conducted by the NRC Office of Investigations (OI) to determine if your Radiation Safety Officer (RSO) and Nuclear Medicine Technologist (NMT) deliberately violated NRC requirements pertaining to radiation safety committee meetings, annual radiation safety program reviews, linearity tests of the dose calibrator, annual refresher training to supervised individuals, wearing of dosimetry, performance of the duties of RSO, and accuracy of records. A synopsis of the results of the investigation is enclosed.

Based on the results of the inspection and investigation, nine apparent violations were identified and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995). These apparent violations pertain to the failure to check each dose calibrator for constancy at the beginning of each day of use, failure to perform quarterly linearity tests on the dose calibrator, failure to perform surveys with a radiation detection survey instrument at the end of each day of use in all areas where radiopharmaceuticals were routinely prepared for use or administered, failure to wear and use individual monitoring devices, failure to monitor the external surfaces of a package labeled with a Radioactive White I, Yellow II, or Yellow III label for radioactive contamination, failure to instruct individuals in the purposes and functions of protective devices employed, failure of the Radiation Safety Committee to

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conduct quarterly meetings, failure of the Radiation Safety Officer to ensure that radiation safety activities were being performed in accordance with approved procedures, and failure to perform surveys for removable contamination once each week all areas where radiopharmaceuticals are routinely prepared for use or administered (repeat apparent violation from the prior inspection). These apparent violations are of significant concern not only because they collectively are indicative of a programmatic breakdown of licensed activities, but also because five of them appear to be willful in nature. OI determined that the apparent violations involving failure to perform linearity tests and failure to wear required dosimetry were caused by your Nuclear Medicine Technologist, who was knowledgeable of your facility's NRC-licensed requirements regarding these items, but deliberately violated those requirements. Additionally, OI determined that the apparent violations involving the failure to provide annual refresher training, failure to conduct RSC meetings, and failure to ensure that radiation safety activities were being performed in accordance with approved procedures were caused by your RSO, who was knowledgeable of your facility's NRC-licensed requirements, but deliberately violated those requirements.

The apparent violations are described in the enclosed report and will be discussed with your staff in a transcribed predecisional enforcement conference. Consequently, a Notice of Violation is not presently being issued for these inspection findings. The number and characterization of the apparent violations may change as a result of further NRC review.

The transcribed predecisional enforcement conference has been scheduled for November 14, 1996, at 12:00 p.m. in the Region III office, 801 Warrenville Road, Lisle, Illinois. The decision to hold an enforcement conference does not mean that the NRC has determined that a apparent violation has occurred or that enforcement action will be taken. The purposes of this conference are to discuss the apparent violations, their causes and safety significance; to provide you the opportunity to point out any errors in our inspection report; and to provide an opportunity for your staff to present your proposed corrective actions. In particular, we expect you to bring with you the consultant audit reports performed in 1994 and 1995, and to address specific actions being performed to ensure that licensed activities, if allowed to resume, will be conducted in full compliance with all NRC requirements and license commitments. These are the same issues for which a meeting was to be held between us in response to the fourth item in the NRC's Confirmatory Action Letter dated April 12, 1996. In addition, this is an opportunity for you to provide any information concerning your perspectives on: (1) the severity of the apparent violations, (2) the application of the factors that the NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.B.2 of the Enforcement Policy, and (3) any other application of the Enforcement Policy to this case, including the exercise of discretion in accordance with Section VII. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding these apparent violations is required at this time.

Because apparent violations were identified as willful on the part of your RSO and Nuclear Medicine Technologist, these two individuals are required to be present at this conference.

To assist you in preparing for the predecisional enforcement conference, we are enclosing a copy of the NRC Enforcement Policy and an Information Notice which provides guidance on the development and implementation of corrective actions.

Please contact Mr. Monte P. Phillips at telephone number (630) 829-9806 if you have any questions.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and enclosures 1 and 2 will be placed in the NRC Public Document Room.

Sincerely,

Original Signed by Roy J. Caniano

Cynthia D. Pederson, Director
Division of Nuclear Materials Safety

License No. 24-20330-01
Docket No. 030-18261

Enclosures:
1. Inspection Report No. 030-18261/96001(DNMS)
2. OI Synopsis
3. Information Notice 96-28
4. Enforcement Policy (NUREG-1600)

bcc w/encls 1 and 2: J. Goldberg, OGC
D. Cool, NMSS
Office of Enforcement
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