

DEC 09 1992

Docket No. 030-01244
CAL No. 1-92-017

License No. 06-00819-03

Yale-New Haven Hospital
ATTN: Norman G. Roth
Administrative Vice President
20 York Street
New Haven, Connecticut 06504

Dear Mr. Roth:

Subject: Confirmatory Action Letter No. 1-92-017

Your Radiation Safety Officer (RSO) informed the NRC Emergency Operations Center at 6:10 p.m., on December 2, 1992, that earlier that afternoon it was discovered that a 35 millicurie cesium-137 source was missing. The source, one of four inserted in a Fletcher apparatus used in the treatment of cancer of the cervix, was implanted in a female patient on November 30, 1992. The sources and apparatus were removed at 4:00 p.m. on December 1, 1992, and assumed to be returned to the licensee's brachytherapy storage area. While the patient and the patient's room were surveyed at the time of source removal and found free of radioactivity, the sources were not counted until the afternoon of December 2, 1992. A dosimetrist cleaning sources on December 2, 1992, could not account for all four sources removed and reported the loss of the source to the RSO. A member of your staff performed a survey of the hospital and did not find the source. Also, a member of your staff performed a survey at your laundry service contractor's facility in Milford, Connecticut. The source was recovered from a washer at the laundry service facility and returned to the hospital. Water samples from the laundry and a leak test of the sealed source found the source to be intact. Your RSO stated that it was believed that the source was probably lost on November 30, when the sources were placed in the patient but that the source did not leave the hospital until the laundry was picked up on December 2, 1992.

Pursuant to a telephone conversation between you and Ms. Jenny M. Johansen of this office, on December 8, 1992, it is our understanding that you have taken or will take the following actions, which will be completed by the dates specified:

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1. That all Radiation Therapy resident physicians will visually check sources upon insertion and removal of sources from the patient.
2. All nurses will be trained to place the linen and pads only in the bag inside the brachytherapy patient's room and not to remove it until the completion of the treatment.
3. Any bloody linen and pads will be surveyed prior to their removal from a patient's room.
4. An inventory will be done on all sources promptly upon removal.

The above corrective actions have or will be completed by December 15, 1992.

Pursuant to Section 182 of the Atomic Energy Act, 42 U.S.C. 2232, and 10 CFR 2.204, you are required to:

1. Notify this office immediately if your understanding differs from that set forth above;
2. Notify this office if, for any reason, you cannot complete your actions within the specified schedule and advise me in writing of your modified schedule in advance of the change; and
3. Notify this office in writing when you have completed the actions addressed in this Confirmatory Action Letter.

Issuance of this Confirmatory Action Letter does not preclude the issuance of an Order formalizing the above commitments or requiring other actions on the part of Yale-New Haven Hospital, nor does it preclude the NRC from taking enforcement action for violations of NRC requirements that may have prompted the issuance of this letter.

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

Your cooperation with us is appreciated.

Sincerely,

Original Signed By
Susan Frant Shankman

Richard W. Cooper, II, Director
Division of Radiation Safety
and Safeguards

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Nuclear Safety Information Center (NSIC)
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bcc:

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