Wadsworth
Medical Center

Wilshire and
Sawtelle Boulevards
Los Angeles, CA 90073

Veterans
Administration

MAR 2 6 1981

Mr. H. E. Book
Chief, Fuel Facility and
Materials Safety Branch
Nuclear Regulatory Commission, Region V
1990 N. California Blvd.
Suite 202, Walnut Creek Plaza
Walnut Creek, CA 94596

SUBJ: Response to Notice of Violation, License No. 04-00181-04

1. Enclosed are three copies of the response to the Notice of Violation dated 2-25-81. This response is filed in accordance with the provisions of 10-CFR 2.201, as stated in Appendix A, Notice of Violations.

2. All items of noncompliance or deviation have been noted and immediate action taken to correct or clarify any existing problems. Preventive steps are being taken to obviate violations on future reviews.

3. I certify that all information contained in this letter, including any supplements attached thereto, is true and correct to the best of my knowledge and belief.

William K. Anderson

WILLIAM K. ANDERSON
Director

Enclosures

NOTARY STAMP

3/26/81

OFFICIAL SEAL
ERNEST BELL
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY
My comm. expires AUG 5, 1983

In Reply Refer To: 691/115

VETERANS ADMINISTRATION
WADSWORTH MEDICAL CENTER
LOS ANGELES, CALIFORNIA

March 23, 1981

LICENSE #04-00181-04: RESPONSE TO NOTICE OF VIOLATION DATED 2-25-81

1. Response to Violation A concerning failure to maintain a record of an evaluation regarding a personnel exposure of 7.7 rems.

As was previously seen in statements given to the investigating team, the incident in question was evaluated upon notification of a possible excessive dose. The staff member was verbally notified and the incident investigated by both the physicist and Service Chief. To the satisfaction of the parties involved, it was determined that the reported dose was in error and that no overdose had occurred.

In order to ensure that any future investigations are properly conducted and records maintained, a new procedure statement has been added to the department procedure manual detailing the appropriate steps (see Attachment 1).

2. Response to Violation B-1 concerning no Medical Radioisotope Committee meetings between March 26, 1980 and October 2, 1980, when quarterly meeting is required.

The required meeting did not, in fact, take place. We have initiated a procedure whereby the Medical Radioisotope Committee will be scheduled to meet during the second week of the second month of each quarter.

3. Response to Violation B-2 concerning precise knowledge of location and distribution of all radioactive materials present within the VA Wadsworth Medical Center by the Radiation Safety Officer.

The incident cited occurred during a period when 5 different persons held the position of RSO, Radiation Therapy Service, over a 4-month interval. The persons served on a consulting basis and there was a definite lack of continuity due to the turnover.

The condition described was discovered by the incoming permanent physicist during his initial survey and inventory. The sources were within the controlled area but had evidently slipped from their proper storage position.

Several measures have been taken since the incident of Feb. 11, 1980 to insure the prevention of future misplacements:

1) The access to the controlled storage area has been severely limited with new locks and tightly controlled key distribution.

2) Since 2-11-80, all implant source preparation has been under the personal supervision of the RSO of the Radiation Therapy Service.

3) Quarterly seed inventories are being taken by the RSO.

4) At the time of inventory and during each implant preparation procedure, the storage room is monitored for stray sources.

5) To alleviate confusion concerning Radiation Safety Officer duties for the Radiation Therapy Service, we have initiated a memo delegating specific radiation safety activities to the Physicist, Radiation Therapy Service (see Attachment 2).

4. Response to Item B-3, requiring that a log be maintained indicating the disposition of sealed radioactive sources.

Documentation was available and recorded for all shipment and receiving of isotopes in the form of shipping papers, receipts, or logbook entries. However, some shipments were not entered into the logbook summary pages even though other documentation was on file.

New logbooks and accounting procedures have been initiated to increase the control of radioactive materials. Copies of procedures for handling and logging radioactive material transfers have been circulated to all department employees. Additional didactic sessions have been held to inform the staff on corrective procedures.

Under current accounting procedures, a record of all receipts, disposals, and internal transfers is maintained in the isotope log. Included in this report are copies of the recently revised procedures (see Attachment 3). Since February 1980, all receipts and shipments have been directly supervised and checked by the department Radiation Safety Officer.

5. Response to Item C, concerning lack of radiation survey maintenance on patients who had implants removed on 4-22-79 and 12-21-79.

It is the current policy of this department to survey all patients and their rooms at the time of implant and after the removal of all sources. A record of these surveys is entered in the patient's chart and in the isotope logbook.

Copies of the specific procedures to follow have been circulated to all staff members and followed with an oral presentation. Emphasis was placed not only on the performance of such surveys but also on their proper recording.

In all cases since February, 1980, these surveys have been personally performed by the Radiation Therapy RSO whether on weekends, holidays, or after hours.

3.

License #04-00181-04: Response to Notice of Violation Dated 2-23-81

6. Response to Violation D-1, requiring quarterly physical inventories for source accountability.

As previously mentioned, the period of late 1979 and early 1980 was a transition period in which several physicists functioned as RSO. The inventory procedures have been reviewed and the reporting system changed to conform with the NRC requested format. Future inventories will be conducted on a quarterly basis and records kept in both the Nuclear Medicine and Radiation Therapy Services.

7. Response to Violation D-2, requiring quarterly physical inventory of all sources.

This has been corrected as of 12-31-80. The Sr-90 eye applicator was not listed on radiation therapy inventory until that date. It was on Radiation Safety Officer, Nuclear Medicine Service, source wiping schedule and was wiped every six months and inventoried once yearly. This averages out to a 4-month interval rather than three. All inventories will be performed quarterly hereafter.

8. Response to Notice of Deviation, Item A, requiring surveys on every incoming shipment.

Isotope receiving and logging procedures have been reviewed with all members of the Radiation Therapy Service staff. A written procedure detailing the actions necessary to process radioactive sources has been circulated and is posted with the isotope logbook.

All receipts and transfers of radioactive material are currently being supervised by the Radiation Therapy Service Radiation Safety Officer.

9. Response to Notice of Deviation, Item B, requiring copy of 49 CFR.

DOT Regulations in 49 CFR had been ordered twice by Radiation Safety Officer, Nuclear Medicine Service - see attached purchase orders of 10-10-79 and 9-12-80 (Attachments 4 & 5). He still has not received a copy in spite of repeated queries to Supply Service. Corrective action will be to re-order this publication once again, and also attempt to obtain a copy from a private source.

SUMMARY

Current practice corrects all violations noted in the NRC Notice of Violations and Deviations Report. All items are presently in compliance except the receipt of a copy of 49 CFR, which is dependent upon Government Printing Office activity.

PROCEDURE FOR INVESTIGATION AND REPORTING OF EXCESSIVE DOSE RECORDED ON PERSONNEL MONITORING DEVICES

1. Upon receipt of information indicating an excessive dose reading of a film badge, TLD, or pocket dosimeter, the RSO shall begin an investigation into the incident.

2. The staff member shall be notified verbally and in writing of the pending inquiry.

3. An attempt shall be made to locate any possible source of excessive exposure, correlate the reported dose with other dosimetry data (i.e., pocket dosimeters, etc.), and reconstruct the events of the time period in question.

4. If it is determined that an accidental exposure may have occurred, the staff member's duties will be evaluated in terms of maximum permissible dose (MPD).

5. A written report shall be filed with the Nuclear Regulatory Commission describing the incident, investigation, and corrective action taken.

Attachment 2

VA Wadsworth Medical Center
Los Angeles, California

Memorandum 9-

214/ZP

RADIATION SAFETY OFFICER, RADIATION THERAPY SERVICE

1. PURPOSE: To designate the Physicist, Radiation Therapy Service, as the Radiation Safety Officer for the Radiation Therapy Service.

2. RESPONSIBILITY: The Radiation Safety Officer, Radiation Therapy Service, will be responsible for radiation safety in all areas of the Radiation Therapy Service where teletherapy sources, interstitial radioisotope implant sources, and external irradiation devices are used. He is responsible for the acquisition, accountability, and disposal of all radioactive isotopes acquired for Radiation Therapy Service usage under the provisions of USNRC License 04-00181-04, and License #04-00181-10.

3. IMPLEMENTATION: The Radiation Safety Officer, Radiation Therapy Service, will serve as a member of the Radiation Safety Committee and the Medical Radioisotope Committee.

4. The Radiation Safety Officer, Radiation Therapy Service, will observe all applicable Nuclear Regulatory Commission rules and regulations regarding the appropriate use of radiation and radioactive materials.

WILLIAM K. ANDERSON
Director

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