U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No. 85-02

License No. 04-15030-01 Priority: 2 Category: G1

Licensee: Veterans Administration Medical Center (VAMC)
3350 La Jolla Village Drive
San Diego, California 92161

Facility Name: Same as above

Conference at: Same as above

Conference conducted: May 31, 1985

Participants: J. L. Montgomery 7/15/85
J. L. Montgomery, Chief Date Signed
Nuclear Materials Safety and Safeguards Branch

J. L. Montgomery for 7/15/85
R. D. Thomas, Chief Date Signed
Nuclear Materials Safety Section

Approved By: Paul Scarano 7/29/85
P. A. Scarano, Director Date Signed
Division of Radiation Safety and Safeguards

Summary:

Enforcement Conference on May 31, 1985 (Report No. 85-02)

The following matters were discussed:

1. The violations involving the loss of iridium 192 seeds and loss of control over licensed radioactive material.

2. NRC enforcement options.

3. NRC Concerns.

4. Licensee Management and radiation safety committee responsibilities.

The enforcement conference involved a total of two hours, utilizing two NRC representatives.

Enforcement Conference

DETAILS

1. Enforcement Conference Participants

J. W. Hollingsworth, Chief of Medicine VAMC
R. Moder, Acting Chief of Staff, VAMC
N. E. Hensley, Acting Director, VAMC
J. W. Verba, Radiation Safety Officer, VAMC
S. E. Halpern, Acting Chief, Nuclear Medicine, VAMC
F. T. Yates, Acting Associate Director
R. D. Thomas, US NRC Region V
J. L. Montgomery, US NRC Region V

2. Enforcement Conference

On May 31, 1985, an enforcement conference was held at the VAMC, San Diego, California with the individuals listed above participating. The enforcement conference was related to the safety inspection conducted at the VAMC, San Diego, California. The activities at this location are authorized by NRC License Number 04-15030-01. The inspection was conducted on May 15-16, 1985, by an NRC Region V inspector. The enforcement conference was announced in a letter to the licensee dated May 22, 1985. A copy of that letter is attached.

Mr. J. L. Montgomery, NRC, stated that the purpose of the enforcement conference was based upon the results of the special inspection which was conducted at the VAMC by an NRC Region V inspector following the loss of four iridium-192 therapy implant seeds. The two violations identified involved the lack of control over licensed radioactive material and it's subsequent loss. The need for strong participation on the part of management and the Radiation Safety Committee to control the overall licensed program was stressed as one of the most significant requirements in maintaining an acceptable radiological safety program.

Mr. R. D. Thomas, NRC, reviewed the past enforcement history of the licensee for the period June 1979 to December 1983. The two violations which were identified during the special inspection were discussed in detail. Mr. Thomas and Mr. Montgomery stressed the need for adequate training of personnel using licensed material, and the strict adherence to written procedures, and NRC regulations.

Dr. J. Verba and Mr. N. Hensley described the incident and the steps they and their staffs had taken to locate the missing iridium sources. Mr. Hensley stated that all therapy at VAMC with iridium 192 seeds would be halted until the incident had been fully investigated and recommendations made to prevent recurrence.

Mr. J. L. Montgomery, NRC, explained the enforcement policies and procedures of the NRC as published in 10 CFR 2, Appendix C. Copies of the enforcement policy were given to the licensee. Escalated enforcement actions such as civil penalties, orders to modify, suspend, or revoke a license, and orders to cease and desist were discussed. The relative significance of the different severity levels was explained.

In summary Mr. J. L. Montgomery, NRC, stated that any information submitted by the licensee would be given due consideration regarding the violations; however, a strong management and Radiation Safety Committee commitment will be expected in the licensed program to preclude future violations.

3. Conclusions

In addition to temporarily suspending further iridium seed implant therapy, the licensee indicated a review of VAMC policies and procedures would be made. Mr. N. Hensley indicated recommendations for improvement would be made to him and appropriate action would be taken.