WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
AT WASHINGTON UNIVERSITY MEDICAL CENTER

DIVISION OF
RADIATION SAFETY

RCD/DCB

January 10, 1991

Roy J. Caniano, Chief
Nuclear Materials Safety
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr. Caniano:

This letter is the reply of Washington University Medical School to the Commission's Notice of Violation dated December 13, 1990 that resulted from an inspection of activities authorized by Materials Licenses No. 24-00167-11 (broad scope medical), No. 2400063-08 (teletherapy) and No. 24-00063-13 (self-shielded irradiator) that was conducted by Mr. J.L. Lynch on October 30, 1990. The Notice of Violation specifies 3 violations with one identified with each license.

The reply to each violation is as follows:

1. **License 24-00167-11**

The cited violation involves a brachytherapy nurse who was not provided an annual radiation safety inservice in 1989 and 1990.

Corrective steps that have been taken and the results achieved; corrective steps that will be taken to avoid further violations; date when full compliance will be achieved:

Radiation Safety and Radiation Oncology personnel discussed the matter. First, multiple inservices have been provided each year in the past. As an example, four inservices were delivered by Radiation Oncology physics and medical personnel in September and October 1990. However, as the inspector correctly discovered, not all of the approximately 90 nurses providing care for brachytherapy patients are provided the training. Hence, a modified training program has been implemented in which a set of inservices (inservices are given for 3 different groups of brachytherapy nurses) will be given every six months and new nurses that begin between the six-month intervals will be given a video presentation or a brief inservice/walk-through detailing brachytherapy procedures and radiation safety practices. In addition, printed information that addresses each of the topics specified by the Commission for appropriate refresher information has been developed by the RSO and a copy will be given to each nurse at least annually. Discussions have been

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held between Radiation Oncology personnel and nursing administration personnel during which the importance of fulfilling the training requirements has been stressed. The modified training applies to the nursing groups of both hospitals of the licensee in which brachytherapy procedures are carried out — Barnes Hospital and Jewish Hospital. Documentation of the training will be carefully examined by the Associate RSO at the time of the extensive annual internal audits that are conducted by Radiation Safety.

The licensee is currently in full compliance with the brachytherapy nurses training requirements of the Commission, to the best of our knowledge.

2. License 24-00063-08

The cited violation involves the approval by our institutional radiation safety committee of two physicians to conduct teletherapy procedures although they did not have appropriate board certification at the time.

Corrective steps that have been taken and achieved; corrective steps that will be taken to avoid further violations; date when full compliance will be achieved:

A meeting of the Radiation Safety Committee was held November 11, 1990 at which the two physicians were re-approved by the Committee to perform teletherapy procedures based on their submitted evidence of appropriate board certification which had been achieved since their initial approval. I, as the RSO, understand the Commission's requirements affecting Committee approval of licensed materials for medical procedures and will be responsible for keeping the Committee informed of the requirements.

The licensee has been in compliance with the requirement since November 11, 1990.

3. License No. 24-00063-13

The cited violation indicates that an irradiator operator used the irradiator while not wearing a personnel monitoring device, contrary to a license condition.

Corrective steps that have been taken and the results achieved; corrective steps that will be taken to avoid further violations; date when full compliance will be achieved:

The incident was discussed with the supervisor of the Blood Bank personnel, the persons who use the irradiator. The importance of always wearing the TLD monitor was emphasized. The supervisor then issued a memorandum to the staff reminding them that "the monitoring badge must be worn when operating the irradiator". Although we believe that the failure to wear a monitor is most unusual for this group of individuals, Radiation Safety personnel will increase their attention to this matter during the on-site inspections of our four irradiator operations that are performed each calendar quarter.

The licensee has been in full compliance with the license condition since October 30, 1990, to the best of our knowledge.

In conclusion, the licensee agrees with the findings of the inspector and has taken prompt actions to correct the deficiencies.

Sincerely,

John Eichling

John Eichling, Ph.D.
RSO

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cc: Robert J. Hickok
Assistant Vice Chancellor for Medical
Affairs, Assistant Dean and Chief
Facilities Officer

Carlos A. Perez, M.D.
Chairman
Radiation Safety Committee