21-26266-01
030-32015

DCD

South Haven SHCH Community Hospital

May 13, 1996

UNITED STATES NUCLEAR REGULATORY COMMISSION
Region III, Medical Licensing Section
801 Warrenville Road
Lisle IL 60532

ATTN: Cynthia D. Pederson, Director
Division of Nuclear Materials Safety

RE: Response to an Apparent Violation; NRC Investigation
Report No. 3-95-025

The purpose of this letter is to respond to your letter dated April 16, 1996 regarding the alleged violations of South Haven Community Hospital's NRC license by a nuclear medicine technologist who was disciplined by removing him from licensed activities. The undersigned is responding in his capacity as CEO of South Haven Community Hospital.

VIOLATION 1

Reason: The nuclear medicine technologist reportedly requested and received delivery of the radiopharmaceuticals at an address not authorized for receipt by our license even though he knew that deliveries were only allowed to our address. He did not discuss this with any South Haven Community Hospital personnel before proceeding.

Corrective Steps: Immediately after the first occurrence on April 7, 1994, the technologist was reminded of the only allowed location of receipt (i.e., our address). A "self identified NRC license violation" form was completed which stated the license violation to be delivery of radioactive materials to an unlicensed address. Kipp Rustenholtz, the technologist responsible for the delivery signed this form.

Immediately after the second reported violation in February, 1995, the Radiation Safety Committee voted to disallow this technologist's privileges of working under our NRC license. The technologist was immediately dismissed and never again involved in the use of radioactive material at our facility or under our NRC license.

1/0

MAY 15 1996

IE07

955 South Bailey Avenue • South Haven, Michigan 49090-9797 • (616) 637-5271

Kate Otto, RT-N, Nuclear Medicine Technologist at South Haven Community Hospital also contacted Kathi Benson, Manager of Syncor, the radiopharmaceutical supplier, located in Grand Rapids and questioned why Syncor had delivered radioactive materials to a location other than South Haven Community Hospital and yet listed South Haven Community Hospital as the recipient. Kate Otto reminded Kathi Benson that the South Haven Community Hospital address is the only address listed on the license for receipt of radioactive materials. Kate Otto then instructed Kathi Benson that Syncor is not authorized to make any further deliveries of radioactive material listing our license as the recipient unless it is delivered to South Haven Community Hospital's address.

Corrective Steps to Avoid Further Violations:

This alleged violation resulted from one technologist's refusal to follow the instructions of South Haven Community Hospital personnel, NRC license conditions and written policies. When it became apparent to our personnel that this individual was purposefully ignoring instructions, he was dismissed from our Hospital. We believe that this behavior reflects solely on the technologist and his attitude. At no point was this activity encouraged or condoned by the staff of South Haven Community Hospital. Kate Otto, RT-N, has instructed Kathi Benson, the manager of Syncor, Grand Rapids, that Syncor is not authorized to make deliveries of radioactive material listing our NRC license as the recipient unless it is delivered to South Haven Community Hospital's address.

Date when full compliance was achieved: February 20, 1995.

VIOLATION 2

Reason:

The dosages in the deliveries mentioned in Violation 1 were not assayed in a dose calibrator as required, because the dosages reportedly were not received at South Haven Community Hospital where the dose calibrator is located.

Corrective Steps:

The technologist was instructed to only receive radioactive materials at the licensed address where the dose calibrator is located and to utilize this dose calibrator to assay all doses before transporting them to remote sites. When we learned that he may not have done so he was immediately dismissed.

Corrective Steps to Avoid further Violations:

This alleged violation resulted from one technologist's apparent refusal to follow the instructions of South Haven Community Hospital personnel, NRC license conditions and written policies. When it became apparent to our personnel that this individual was purposefully ignoring instructions, he was immediately dismissed from our hospital. We believe that this behavior reflects solely on the technologist and his attitude. At no point was this activity encouraged or condoned by the staff of South Haven Community Hospital.

Date when full compliance was achieved: February 20, 1995

VIOLATION 3

Reason:

The technologist reportedly recorded a calculated value based on the assay indicated by the radiopharmaceutical supplier not a measured value because the dosages were not assayed in the dose calibrator at South Haven Community Hospital.

Corrective Steps:

The technologist was instructed to only receive radioactive materials at the licensed address where the dose calibrator is located and to utilize this dose calibrator to assay all doses before transporting them to remote sites. When we learned that he may not have done so, he was immediately dismissed.

Corrective Steps to Avoid further Violations:

This alleged violation resulted from the technologist's refusal to follow the instructions of South Haven Community Hospital personnel, NRC license conditions and written policies. When it became apparent to our personnel that this individual was purposefully ignoring instructions, he was immediately dismissed from our Hospital. We believe that this behavior results solely on the technologist and his attitude. At no point was this activity encouraged or condoned by the staff of South Haven Community Hospital.

Date when full compliance was achieved: February 20, 1995

VIOLATION 4

Reason:

It appears that the technologist recorded a value as a measured value when, in fact, it was not measured as required.

Corrective Steps: The technologist was immediately dismissed and is no longer allowed to work at South Haven Community Hospital.

Corrective Steps to Avoid further Violations: This alleged violation resulted from the technologist's refusal to follow instructions of South Haven Community Hospital personnel, NRC license conditions and written policies. When it became apparent to our personnel that this individual was purposefully ignoring instructions, he was immediately dismissed from our Hospital. We believe that this behavior reflects solely on the technologist and his attitude. At no point was this activity encouraged or condoned by the staff of South Haven Community Hospital.

Date full compliance was achieved: February 20, 1995

All due diligence will be devoted to the prevention of further occurrences of this nature as we no longer participate in the routine transportation of radioactive materials to remote sites per a memo dated April 10, 1995 to the Radiation Safety Committee. In addition, Kate Otto, RT-N, the only technologist authorized to transport radioactive materials under our NRC license participates in periodic instruction of NRC license conditions as provided by our physicist from Medical Physics Consultants, Inc.

If you have any further questions regarding the corrective steps we have taken, please contact James Hoffman, RT (R), Director of Radiologic services, or myself.

Sincerely,

Craig J. Marks

Craig J. Marks
President/CEO

CJM:bb
May96/1

JULIA QUINN
Notary Public VanBuren Cty., MI
My Comm. Expires June 1, 2000
Julia Quinn
5-13-96