



Andrea D. Browne  
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Community Hospital East  
1500 N. Ritter Avenue  
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## Community Hospitals Indianapolis

March 12, 2002

U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D.C. 20555

### REPLY TO A NOTICE OF VIOLATION

Dear Sir or Madam:

The following is submitted in response to NRC Inspection Report 03001625/2002-001 (DNMS) and Notice of Violation – Community Hospitals of Indiana, Inc.

#### Violation 1

**Cause** As noted in our letter to the Region III Office on Sept. 25, 2001, the seed count at the end of an implant procedure utilizing I-125 seeds was below the expected count by one. We were unable to locate the missing seed, although area surveys of all locations where the seeds were stored or handled indicated no exposure levels above background. At this location seeds were not counted prior to sterilization and handling to insure that the manufacturer's inventory was correct. We are not sure that the order contained the number of seeds ordered.

**Corrective Steps Taken** Effective immediately after the August 29<sup>th</sup> occurrence the staff in the CHS nuclear medicine department were requested to count all seeds at the time of the initial package receipt and survey. In addition, the radiation oncology staff would be responsible for transporting the seeds to the surgery sterilizer and the seed sterilization procedure.

**Steps taken to avoid further violations** The procedure described above has been modified to have all seeds to be utilized at Community Hospital South (CHS) delivered to Community Hospital East (CHE). The CHE radiation oncology physics or dosimetry staff will be responsible for login, count and survey procedures. The seeds will then be appropriately packaged and taken to CHS for sterilization by the oncology staff and subsequent use.

**Date of full compliance** Revised procedure was in place on 8/31/2001.

Sincerely,

Andrea D. Browne, Ph.D.  
Radiation Safety Officer

Copy to: USNRC Region III Office  
Mark E. Moore, CEO, Community Hospitals



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