DEPARTMENT OF VETERANS AFFAIRS
Medical Center
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January 9, 1997

L. J. Callan, Regional Administrator
United States Nuclear Regulatory Commission, Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, Texas 76011-8064

In Reply Refer To

SUBJECT: RESPONSE TO SUPPLEMENT TO CONFIRMATORY ACTION LETTER (CAL) 4-96-006

Dear Mr. Callan:

A Theratronic's serviceman, prior to the end of January 1997, plans to resume investigation of the source drawer malfunction that occurred after the dual timer was installed and attempt to determine the reason for the malfunction .

The operator is to continue to pay visual attention in particular to the Co-60 radiation area monitor readings and the beam on/off indicators on the console and insure that they are functioning correctly.

The following is a description of the operational and procedural controls to be implemented should a source drawer malfunction occur. The operator is to record the time, the date, the patient's name, the primary timer reading, the secondary timer reading, the set time, and the error code displayed on the dual timer at the time the source drawer malfunction takes place. The Co-60 teletherapy unit will be left unaltered until a Teletherapy Physicist or the Teletherapy Radiation Safety Officer (RSO) is able to investigate the situation.

If there is a source drawer malfunction or any other malfunction of the Co-60 teletherapy unit, the following are to take place in order to continue treating patients with the unit. The operator of the Co-60 teletherapy unit will immediately notify one of the Teletherapy Physicist and if neither one can be found by the operator then the RSO will be immediately notified. Upon notification by the operator, the procedure would be to ask the operator if he/she observed the Co-60 radiation area monitor and the beam on/off indicators on the console and if they performed as expected when the source drawer malfunction occurs. Then the Teletherapy Physicist or RSO would verify that the malfunction that occurred is not a new problem and would then test the operation of the unit to confirm that the operation of the Co-60 teletherapy unit is functioning correctly. Once confirmed the operator will be given permission to continue treatment under the same guidelines. The operator then must turn the key-switch located on the left-hand side of the console unit in order to operate the Co-60 teletherapy unit after a source drawer failure. The key-switch acts as an interlock that prevents the operation of the Co-60 teletherapy unit without the operator acknowledging a failure has taken place.

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Within 24 hours of the source drawer malfunction or any other unit malfunction a Teletherapy Physicist or the RSO on the license will contact notify the NRC.

Radiation Therapy Service has indicated that they are completely committed to the implementation of these operational and procedural controls.

Radiation Therapy Service will have all Co-60 teletherapy unit operators sign and date a statement to the effect that they have been given these instructions verbally and have read this letter and fully understand both and intend to comply completely regarding these operational and procedural controls.

Sincerely yours,

Kenneth Clark
Executive Director

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