UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

December 18, 1996

EA 96-504

Joseph J. Feretti, Ph.D.
Senior Vice President and Provost
University of Oklahoma Health Sciences Center
P.O. Box 26901
Oklahoma City, OK 73190

SUBJECT: UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER (OUHSC)
MEMORANDUM DATED AUGUST 19, 1996

Dear Dr. Feretti:

This letter refers to an internal OUHSC memorandum dated August 19, 1996, (copy enclosed) provided to an NRC inspector on September 6, 1996, during the course of an inspection and investigation of waste handling and transportation activities at OUHSC.

According to the memorandum, a nuclear pharmacy driver failed to secure licensed materials in a delivery vehicle before leaving the vehicle unattended. This failure was identified by your radiation safety officer (RSO) and the University's assistant chief of campus police and public safety while they were conducting an unannounced audit of radiopharmaceutical deliveries. The audits are part of your corrective actions implemented in response to a Notice of Violation (Notice) issued by the NRC June 17, 1996. Since the driver's failure to secure licensed materials was identified during an audit, your RSO was able to provide surveillance over the material after the driver left the vehicle unattended, and the RSO secured the material before he left the area.

We have reviewed the additional corrective actions discussed in your memorandum and find them responsive to the concerns expressed by the NRC in the Notice dated June 17, 1996. Therefore, no response to this letter is required. Further, based on the disciplinary actions you have already taken against the driver who failed to secure the licensed materials, the NRC is not pursuing enforcement action against him at this time.

Should you have any questions concerning this correspondence, please contact William H. Radcliffe at (817) 860-8151 or Linda L. Howell at (817) 860-8213.

Sincerely,

Ross A. Scarano, Director
Division of Nuclear Materials Safety

Docket No.: 30-12750
License No.: 35-03176-04MD

Enclosure: University of Oklahoma Health Sciences Center
Memorandum dated August 19, 1996.

cc without enclosure: Oklahoma Radiation Control Program

bcc w/enclosure to DMB (IE07)

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ENCLOSURE

The University of Oklahoma

Health Sciences Center

RADIATION SAFETY OFFICE

MEMORANDUM

TO: Joseph J. Ferretti, Ph.D.
Senior Vice President and Provost

THROUGH: Tom Godkins, M.P.H. TGH
Assistant Vice President

FROM: Subhash Danak, M.S., D.A.B.R.
Radiation Safety Officer

DATE: August 19, 1996

SUBJECT: NRC Violation

Pursuant to our reply to the last NRC violation, I am reporting a significant violation which occurred on August 12, 1996. Major Welch, Assistant Chief of Campus Police and Public Safety, and I observed a Nuclear Pharmacy driver leave radiopharmaceutical dosages unsecured in the public domain at St. Anthony Hospital on August 12, 1996 (see attached report). Obviously, this is a disappointment. This violation will be reported to the RSC for review. The NRC staff will review it during their next unannounced inspection.

I am also reviewing two recent non-reportable misadministrations at Children's Hospital of Oklahoma due to an error made in our Nuclear Pharmacy by a staff pharmacist. The report will be forwarded to you after the Radiation Safety Committee has reviewed it at the September 1996 meeting.

/lsv

Attachment

Self-Identified Violation
University of Oklahoma Health Sciences Center
Nuclear Pharmacy

VIOLATION:

On August 12, 1996 at 6:50 a.m., a Nuclear Pharmacy employee did not secure from unauthorized removal or maintain constant surveillance of licensed material, i.e., radiopharmaceuticals, in an unrestricted area. The Assistant Chief of OUHSC Campus Police and Public Safety and the Campus RSO observed a Nuclear Pharmacy driver leave radiopharmaceuticals in ammo boxes unattended in an unlocked vehicle (i.e., unlocked bed cover or ammo box container) at St. Anthony Hospital. Title 10, Code of Federal Regulations, Part 20.1801 requires that a "licensee secure from unauthorized removal or access licensed materials that are stored in controlled or unrestricted areas." Also, Part 20.1802 requires that a "licensee control and maintain constant surveillance of licensed material that is in a controlled or unrestricted area and not in storage."

DISCUSSION:

The Assistant Chief of Campus Police and Public Safety and the OUHSC RSO conducted an "unannounced inspection" of Nuclear Pharmacy Vehicle, P-238, licensee #1-15231, a Chevrolet truck, at St. Anthony Hospital on August 12, 1996, at 6:50 a.m. This inspection was performed in accordance with "Corrective Actions that will be taken to Avoid Further Violations" included in the "Reply to a Notice of Violation" submitted to the Nuclear Regulatory Commission on July 12, 1996. The corrective action included unannounced inspections of Nuclear Pharmacy vehicles by the OUHSC RSO and a representative of the Campus Police Department at area hospitals and clinics to ensure that radioactive materials are not left unattended while in the public domain.

The Assistant Chief agreed to notify the Director of Nuclear Pharmacy prior to inspections, at a meeting held at Site Support on June 27, 1996. At that meeting, the Assistant Vice President, OUHSC RSO, Director of Nuclear Pharmacy, and the Interim Dean of the College of Pharmacy strongly supported the concept of unannounced inspections, and it was agreed that the Director of Nuclear Pharmacy would be forewarned of these inspections.

The Assistant Chief and OUHSC RSO met at the Radiation Safety Office at 6:20 a.m. on August 12, 1996, and drove to St. Anthony Hospital in an unmarked vehicle and parked the vehicle on the street in front of the hospital. About 6:45 a.m. the Nuclear Pharmacy vehicle drove to the front door of the hospital. The driver was observed locking the front door of the vehicle. The bed cover and ammo box container could not be observed directly and therefore, the Assistant Chief and RSO went to the vehicle after the driver removed the ammo box for delivery to the Nuclear Medicine Department. The following observations were made:

1. The bed cover was not locked and was easily opened by the Assistant Chief.

2. The Assistant Chief also observed that the lock for the ammo box(es) container was on the floor.

3. The Assistant Chief was able to open the ammo box container easily and observed several ammo boxes containing radiopharmaceuticals present. The RSO also observed the presence of ammo boxes in the wooden container. The Assistant Chief locked the container and secured the radiopharmaceuticals in the vehicle.

The Assistant Chief and RSO left St. Anthony Hospital after securing the radiopharmaceuticals in the vehicle.

The RSO interviewed the Director of Nuclear Pharmacy at 2:00 p.m.. He indicated that the driver told him that he forgot to lock the ammo boxes container or the bed cover of the vehicle. Also, the RSO was informed that the driver resigned after being given the choice to do so or be terminated. The Director indicated that, according to his secretary, the driver indicated that he knew he was to be dismissed for failure to lock the vehicle.

The RSO was also provided with the shipping papers from the hospitals and clinics where the driver had delivered radiopharmaceutical dosages. The RSO noted that the driver delivered to St. Anthony Hospital, Cardiac Imaging Center, Inc., Hillcrest Health Center, Southwest Medical Center, and Shawnee Regional Hospital, in that order. This indicated that when the Nuclear Pharmacy vehicle was inspected by the Assistant Chief and RSO at St. Anthony Hospital, it contained the following radiopharmaceuticals with the respective radioactivities:

Tc-99m	499.25 mCi
Tl-201	16.98 mCi
I-123	0.30 mCi

The RSO met with the Interim Dean of the College of Pharmacy, Assistant Vice President, Assistant Dean of the College of Pharmacy, and the Director of Nuclear Pharmacy at 1:00 p.m. on August 13, 1996. The summary of this discussion is as follows:

1. The Dean of the College of Pharmacy and the Director of Nuclear Pharmacy had a meeting with all Nuclear Pharmacy employees at 12:00 noon. The importance of NRC regulations and license conditions were reviewed, and it was reinforced that disciplinary action will be taken against individual(s) responsible for the violations. It was also reiterated to all Nuclear Pharmacy employees that any violation of the NRC regulations and license conditions are not tolerated and any employee who willfully violates an NRC regulation will be summarily terminated.

2. The Interim Assistant Dean recommended improved locks on each Nuclear Pharmacy vehicle.

3. The RSO indicated that Nuclear Pharmacy has a model radiation safety program, however, the day-to-day details of compliance with the NRC regulations and license conditions need to be attended to meticulously. The recent fine and this repeat violation indicate the need for constant reinforcement.

4. The Dean and the Assistant Vice President directed the RSO to interview the driver by phone, even though he was no longer an employee of the University.

The RSO contacted the driver at home and the investigative findings were as follows:

1. The driver discovered that the ammo box container was locked when he returned from the delivery at the Nuclear Medicine Department of St. Anthony Hospital, and believed it was locked by the NRC.

2. He concluded his route and returned to the Nuclear Pharmacy at 9:00 a.m.

3. He indicated that he just forgot to lock the bed cover (usually he locked the bed cover and not the ammo box). He was on vacation for a week, and it was his first day back at work following his vacation.

4. He stated that he was not aware of this type of internal surveillance, however, he also indicated that the other drivers knew about the possibility of such unannounced inspections. He believed that his vehicle was being inspected by NRC officers.

5. The Director of Nuclear Pharmacy gave him two options, either he could resign or be dismissed. Therefore, he resigned.

ROOT CAUSE OF THE VIOLATION:

The Nuclear Pharmacy driver did not fulfill his responsibility of securing radiopharmaceuticals in the public domain at St. Anthony Hospital.

CORRECTIVE ACTION:

Significant corrective action was taken by the Director of Nuclear Pharmacy to assure the security of radiopharmaceuticals in the public domain. The Nuclear Pharmacy driver responsible for the violation is no longer employed at Nuclear Pharmacy.

The Interim Dean and the Director of Nuclear Pharmacy informed the Nuclear Pharmacy staff on August 13, 1996 that any violation of the NRC regulations and/or license conditions will result in severe disciplinary action toward the responsible individual. Details of each regulatory requirement must be met meticulously.

FOLLOW-UP ON CORRECTIVE ACTION:

The Assistant Chief of Campus Police and Public Safety and the OUHSC RSO will continue to conduct unannounced inspections of the Nuclear Pharmacy vehicles in the public domain. The Nuclear Pharmacy will continue to reinforce NRC regulations.

RECOMMENDATION TO THE RSC AND ADMINISTRATION:

The approval of this Self-identified Violation and the actions taken is recommended.

Attachments

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