

Notice of Violation (Corporation)

Date of notice: May 9, 2025 AMP number: 2025-AMP-03

Violation committed by:	Amount of penalty:
MyHealth Partners Inc.	\$ 15,820

Violation

Failure to implement a radiation protection program that keeps the effective dose and equivalent dose as low as reasonably achievable, taking into account social and economic factors, through the implementation of control of occupational and public exposure to radiation in violation of subparagraph 4(a)(iii) of the *Radiation Protection Regulations*.

Relevant facts

I, Karen Owen-Whitred, Director General of the Directorate of Nuclear Substance Regulation and designated officer authorized by the Canadian Nuclear Safety Commission (CNSC) to issue notices of violations, believe on reasonable grounds that MyHealth Partners Inc. committed the above violation. The facts relevant to the violation and the penalty calculation are as follows:

- The Radiation Protection Regulations, subparagraph 4(a)(iii), requires that a licensee must implement a radiation protection program that keeps the effective dose received by and committed to persons as low as reasonably achievable, taking into account social and economic factors, through control of occupational and public exposure to radiation.
- 2. Section 4.4 of REGDOC 2.7.1 provides guidance on radiation protection programs and the principles of worker dose control. This includes policies and procedures around engineered controls, such as shielding to limit radiation exposure, and the implementation of administrative controls like access controls, written safety policies, and training to ensure that protection is optimized.

Timeline:

3. MyHealth Partners Inc. operates 15 nuclear medicine clinics,14 of which are in Ontario. Their CNSC licence was amended on January 7, 2025 to add an additional location at Suite 250, 1016 68 Avenue SW in Calgary, Alberta. On January 15, 2025, this new location first received nuclear substances for injection into patients and started performing nuclear medicine procedures.





- 4. On February 25, 2025, the CNSC inspector performed an inspection of the licensee's Calgary location. The inspector identified several items of non-compliance which demonstrated that the licensee was not effectively controlling occupational and public exposure to radiation to keep doses as low as reasonably achievable. These findings are documented in Inspection Report DC-17320-JJ-250225-1 and summarized below.
- 5. CNSC inspectors conducted inspections of 6 other locations operated by this licensee in 2024. In 5 of those inspections, the licensee was cited for non-compliances related to contamination detection and proper calibration of instrumentation, which are related to the implementation of an effective radiation safety program. These non-compliances are documented in the following inspection reports:
 - DC-17320-JF-240201-1
 - DC-17320-DS-240517-1
 - DC-17320-MW-240924-1
 - DC-17320-JF-250115-1
 - DC-17320-JF-250115-2

Inspection findings:

Use of syringe shields

- 6. The CNSC inspector observed the Nuclear Medicine Technologist (NMT) on duty handle and administer a patient dose of Tc-99m without the use of a syringe shield. This NMT stated in discussion with the inspector and RSO that they do not use syringe shields for patient injections.
- 7. Syringe shields are a type of shielding routinely used in nuclear medicine to reduce the radiation exposure to workers handling radioactive medications. MyHealth Partners Inc.'s "Syringe Shield Policy", in their "Nuclear Medicine Policies + Procedures" (1st edition, February 2025) and confirmed to be in effect by the Corporate Radiation Safety Officer (CRSO) during the inspection, states that "it is expected that all nuclear medicine technologists will use syringe shields in their routine practice." This policy notes that syringe shields can decrease worker radiation dose by up to 99%.

Use of personal dosimeters

8. Whole body dosimetry is used to measure radiation dose to the whole body of an individual, particularly their internal organs. The licensee's "Policy on Dosimetry" from page 25 of the Radiation Safety Manual (RSM) and the CNSC Proper Care and Use of Personal Dosimeters poster, which was posted in the department, state that whole body dosimeters must be clipped firmly to clothing between the waist and neck. The inspector observed multiple workers wearing whole-body dosimeters mid-thigh. The inspector asked workers if they knew the correct place to wear a dosimeter and these workers were not aware of the correct place. By wearing the dosimeter incorrectly, the dose recorded by the dosimeter will not necessarily reflect the actual dose to the worker.







9. The NMT did not wear their extremity dosimeter until directly instructed to do so by the inspector during the inspection. Extremity dosimetry is used to measure radiation dose to the hands. This worker was not wearing extremity dosimetry, which is required by licensee procedures ("Policy on Dosimetry" – "Extremity Dosimeter" from the RSM) and stated that this was a common practice.

Personal contamination monitoring

- 10. The CNSC requires nuclear medicine workers to frequently monitor their hands for radioactive contamination. This requirement is described in the CNSC's Nuclear Medicine Procedures poster, which instructs workers to "wash hands regularly and monitor them for contamination frequently", as part of "safe work practices to be followed when working in this room." Copies of this poster were posted around the licensee's department in accordance with the requirements of their licence (licence condition 2570). The CRSO confirmed to the inspector during the inspection that licensee policy is for NMTs to perform personal contamination monitoring at minimum prior to all breaks and at the end of the day, and for results to be recorded.
- 11. The CNSC inspector identified radioactive contamination on the NMT's clothes and neck during the inspection, using CNSC contamination monitoring instrumentation. Based on dose estimates performed by the licensee's Radiation Safety Officer and a CNSC Radiation Protection Specialist, this skin contamination resulted in a radiation dose of as much as 334 mSv, which is 67% of the annual equivalent dose limit for a nuclear energy worker (500 mSv, *Radiation Protection Regulations*, Paragraph 14).
- 12. The NMT stated to the inspector and CRSO that they were not performing frequent personal contamination monitoring only performing monitoring at the end of the workday. The NMT also stated that Calgary staff were not recording the results of their personal contamination monitoring, and no record of monitoring was available. The NMT stated that they were not aware that this was a requirement, despite records of training being available for this worker.
- 13. When determining dose from a skin contamination, the total dose is directly related to the amount of time the contamination is on the skin. The longer the contamination is on the skin, the greater the dose. This is why workers must monitor for contamination frequently. The inspector discovered contamination at around 10:30am, partway through the worker's day. Had the worker only performed contamination monitoring at the end of their shift, the contamination would have stayed on the worker's neck for several more hours, at minimum. The ongoing presence of this contamination would have resulted in an even higher dose, likely exceeding regulatory limits.
- 14. As noted on the Preliminary Inspection Report (PIR) and inspection report, it was not clear that this contamination would have been identified if an inspection had not occurred, or if licensee staff would have known what actions to take on discovery of the contamination. Per licensee documentation reviewed at the Calgary location, the department is monitored for loose contamination once per week, on Fridays. As the contamination event happened on a Tuesday, it is unlikely the licensee's contamination monitoring procedures would have identified any radioactive contamination that may have spread around the department (Tc-99m has a half-life of six hours after two-and-a-half days the original activity will have decreased by 99.9%). As



such, there is risk that other licensee employees, such as cleaning staff, or members of the public, could have become contaminated.

Access control

15. The inspector noted during the inspection that the hot lab was not locked, meaning that access to this room (where nuclear substances are handled and stored) was not limited to staff trained and authorized to handle nuclear substances for the duration of the inspection. This is contrary to CNSC Licence Condition 2575, which states that when in storage, radioactive nuclear substances are accessible only to persons authorized by the licensee. This condition is in place both for the security of nuclear substances, as well as to limit radiation exposure to unauthorized individuals, such as members of the public and other licensee staff who do not handle nuclear substances as part of their job.

Instrument calibration

16. Based on records submitted by the licensee, the licensee's portable radiation detector (instrument) efficiency and minimum detectable activity (the smallest amount of radiation an instrument can detect) were calculated after an inspection notification requesting this information was sent to the licensee (on February 4, 2025). This should have been done prior to the clinic beginning any operations, as part of choosing an instrument, not after. These calculations are to ensure the licensee's instruments are being used correctly and can detect the type of nuclear substance the licensee uses.

Training

17. Per the licensee's "Worker Training Policy" in the radiation safety manual, "all individuals who work with radioactive materials... or who may get exposed during their work must be properly trained and informed of the hazards/risks associated with exposure to ionizing radiation." Five workers in the department were noted to have been working in the department without a documented record of radiation safety training by the licensee. This includes two physicians, who were made nuclear energy workers by the RSO the day before the inspection and had not yet received training from the licensee, an advanced care paramedic who had not yet received training from the licensee, and two cleaning staff who were trained the day before the inspection by the RSO but had been working in the department prior to receiving this training.

These above facts demonstrate that the licensee began operating at this location prior to implementing effective controls over occupational and public exposure to radiation. This is evidenced by the failure of staff to follow licensee procedures including those for the use of syringe shields, dosimetry and personal contamination monitoring. One worker's personal contamination went undetected by the licensee and could have resulted in a regulatory overexposure had it not been for the intervention of a CNSC inspector. Furthermore, the licensee failed to control access to the hot lab and allowed workers to work in the department without providing them with documented training of the risks and hazards in the department.





Based on my review of this matter, I am of the opinion that an administrative monetary penalty will deter recurrence of the above violation and promote future compliance with CNSC regulatory requirements.

In consideration of the seven factors in section 5 of the *Administrative Monetary Penalties Regulations* (*Canadian Nuclear Safety Commission*), the amount of the penalty was determined based on the following relevant facts:

1. Compliance history: Assessed score = +2

A +2 has been assigned because non-compliances related to instrumentation and the detection and monitoring for contamination were cited in inspections at five of six licensee locations inspected by the CNSC since the beginning of 2024. This repeated non-compliance suggests corrective actions are not being effectively implemented across the licensee's program.

2. Intention or negligence: Assessed score = +3

A +2 has been assigned because the requirements related to a Radiation Safety Program are clearly stated in subparagraph 4.a.iii of the *Radiation Protection Regulations* and further articulated in REGDOC-2.7.1, in the conditions of the licence, and in the licensee's own Radiation Protection Manual. Furthermore, the Calgary lab is the licensee's 15th location, indicating that they have prior practical experience with implementing the requirements of a Radiation Safety Program. Finally, the licensee's CRSO participated in the February 2025 inspection and performed an internal review of the Calgary location the day before this inspection, during which the CRSO identified and addressed several issues. This demonstrates that the licensee has a RSO with knowledge in radiation safety.

Despite all of this, the number and extent of the non-compliances discovered during the February 2025 inspection demonstrate a degree of negligence.

3. Actual or potential harm: Assessed score = +3

While the contamination of the NMT's clothes and neck discovered by the inspector during the inspection did not exceed a regulatory dose limit, there was potential for harm – had the worker performed contamination monitoring at the end of the day, which was the standard method described to the inspector by the worker, this contamination would have stayed on the worker's skin for several more hours. The ongoing presence of this contamination would have resulted in a significantly higher dose, exceeding regulatory limits. Furthermore, as noted on the PIR and inspection report, due to the failure to follow personal contamination monitoring procedures, it was not clear that this contamination would have been identified if an inspection had not been taking place, or that licensee staff would have known what actions to take on discovery of the personal contamination. It is possible other undiscovered/unreported contamination events have occurred, increasing the potential for harm. Finally, the potential for harm is exacerbated by other safety





significant non-compliances that the inspector found during the February 2025 inspection, including the fact that some licensee staff members were untrained in radiation safety, and the failure to secure access to the hot lab.

4. Competitive or economic benefit: Assessed score = +2

A +3 has been assigned as the Calgary location inspected on February 25, 2025 is a privately owned medical clinic that bills for services. By commencing licensed activities at a new location prior to implementing effective controls for occupational and public exposure to radiation, the licensee stood to realize a monetary advantage as a result of the non-compliance by providing billable services sooner.

5. Efforts to mitigate or reverse effects: Assessed score = +1

A +1 has been assigned as findings from the inspection on February 25, 2025 indicate that the licensee only began implementing mitigating measures such as identifying untrained workers, calculating instrument efficiency and informing nuclear energy workers of their status after being notified by the CNSC of an upcoming inspection. However, these actions were not sufficient to establish effective control of occupational and public exposure to radiation.

6. Assistance to Commission: Assessed score = 0

A 0 has been assigned as the findings from the inspection on February 25, 2025 were gathered by the CNSC inspector and did not require assistance from the licensee.

7. Attention of Commission: Assessed score = 0

A 0 has been assigned, as there was no reporting required.





Attachments

- CNSC Document 7433759 MyHealth Partners Inc. CNSC Licence 17320-1-28.2
- CNSC Document 7477188 Penalty calculation worksheet
- CNSC Document 7480738 Inspection Index DC-17320-JJ-250225-1
- CNSC Document 7451443 Inspection Index DC-17320-JF-250115-1, DC-17320-JF-250115-2
- CNSC Document 7389080 Inspection Index DC-17320-MW-240924-1
- CNSC Document 7290628 Inspection Index DC-17320-DS-240517-1
- CNSC Document 7512564 Inspection Index D-17320-JF-240201-1
- CNSC Document 7482278 Licensee Dose Estimation for Worker Skin Contamination
- CNSC Document 7482279 CNSC Dose Estimation for Worker Skin Contamination
- CNSC Document 7170331 MyHealth Partners Inc. Radiation Protection Program Manual
- CNSC Document 7484471 MyHealth Partners Inc. Policies + Procedures Manual 2024 Calgary
- <u>CNSC Website</u> CNSC Nuclear Medicine Procedures Poster





Penalty calculation:

(See Administrative Monetary Penalties Regulations (Canadian Nuclear Safety Commission) SOR/2013-139)

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To request a review

As a person subject to an administrative monetary penalty, you have the right to request a review of the amount of the penalty or the facts of the violation, or both. Your request must be made in writing indicating the reasons why you are requesting a review and providing supporting information.

If you choose to request a review, you must do so in writing by June 9, 2025 to:

Canadian Nuclear Safety Commission c/o Candace Salmon Commission Registrar P.O. Box 1046, Station B Ottawa, ON K1P 5S9

Fax: (613) 995-5086 Telephone: (613) 995-6506 Email: registry-greffe@cnsc-ccsn.gc.ca

Payment

You may pay this administrative monetary penalty by sending a cheque to:

Receiver General for Canada c/o Canadian Nuclear Safety Commission Finance Division P.O. Box 1046, Station B Ottawa, ON K1P 5S9

For other payment methods and further instructions, please refer to the attached notice of payment due.

Should you neither pay the penalty nor exercise your right to a review, you will be considered as having committed the violation and will be liable to the penalty set out herein.





Issued by

Karen Owen-Whitred Designated Officer Date

Telephone: (613) 410-8644

Email: karen.owen-whitred@cnsc-ccsn.gc.ca

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