DCS No: 03031765921207
Date: December 8, 1992

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN19274

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:
Oncology Services Corporation
775 South Arlington Avenue
Harrisburg, PA 17109

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Site:
Greater Pittsburgh Cancer Center
1145 Beaver Hill Road
Pittsburgh, PA

Docket No.: 030-31765
License No.: 37-28540-01
Event No.: NONE
Event Location Code: MAT

Subject: SOURCE BREAKS OFF FROM DRIVE WIRE OF AN OMNITRON 2000 REMOTE HIGH DOSE RATE AFTERLOADING BRACHYTHERAPY DEVICE

The licensee's medical physicist informed NRC Emergency Operations Center at 4:54 p.m. on December 7, 1992, that a 3.5 curie, iridium-192 sealed source broke off of its drive cable while treating an 81 year old female patient for bronchial cancer with an Omintron 2000 remote high dose rate after-loading brachytherapy device (HDR). The licensee's senior physicist responding to an error message on the computer entered the treatment room and observed the Prime Alert Radiation Monitor flashing and what appeared to be the sealed source broken off in the catheter outside the patient's body. The licensee's authorized user physician immediately cut the catheter and removed the patient from the room. The patient was surveyed with a portable radiation detection instrument which confirmed that the patient contained no radioactive material. The source was placed in a shielded container. The licensee's representative stated that the patient may have pulled on the catheter which contained the source drive wire prior to the source breaking off from the drive wire.

This is the second event the licensee has reported involving the Omnitron 2000 HDR. On December 1, 1992, a source broke off another Omintron HDR at the licensee's Indiana, Pennsylvania site, which remained in the patient. The leader of the NRC's Incident Investigation Team (IIT) and several other team members, who are investigating the Indiana, PA incident are on the way to the licensee's Pittsburgh facility to investigate this second event. Region I has sent inspectors to the licensee's Exton and Lehighton, Pennsylvania facilities to review training, the licensee's procedures, and any actions taken at these sites as a result of the incident at the Indiana facility.

The Commonwealth of Pennsylvania has been informed of this event. Region I is prepared to respond to media inquiries.

This information is current as of 9:15 pm, December 7, 1992.

IE-34

CONTACT: J. Johnsen 215-337-5304 S. Shankman 215-337-5283

DISTRIBUTION:

OWFN	MNBB	L-St.	NL	Mail: ADM:DMB
Chairman Selin	AEOD**	PDR	RES	
DOT:Trans only**				
Comm. Rogers	IRM			
Comm. Curtiss	OIG**			NRC Ops Ctr**
Comm. Remick				
Comm. de Planque				INPO** 11:23a.m.
OCAA				NSAC** 11:22a.m.
OIP				

		Phillips
OCA	EDO	ACRS**
OGC	NMSS	
OPA	NRR** (Phone Verif: A. Byrdsong 964-1168 or 964-1166)	
	OE	
	OSP	Regional Offices _____ RI Resident Office _____

EWW
OIG

Licensee:

(Reactor Licensees)

** General list for sending PNs by FAX

Region I Form 83
(Rev. November 1992)