



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
National Health Physics Program
2200 Fort Roots Drive
North Little Rock, AR 72114

NOV 3 2 2004

In Reply Refer To: 598/115HP/NLR

Kevin G. Null
Division of Nuclear Material Safety
Nuclear Regulatory Commission (NRC), Region III
2443 Warrenville Road, Suite 210
Lisle, Illinois 60532-4352

Re: NRC License 03-23853-01VA

Dear Mr. Null:

I am forwarding the enclosed report for NRC Event Number 41153.

The report is submitted per 10 CFR 20.2201(b) for a loss of radioactive material (10 millicuries of ^{125}I sodium iodide liquid in a volume of less than 1 milliliter) that occurred on October 26, 2004, at the VA Medical Center, New Orleans, Louisiana, VHA Permit Number 17-01322-07. The event was discovered on October 27, 2004, and reported to the NRC Operations Center the same day.

My staff completed a reactive inspection on November 3, 2004, to evaluate the circumstances of the loss. We are continuing our review of the event. Initial inspection results have determined the container used to ship the radioactive material was likely not labeled or marked by the manufacturer per Department of Transportation regulations.

If you have any questions, please contact me at (501) 257-1571.

Sincerely,

A handwritten signature in black ink, appearing to read "E. Lynn McGuire".

E. Lynn McGuire
Director, National Health Physics Program

Enclosure

NOV 24 2004

Report of Loss of Licensed Material

This report is submitted per 10 CFR 20.2201(b) for Nuclear Regulatory Commission (NRC) Event Number 41153.

1. The licensee's name:

a. Licensee

Department of Veterans Affairs
Under Secretary for Health
Washington, D. C. 20420
NRC License Number 03-23853-01VA

b. Permittee:

VA Medical Center
1601 Perdido Street
New Orleans, Louisiana 70112
VA Permit Number 17-01322-07

2. Description of the licensed material involved, including kind, quantity, and chemical and physical form

I-125 as sodium iodide, 10 millicuries, normal form (liquid in a small vial) intended for research.

3. Description of the circumstances under which the loss or theft occurred

The loss of the package containing the I-125 is assumed to have occurred on the evening of Tuesday, October 26, 2004. The package was likely placed on a trash container in a secured laboratory by which housekeeping personnel presumably discarded it into the hospital trash compactor.

4. Statement of disposition, or probable disposition, of the licensed material involved

The package containing the I-125 most likely was placed into the hospital trash compactor, compacted, and then sent to the local landfill on the morning of Wednesday, October 27, 2004.

5. Exposures of individuals to radiation, circumstances under which the exposures occurred, and the possible effective dose equivalent to persons in unrestricted areas

No exposure of individuals is expected from the possible disposal or discarding of the package containing the shielded vial of I-125. Once the package was discarded, it was placed in the hospital compactor/dumpster and taken to the landfill. Personnel at the landfill do not handle waste from dumpsters. Also, the landfill gate monitors were not set-off; therefore, one can conclude that the vial was still safely shielded in its container.

6. Actions that have been taken, or will be taken, to recover the material

VA Medical Center, New Orleans, staff made a site visit to the landfill and learned that 3000 to 4000 tons of trash is dumped each day in the area where the contents of the hospital dumpster was emptied. The technical director of the landfill surveyed the area of interest on the morning after the site visit. His survey was performed with a Ludlum Model 3 instrument with a NaI probe. The technical director stated that he did not locate the package and had no readings above background. Therefore, the medical center does not have any further plans to attempt to recover the package.

7. Procedures or measures that have been, or will be, adopted to ensure against a recurrence of the lost or theft of licensed material

The following actions have been or will be taken to ensure a recurrence of the loss of material does not happen:

a. Training with regard to incoming radioactive material packages was immediately scheduled for hospital Materials Management and Housekeeping Personnel. Initial training was provided on November 1, 2004 with final training for all staff scheduled for completion by November 23, 2004.

b. The medical center Radiation Safety Committee will evaluate these modifications to radiation safety procedures:

(1) Modify the address line for all incoming radioactive orders to ATTN: RSO, SAFETY MANAGEMENT BLDG 2 RM 216, Ext 5233. For radioactive materials deliveries that may occur directly to a research laboratory, the recipient will be required to immediately notify the Radiation Safety Officer who will take custody of the package for survey, inventory, and proper disposition. The Radiation Safety Officer will then investigate why the package was delivered directly to the user, take corrective actions, and report the incident and investigation results to the Radiation Safety Committee.

(2) Coordinate and initiate a procedure to identify and train new Materials Handlers and Housekeeping staff prior to their assuming duties that cause them to enter restricted areas or handle radioactive packages.