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> NRC STAFF CITES WASHINGTON HOSPITAL CENTER FOR ALLEGED VIOLATIONS, PROPOSES \$5,000 FINE

The Nuclear Regulatory Commission staff has proposed a \$5,000 civil penalty against Washington Hospital Center in Washington, D.C., for five alleged violations of agency requirements in its use of radioactive materials for medical services.

The errors were found during an NRC inspection conducted September 17 through 26 of last year and a subsequent investigation by the NRC Office of Investigations.

Two of the alleged violations involve multiple instances of failure to perform required thyroid bioassays, or exposure measurements, on employees, as well as a failure to provide adequate training in this area. The other three violations pertain to the loss of an iodine-125 seed; failure to perform an adequate survey in an attempt to recover the missing material; and failure to notify the NRC of the loss of the material.

In the case of the bioassay violations, the NRC determined a number of hospital staffers failed to measure their thyroid exposure within 72 hours of administration of iodine-131 to patients, even though the facility's radiation safety officer (RSO) reminded them to do so. More importantly, the RSO and Radiation Safety Committee chairman were aware of the problem but apparently failed to recognize its significance; did not raise the issue in a committee meeting or to upper management; and did not take effective corrective action to prevent a recurrence. The performance of bioassays is important because individuals involved in the preparation and administration of iodine-131 doses can receive a significant uptake of the radioactive material. Minus a bioassay, any unsafe levels of exposure could go undetected.

"Collectively, the two violations are of significant regulatory concern because they are indicative of a lack of management attention towards licensed responsibilities," Region 1 Administrator Hubert J. Miller wrote to Washington Hospital Center. Regarding the iodine-125 seed, the NRC has expressed concern about the potential safety consequences of the loss of licensed material. The seed that could have delivered a significant radiation dose if it had come into contact with an individual's skin. What's more, the NRC has expressed concern that, due to an apparent lack of understanding of the requirements, the loss of the seed had not been reported to the agency as of January 31, even after the NRC informed the hospital it had to be reported.

The hospital has 30 days to pay the proposed fine or request in writing that all or part of the penalty be withdrawn.

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