UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION V
SUITE 202, WALNUT CREEK PLAZA
1990 N. CALIFORNIA BOULEVARD
WALNUT CREEK, CALIFORNIA 94596

INSPECTION REPORT NO. ____________

Veteran's Administration Center
Wadsworth Hospital
Los Angeles, Calif

Telephone No: ____________

Attached
[ ] Appendix A
[ ] Appendix B
[✓] Appendix C
[ ] Memo

License No. 04-00161-04 Last amendment & date: 70 / Nov 20, 1978
Category: G1 & Priority: 3, as of last amendment.
Inspection date(s): Jan 9, 1979 Type of inspection: Special

SUMMARY OF FINDINGS AND ACTION

[ ] No noncompliance, clear 591
[ ] Noncompliance, Appendix A
[ ] Action on previous n/c, App B
[ ] Noncompliance, 591 issued
[ ] Regional action [ ] HQ action
[ ] Supplemental info, App C

RECOMMENDATIONS

See basis in Appendix C or attached memo.

[ ] Change Category to: ____________
[ ] Change Priority to: ____________
[ ] Next inspection date: ____________

PERSONS CONTACTED

L. W. Wetterau, Jr.; RSO

Note: Because of the very limited aspect of this inspection and report, no 766 of the type submitted and no change should be made in file or computer. AEB

Inspector: [signature] Feb 28, 1979
P. Z. Zurakowski 2 March '79
Approved: A. E. Book 3/22/79

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APPENDIX C - SUPPLEMENTARY INFO

Licensee: V.A. CENTER, WADSWORTH HOSPITAL License no: 04-00181-04
LOS ANGELES, CA

[ ] Uncorrected/repeated noncompliance [✓] Unresolved items

[ ] Unusual occurrence, conditions, etc [ ] Inspector's comments

[ ] Basis for change of Category or Priority

During the inspection of this hospital, tele therapy licensee, we reviewed the reported loss of material which occurred on or about September 12, 1978. The lost source was a 7.5mCi Ir-192 implanted pellet and was verbally reported to RV on September 13 and confirmed in a letter dated September 15, 1978 since the pellet was used under LN04-00181-04, Mr. L. W. Wetterau, RSO, represented the hospital.

As a result of this incident, the hospital on September 18 convened a Board of Investigation. (Attached are the minutes of the Board.) The probable cause of the loss was concluded to be the loss of the implant from accidental patient displacement followed by unauthorized removal of the patient's dressing from the room. Mr. Wetterau further assumed that the pellet is now buried at an offsite trash burial area. The assumption was based on the radiation survey of the hospital (patient's room, laundry, pathway, etc.) which was negative and a laundry worker reported to have disposed of an item similar to the ribbon in the normal trash.

The Board recommended actions to prevent recurrence of such loss were to applied implant dressing, secure implants with crimps, additional patient post and annual training of ancillary staff (eg nurses, janitor, guards etc). (over)

IE:V Form 620

Examination of the RSO training logs revealed that from December, 1978 to the present the RSO have been providing radiation safety classes to nurses, x-ray staff, and janitorial services personnel. These training classes also included film strips and audio-visual aids as modified by Radiation Management Corp.

Attendees, date, and course were noted in a notebook maintained by the RSO. Approximately 50 persons have finished the training currently and the training will continue until the targeted staff have been provided with this hospital's radiation safety indoctrination. At the end of the year, annual refresher classes will be conducted.