

U.S. Nuclear Regulatory Commission  
Office of Public Affairs, Region IV  
611 Ryan Plaza Drive - Suite 400  
Arlington, Texas 76011-8064

RIV: 98-18  
CONTACT: Breck Henderson  
OFFICE: 817/860-8128  
PAGER: (800) 443-7243 (065477)

FOR IMMEDIATE RELEASE  
April 28, 1998

**NRC PROPOSES TO FINE WOOD RIVER MEDICAL CENTER \$2,750  
FOR VIOLATIONS IN ITS NUCLEAR MEDICINE PROGRAM**

The Nuclear Regulatory Commission staff has proposed a \$2,750 civil penalty against Wood River Medical Center of Sun Valley, Idaho, for numerous violations of NRC requirements in its nuclear medicine program.

NRC is taking this action as the result of findings from an inspection conducted last November 4-December 30; an investigation that was completed on February 23; and information provided by the medical center before the inspection and during an enforcement conference held February 6 at the NRC Region IV office in Arlington, Texas.

NRC's inspection and investigation confirmed that a technician deliberately falsified required radiation surveys. The civil penalty is based on this violation and 20 other instances of noncompliance with NRC administrative, monitoring, training and record-keeping requirements. Wood River also was cited for another procedural violation, but a fine was not proposed.

The NRC has determined that none of these safety violations resulted in a radiation exposure to hospital staff or patients. In his letter informing Wood River of the civil penalty, NRC Regional Administrator Ellis Merschoff noted that the violations were discovered after a former medical center technologist, on his own initiative, told hospital management that he had prepared inaccurate records of radiation surveys never performed. The medical center then contracted with a consultant to review its nuclear medicine program, informed the NRC of the reported records falsification, and later reported the consultant's findings to the agency. Although the consultant did not find every violation, Mr. Merschoff said, he identified the more significant ones.

Mr. Merschoff pointed out that a lack of oversight by the radiation safety

officer and hospital administration contributed to the willful falsification of records. NRC investigators determined that the former employee involved had never been formally trained as a nuclear medicine technologist. The individual also said he was working up to 200 hours during a two-week pay period and did not fully understand many of the tasks he was assigned.

“These violations clearly indicate a deterioration of your radiation safety program,” Mr. Merschhoff wrote. He added that training and program reviews scheduled after an NRC inspection in 1993 proved ineffective in ensuring lasting corrective actions for violations observed at that time because of a similar lack of oversight. The regional administrator said NRC decided to propose a fine because of “the lack of oversight...over a period of several years and the pervasiveness of the breakdown in your radiation safety program.”

The hospital must respond to the Notice of Violation in writing within 30 days. The response must document specify actions taken to prevent recurrence of the violations. During this time the company may pay the fine or file a protest.

###