DCS No.: 03003296040221
Date: February 24, 2004

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-I-04-007

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
University of Virginia
Charlottesville, Virginia

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

Docket No.: 030-03296
License No.: 45-00034-26

SUBJECT: LOST BRACHYTHERAPY SOURCE

On February 23, 2004, the licensee reported to the NRC Operations Center that it had lost a brachytherapy source for a short time on February 21, 2004. The source was a ribbon with seven seeds each containing approximately 0.74 millicuries of iridium-192 for a total of approximately 5.18 millicuries in the entire ribbon. The ribbon was implanted with seven others of the same activity on February 19, 2004 for a gynecological treatment. On February 21, 2004, the sources were removed from the patient at approximately 8:00 a.m. The waste from the removal procedure remained in the room while the sources were removed to a storage area in a shielded container. While inventorying the sources after removal, the licensee discovered that one ribbon was missing. The patient's room and other areas were searched to no avail. Following discussions with housekeeping personnel, the licensee found that the waste had been removed from the patient's room. The licensee's Radiation Safety Officer was contacted and radiation safety personnel responded to the main hospital waste area. Radiation safety personnel surveyed the waste area and found elevated levels in and around the waste compactor. At approximately 10:30 a.m. on February 21, radiation safety personnel retrieved the source from the compactor and secured it with the other sources for proper disposal. The licensee is continuing its review of the event including evaluation of potential doses to other employees involved (i.e., nursing and housekeeping). The loss of the ribbon occurred after the patient's treatment was concluded and did not affect the prescribed dose.

This information is current as of 11:00 a.m., February 24, 2004.

The Commonwealth of Virginia has been notified of this event. The Region I Office of Public Affairs is prepared to respond to media inquiries.

Contact: Bryan A. Parker 404-562-4728
Hector Bermudez 404-562-4734

DISTRIBUTIONS:
BY E-MAIL:

OWFN	TWFN	LST
Chairman Diaz	IRO	PDR
Comm. McGaffigan Jr.	NMSS	
Comm. Merrifield	OIG	
OIP	RES	
OCA		
OGC		
EDO		
OE		
NRR		
SECY		
Regional Offices		

BY FAX:
DOT:Trans
INPO
NSAC
RI Resident Office
Licensee: _____
(Reactor Licensees)

DOCUMENT NAME: S:\PN\PN104007.WPD

OFFICE	RI/DNMS	RI/DNMS	RI/PAO	RI/DNMS	
NAME	B Parker BAP	G Pangburn GCP	D Screnci DPS	H Bermudez HXB1	
DATE	2/24/04	2/24/04	2/24/04	2/24/04	

Region I Form 83
(Rev. July 2, 2003)