



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
WASHINGTON, D.C. 20555-0001

September 2, 2026

Nathan Burt, Vice President of Operations
West Virginia University Hospitals, Inc.
P.O. Box 9006
Morgantown, WV 26506

SUBJECT: WEST VIRGINIA UNIVERSITY HOSPITALS, INC. - NRC INSPECTION
NO. 030-20233/2026-003

Dear Nathan Burt:

This letter refers to your July 29, 2026, correspondence (Agencywide Documents Access and Management System (ADAMS) Accession No. [ML26212A429](#)), in response to our letter dated July 8, 2026 (ADAMS Accession No. [ML26182A047](#)). Thank you for informing us of the corrective and preventive actions documented in your letter. These actions will be examined during a future inspection of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

**MONICA
FORD**

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MONICA FORD
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Monica Ford, Branch Chief
Inspection and Licensing Branch - East
Division of Federal Materials Programs
Office of Nuclear Material Safety & Safeguards

Docket No. 030-20233
License No. 47-23066-02

cc:

Steven I. Root, Radiation Safety Officer
Kristen Daft, Associate Radiation Safety Officer
State of West Virginia

July 29, 2026

ATTN: Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Subject: West Virginia University Hospitals, Inc. – NRC Inspection
No. 030-20233/2026-003
Reply to a Notice of Violation

To whom it may concern:

This letter serves as the “reply to a notice of violation” to two severity IV violations discovered during NRC inspections at West Virginia University Hospitals, Inc. (license # 47-23066-02 conducted on March 3, 17, and April 14-16, 2026.

The following addresses the violation received in the notice of violation under letter A regarding 10 CFR 35.27(a)(2) requiring that a supervised individual follow the instruction of the supervising authorized user, written radiation protection procedures, NRC regulations and license conditions for medical uses of byproduct material.

1. Reason for the violation: The violation was caused by human error. In the case where the technologist administered the wrong radiopharmaceutical, the technologist failed to confirm that they had the correct prescribed radiopharmaceutical. In the case where the technologist administered the radiopharmaceutical to the wrong patient, the technologist failed to confirm the correct patient prior to administration of the radiopharmaceutical.
2. Corrective steps that have been taken and the results achieved: PET/CT technologists are now required to print the physician’s order from the hospital’s patient management system and bring the order to the injection room to verify correct patient, exam, and radiopharmaceutical. All PET/CT staff were educated on the updated patient/exam identification process. Nuclear Cardiology’s patient identification policy was updated to include the following standardized steps: 1. The technologist must carry the physical order/requisition to the waiting room; and 2. The technologist will ask the patient to state their full name and date of birth, comparing it to the order/requisition to verify patient identity prior to entering the

department. All Nuclear Cardiology technologists were educated on the updated patient identification policy. In addition, a facility wide radiopharmaceutical administration protocol was created to provide guidance for the administration of radiopharmaceuticals in accordance with physician orders, manufacturer recommendations, regulatory requirements, and institutional standards. This protocol promotes the safe and effective use of radiopharmaceuticals by ensuring appropriate patient identification, exam verification, dose verification, appropriate administration, proper documentation, radiation safety practices, and monitoring to optimize patient care and minimize radiation exposure. This protocol standardizes the process of radiopharmaceutical administration across all areas of use to ensure patient safety, regulatory compliance, and diagnostic or therapeutic accuracy.

3. Corrective steps that will be taken to avoid further violations: Periodic meetings will be scheduled to ensure full transparency regarding radiation safety events across all radiopharmaceutical administration areas. During these meetings, we will review recent incidents, track safety metrics, and discuss any corrective actions needed to maintain compliance and protect staff and patients.
4. The date full compliance will be achieved: Full compliance has already been achieved.

The following addresses the violation received in the notice of violation under letter B regarding 10 CFR 35.63(d) requiring that unless otherwise directed by the authorized user, a licensee may not use a dosage if the dosage does not fall within the prescribed dosage range or if the dosage differs from the prescribed range by more than 20 percent.

1. Reason for the violation: The violation was caused by a misinterpretation of the dosage limits. The technologists assumed that the prescribed dose range included an extra 20 percent buffer on each end of the range.
2. Corrective steps that have been taken and the results achieved: Nuclear Medicine management reviewed all radiopharmaceutical doses with the Authorized User. A radiopharmaceutical dosages guideline document was created to serve as a reference for technologists to determine the appropriate administration activity for each type of exam. The guideline includes prescribed dose ranges or prescribed doses (+/- 20%) for each type of exam, which were reviewed and approved by the Authorized User. The guideline also states that if the dose amount is outside +/- 20 percent of the prescribed dose or outside of the prescribed dose range, then the technologist must consult the Authorized User for approval prior to administration. The dosage guidelines have been discussed with Nuclear Medicine staff, and a copy of the guidelines is posted in the hot lab for the technologist's reference.

3. Corrective steps that will be taken to avoid further violations: Nuclear Medicine radiopharmaceutical dosages will be reviewed annually by the Authorized User. All imaging protocols will be reviewed annually by the technologists. To ensure facility wide compliance and prevent future violations, the PET/CT and Nuclear Cardiology areas also updated their dosage guidelines to include verbiage similar to the Nuclear Medicine dosage guideline. These dosage guidelines were communicated to technologists during staff meetings.
4. The date full compliance will be achieved: Full compliance has already been achieved.

If any additional information is needed, please contact Stephen Root at 304-293-3413 or sroot@hsc.wvu.edu



Nathan Burt
Chief Operating Officer

CC: U.S. NRC Region1 Regional Administrator