SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED:
   West Virginia University Hospital, Inc.
   Medical Center Drive
   Morgantown, WV 26506-9006

   REPORT NUMBER(S) 2018001

2. NRC/REGIONAL OFFICE
   U.S. Nuclear Regulatory Commission
   Region I, 2100 Renaissance Blvd, Suite 100
   King of Prussia, Pennsylvania 19406-2713

3. DOCKET NUMBER(S) 030-20233
4. LICENSE NUMBER(S) 47-23066-02
5. DATE(S) OF INSPECTION 11-6 to 8-2018; 12-14-18

The inspection was an examination of the activities conducted under your license as they relate to radiation safety and to compliance with the Nuclear Regulatory Commission (NRC) rules and regulations and the conditions of your license. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observations by the inspector. The inspection findings are as follows:

☐ 1. Based on the inspection findings, no violations were identified.
☒ 2. Previous violation(s) closed.
☒ 3. The violation(s), specifically described to you by the inspector as non-cited violations, are not being cited because they were self-identified, non-repetitive, and corrective action was or is being taken, and the remaining criteria in the NRC Enforcement Policy, to exercise discretion, were satisfied.

Non-cited violation(s) were discussed involving the following requirement(s) and corrective action(s):

2. 10 CFR 35.40(a) - written directive (WD) not signed by an authorized user (AU) before the administration of I-131 sodium iodide greater than 30 microcuries on July 31, 2017. The licensee identified on August 10, 2017, that the physician who signed the WD for a hyperthyroid treatment had not been approved for this use. Subsequently, the licensee approved the physician as an AU and confirmed with a current AU that the administration was appropriate. The licensee retrained all physicians on WD requirements.

4. 10 CFR 20.1801 – On November 8, 2016, the licensee’s staff did not secure from unauthorized removal or access licensed materials that were stored in the pathology lab, a controlled area. Specifically, a single seed containing 241 microcuries of I-125 (less than 1000x App. C, Part 20) was noted as missing from the inventory of sources on January 8, 2017, and was likely disposed of to the normal trash. The licensee retrained all pathology staff on surveys and storage of seeds and implemented new checks by radiation safety.

☒ 4. During this inspection, certain of your activities, as described below and/or attached, were in violation of NRC requirements and are being cited in accordance with the NRC Enforcement Policy. This form is a NOTICE OF VIOLATION, which may be subject to posting in accordance with 10 CFR 19.11. (Violations and Corrective Actions)

See Part 2

Statement of Corrective Actions

I hereby state that, within 30 days, the actions described by me to the Inspector will be taken to correct the violations identified. This statement of corrective actions is made in accordance with the requirements of 10 CFR 2.201 (corrective steps already taken, corrective steps which will be taken, date when full compliance will be achieved). I understand that no further written response to NRC will be required, unless specifically requested.

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<tr>
<th>Title</th>
<th>Printed Name</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>LICENSEE’S REPRESENTATIVE</td>
<td>Stephen L. Marcia</td>
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<td>12/15/18</td>
</tr>
<tr>
<td>NRC INSPECTOR</td>
<td>Penny Lanzinera</td>
<td></td>
<td>12-14-18</td>
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<tr>
<td>BRANCH CHIEF</td>
<td>Donna Janda</td>
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*NRC FORM 591M PART 1 (07-2012) (RI Rev. 09/12/2013) G:\WBL Documents\WBL Inspection Records\R47-23066-02.2018-001.591M-Part1.doc

SUNSI Review Completed By: /RA/ PL x Public x Non-Sensitive

This document becomes an NRC Official Agency Record once it is signed by the Branch Chief
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(Continued)

10 CFR 35.633(b)(5) requires, in part, that a licensee authorized to use a remote afterloader unit for medical use shall perform full calibration measurements on each unit to include timer accuracy and linearity over the typical range of use.

Contrary to the above, as of November 6, 2018, the licensee was authorized to use a remote afterloader unit for medical use and did not perform full calibration measurements on the unit to include timer accuracy and linearity over the typical range of use. Specifically, the timer linearity was performed from zero to 5 minutes; however, the typical range of use was zero to 15 minutes.

This is a Severity Level IV violation (Section 6.3)

The licensee performed the linearity from zero to 15 minutes on November 8, 2018 and retrained all staff on requirements.