SEP 1 9 1990

Docket No. 030-09588
Cal No. 1-90-016

License No. 08-03604-04

Washington Hospital Center
ATTN: Rosemary Clive
Executive Director,
Cancer Institute
110 Irving St., N.W.
Washington, D.C. 20010

Gentlemen:

Subject: Confirmatory Action Letter No. 1-90-016

On September 18, 1990, Mr. David Dickey of your staff, reported to NRC Region I an incident involving the malfunction of a teletherapy machine operated at your facility. The malfunction of the machine resulted in the addition of a small increment of time (12 seconds) to the desired patient treatment time. Pursuant to a telephone conversation between you and Dr. M. Shanbaky of this office on September 19, 1990, it is our understanding that you have taken or will take the following actions with regard to the use of the Theratron 780 (T-780) teletherapy machine involved in that incident.

1. Immediately terminate ongoing treatment and suspend future treatment.
2. Determine the cause(s) of the teletherapy machine malfunction and take appropriate corrective action, including all necessary repairs and calibrations to ensure safe conduct of teletherapy operations.
3. Review and revise your written emergency operating procedures of the T-780 to ensure that timely and appropriate action is taken to minimize radiation exposure to patients and personnel.
4. Provide training to all personnel involved in the September 18, 1990 teletherapy incident. Training will include lessons learned, any procedural changes described in item 3 above, and sensitization of the staff to the need to follow procedures. The training will be completed prior to the resumption of teletherapy treatment.
5. Immediately notify the NRC Region I directly (215-337-5000) or through the NRC Headquarters Operations Center (301-951-0550) of the cause of the teletherapy machine malfunction, affected repairs and other corrective action completed.

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Further, we understand that all actions established by this letter will be adhered to and will not be changed unless you receive authorization from the Regional Administrator, NRC Region I.

The response directed by this letter is not subject to the clearance procedures of the Office of Management and Budget, as required by the Paperwork Reduction Act of 1980, PL 96-511. In accordance with 10 CFR 2.790(a), a copy of this letter will be placed in the NRC Public Document Room.

Issuance of this Confirmatory Action Letter does not preclude the issuance of an Order formalizing the above commitments. If your understanding differs from that set forth above, please call me immediately.

Sincerely,

R W Cooper

Malcolm R. Knapp, Director
Division of Radiation Safety
and Safeguards

cc:
Public Document Room (PDR)
Nuclear Safety Information Center (NSIC)
District of Columbia

bcc:
Region I Docket room (w/concurrences)
Management Assistant, DRMA
J. Lieberman, OE
J. Goldberg, OGC
R. Cunningham, NMSS
T. Martin, RI
M. Knapp, RI
D. Holody, RI
R. Bellamy, RI
M. Shanbaky, RI
M. Cahill

RI:DRSS	RI:DRSS	RI:DRSS	RI:DRSS	RI:DRA
Cahill/gcb	Shanbaky	Bellamy	Knapp MRK	Kane
09/19/90	09/19/90	09/19/90	09/19/90	09/19/90

OFFICIAL RECORD COPY CAL WASHINGTON - 0002.0.0
09/19/90

08-03604-05

CONVERSATION RECORD

TIME: 7:30 am

DATE: [illegible]

TYPE

☐ VISIT ☐ CONFERENCE ☐ TELEPHONE

☐ INCOMING

☐ OUTGOING

Location of Visit/Conference:

NAME OF PERSON(S) CONTACTED OR IN CONTACT WITH YOU	ORGANIZATION (Office, dept., bureau, etc.)	TELEPHONE NO
Dara Lickey, RSO	[illegible] Hospital	[illegible]

ROUTING	
NAME/SYMBOL	IN

SUBJECT

Licensee Response to CAL Reporting of an Incident Involving [illegible] [illegible] (T-73)

SUMMARY

Dara Lickey, RSO indicated that [illegible] [illegible] personnel [illegible] [illegible] on 9/21/90 and believed the failure of the source to retract [illegible] to be due to a piece of dirt in a solenoid valve which [illegible] with air pressure [illegible] being released to allow source to retract. The solenoid valve and a relay (?) switch were replaced.

Training was provided to all personnel involved in the incident.

Procedures were reviewed as submitted in '89 renewal application and no changes were deemed necessary.

A full calibration was performed on 9/22/90 - no problems were [illegible]

ACTION REQUIRED

NAME OF PERSON DOCUMENTING CONVERSATION	SIGNATURE	DATE
Mary K Cahill	Mary K Cahill	9/21/90

ACTION TAKEN

Called Ken Williams at 8:45 A.M. 9/24/90 and informed him the CAL was closed out.

SIGNATURE	TITLE	DATE
Ronald R. Bellamy		9/29/90

50271-101 CONVERSATION RECORD OPTIONAL FORM 271 (12-7

U.S. G.P.O. 1983-381-526/8346 DEPARTMENT OF DEFENSE

A/2

DCS No: 03000234901129
Date: November 30, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-90-102A

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region I staff on this date.

Facility:
Medical Center of Central
Massachusetts/Memorial
(Worcester Memorial Hospital)
119 Belmont Street
Worcester, Massachusetts 01605
License No. 20-02452-03

Licensee Emergency Classification:
☐ Notification of Unusual Event
☐ Alert
☐ Site Area Emergency
☐ General Emergency
☒ Not Applicable

Subject: POSSIBLE FIRE IN A TELETHERAPHY MACHINE--UPDATE

As a follow up to a reported possible fire in a teletherapy machine, Region I called the licensee on November 30, 1990, at approximately 10:00 a.m. to obtain updated information.

A service representative from Theratronics arrived at the licensee's facility at approximately 4:30 p.m. on November 29, 1990. He found what appeared to be a burnt piece of a rubber grommet on the light field indicator lamp. The licensee stated it appeared that the grommet had been dislodged and fell inside the machine collimators as a result of repair work performed on November 28, 1990. The repair work had been performed on the optical distance indicator which was flickering due to a loose plug. The licensee believes that the grommet dislodged from the collimators and fell onto the light field indicator lamp during the last patient treatment performed on November 29, 1990 when the patient was treated posteriorly (i.e., gantry angle at 180°).

The licensee will report the incident to the Medical Device Reporting System at FDA and the Commonwealth of Massachusetts.

The Region considers this issue closed and intends no further involvement. This information is current as of 10:30 a.m. on November 30, 1990.

CONTACT: Jean Grosick-Schugsta M. Shanbaky
(FTS) 346-5382 (FTS) 346-5209

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3:50
[illegible]

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PDR I&E
PNO-I-90-102A PDC

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Region I Form 83
(Rev. April 1988)