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I-97-109 August 22, 1997
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NRC STAFF PROPOSES $2,750 FINE FOR VIOLATIONS AT OVERLOOK HOSPITAL

The Nuclear Regulatory Commission staff has cited Overlook Hospital in Summit, N.J. for two violations of NRC requirements. The staff has proposed a $2,750 fine.

An NRC inspection was conducted at the hospital on May 7, to review the circumstances surrounding a misadministration of iodine-131 (I-131) to a patient at the facility two days earlier. A patient was administered approximately 7 millicuries of iodine-131 rather than the intended dose of approximately 2 millicuries. (A misadministration occurs when the administered dosage differs from the prescribed dosage by more than 20 percent.)

Based on the information developed during the inspection, as well as information provided during a predecisional enforcement conference on July 16, two violations are being cited. Those violations are: failure to prepare a written directive prior to administration of a radiopharmaceutical and failure to provide adequate supervision over licensed activities.

In a letter to the hospital, Region I Adminstrator Hubert J. Miller said, “Along with the concern that there was a misadministration, the NRC is concerned that the required written directive was not completed, as required, prior to the administration of I-131. This failure to complete the directive was a contributing factor to the misadministration.”

Mr. Miller added that it was also clear during the inspection that the technologist was not sufficiently familiar with the hospital’s quality management program because he did not know the correct definition of a misadministration. (NRC requires that hospitals have a quality management program to provide high confidence that byproduct material will be administered as directed by the authorized user physician.) “Clearly, the level of supervision provided by the authorized users over licensed activities, including the supervision of the technologist, was inadequate,” Mr. Miller wrote.

The regional administrator also said this misadministration takes on “added significance because your facility has experienced two prior misadministrations of iodine-131 for whole body scans in 1990 and 1991.”

Mr. Miller recognized that the hospital has taken a number of steps to correct the violations and prevent recurrence, including retraining all authorized users and nuclear medicine technologists in quality management plan requirements; developing a competency examination for all authorized users and technologists, with a stipulation that no individuals use NRC material until the examination is passed; and developing specific sanctions for failure to comply with the quality management plan.

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

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