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PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-03-012

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 III staff on this date.

Facility

Cook County Hospital
Chicago, Illinois
License: IL-01768-01
(Agreement State licensee)

Licensee Emergency Classification

Notification of Unusual Event
 Alert
 Site Area Emergency
 General Emergency
 Not Applicable

SUBJECT: LOST STRONTIUM-90 EYE APPLICATOR SOURCE

DESCRIPTION:

On March 14, 2003, the Illinois Department of Nuclear Safety (IDNS) notified the NRC Operations Center that an eye applicator containing approximately 11 millicuries of strontium-90 was missing from storage at Cook County Hospital in Chicago, Illinois.

On March 13, 2003, IDNS received notification, from the licensee radiation safety officer, of the missing eye applicator contained in a wooden storage box. Hospital staff performed a routine inventory on March 11, 2003, which identified that the eye applicator, exempt calibration sources, and other non-radioactive equipment, were missing from a storage cabinet in the oncology department. Licensee staff performed a search of the facility and interviewed personnel who had access to the storage area. The licensee determined that the cabinet had been cleaned out by a technician in late January 2003 and that the eye applicator was likely disposed of in the trash.

The device was confirmed to be in storage during the previous source inventory in January 2003. IDNS also performed an inspection of the licensee in January which verified that the device was in storage.

The eye applicator dates to 1955, and was manufactured by a German company, Trauslat. The radiation level at the surface of the box is approximately 17 millirem per hour. The model number of the eye applicator is RA-1 and the serial number is 183. The device had an original source strength of 35 millicuries.

An IDNS inspector performed surveys and interviewed hospital staff members but was unable to locate the device at the licensee facility.

The NRC's Incident Assessment Team, Office of State and Tribal Programs and Office of Nuclear Materials Safety and Safeguards have been notified. The NRC's Region III (Chicago) Office is monitoring the State's investigation. This information is current as of 9:00 a.m. CST on March 17, 2003.

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