



Office of the Vice President

October 22, 2001

F. Congel, Director
Office of Enforcement
United States Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, MD 20852-2738

**Ref: Reply to Notice of Violation – NRC Inspection Report No. 030-09926/2001-001
License No. 29-02957-13
Your Letter Dated September 25, 2001
Our Letters Dated June 22, 28, and September 5, 2001**

Dear Mr. Congel:

We appreciate the insight on radiation protection that the Nuclear Regulatory Commission (NRC) provided our Office of Radiation Safety Services (ORSS) during the special inspection conducted on May 26, and 30, 2001, in response to our May 25, 2001, notification of the missing ¹⁹²Ir ribbon (a brachytherapy source) containing 7.71 millicuries.

Payment of Civil Penalty:

The University of Medicine and Dentistry of New Jersey admits the loss of a sealed ¹⁹²Ir ribbon (a brachytherapy source) containing 7.71 millicuries. The UMDNJ - Office of Radiation Safety Services processed the check request for \$3000.00 and the check number 00565381 was cut and mailed on October 11, 2001, by the UMDNJ-Accounts Payable Department.

The following information describes the corrective measures implemented in response to the apparent violations during your site inspection. The corrective measures will be fully implemented as of August 30, 2001.

The UMDNJ-Newark campus ORSS conducted a thorough review of the circumstances that led to violations as summarized in your letter dated August 9, 2001.

Reason for Violation:

As stated in our letters dated June 22, 28, and September 5, 2001, that since a thorough search could not find the missing/lost ¹⁹²Ir ribbon, the UMDNJ-Newark campus came to the following conclusion:

The patient was observed holding a small piece of towel material on the implanted area to help absorb secretions from surgery. The UMDNJ-Newark campus believes that the missing/lost ribbon might have been entrapped in the towel and afterwards may have fallen into the toilet system and been flushed into the sewer system.

Corrective Actions Taken to Prevent in The Future:

1. A notice including a picture of a nylon ribbon with seeds was placed throughout the nursing units with a request to call ORSS, should the ribbon be found.
2. Several refresher training sessions were conducted for all University Hospital Environmental Services staff in the week of June 10, 2001. The ORSS specifically emphasized the reason for suspension of the waste removal from patient room during brachytherapy procedures at University Hospital.
3. All personnel involved with brachytherapy procedures were given refresher training on September 12, 2001.
4. Radiation alarm rate meters (mounted on the ceiling) were placed outside of brachytherapy patient rooms to detect any unusual events. We are frequently inspecting rooms and surveying inside and outside the patient rooms with GM counters. However, only a final survey will be recorded.
5. Violations were issued internally to both the Radiation Oncologist and the Executive Housekeeper of the Environmental Services. The corrective actions taken by the above individuals were reviewed and accepted on September 6, 2001, by the Human Use Subcommittee and accepted by the Radiation Safety Committee on September 24, 2001.
6. Only colored ribbons will be ordered for future brachytherapy procedures. If non-colored ribbons are received, they will be marked with a color marker for easy identification should they be accidentally dropped to the floor.

Date of Full Compliance Achieved:

All corrective actions were implemented as of October 15, 2001.

Should you have any questions please contact Mr. Venkata K. Lanka, Radiation Safety Officer at (973) 972-5305.

Thank you again for your guidance and cooperation.

Sincerely yours,



Celia Dorantes Abalos, Esq.
Vice President for Regulatory Affairs

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