GREENBRIER VALLEY
MEDICAL CENTER

202 Maplewood Avenue • Ronceverte, West Virginia 24970
Phone (304) 647-4411 • *Facsimile* (304) 647-6010 • www.gvmc.com

Reply to Notice of Violation

March 21, 2005

Copy

USNRC
ATTN: Document Control Desk
Washington, DC 20555

USNRC
Region 1
Regional Administrator
475 Allendale Road
King of Prussia, PA 19406-1415

Docket No. 03012343
License No 47-17199-01

To whom it may concern,

This document is being submitted in response to the notice of violation issued on March 11, 2005.

A.

1. The licensee erroneously notified NRC Region II of the incident via postal correspondence within 30 days of the discovery of the occurrence.
2. All involved personnel were notified of the error.
3. All involved personnel have been reeducated that the correct response to any loss or theft of materials in excess of the limits identified in 10 CFR 20.2201 (a) (2) (ii) required Telephone notification of the occurrence to the NRC operations center within 30 days of the discovery of the occurrence.
4. Full compliance has been achieved as of the date of this document.

B.

1. This violation occurred due to unnecessarily excessive inventory procedures (see item A of the appended report to the commission dated 8/5/03).
2. Corrective actions were implemented on 8/5/03 and identified in the NRC notification letter. (Additionally, since that date, all Iodine – 125 seeds are loaded into the applicator by the nuclear pharmacy prior to receipt at the facility.
3. The corrective steps that have been taken will avoid further violations.
4. Full compliance has been achieved as of the date of this document.

Sincerely,

Heather Rose,
Radiation Safety Officer

IE07

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8/5/03

U.S.N.R.C.
Region II
61 Forsyth Street, NW, Suite 23 T 85
Atlanta, GA 30303-3415
Re: License Number 47-17100-01

To Whom It May Concern:

This report has been prepared in accordance with 10 CFR 20.2201 (a) (ii).

On 7/11/03 it was discovered that an Iodine -125 interstitial prostate seed was apparently lost. This seed contained ~0.425 mCi of I-125 in a solid seed form thus, a 30 day reporting requirement applied to the incident. Please note the following information regarding the incident:

A. The facility procedure for maintaining inventory control of sealed sources included counting the sources in the Nuclear Medicine Hot Lab just after delivery and then recounting the sources in surgery prior to implanting. The apparent loss occurred in the nuclear medicine hot lab when the seeds were being counted just after delivery from the vendor.
B. A diligent search using detection equipment was performed.
C. Since the sources were typically counted using a white sheet/pillow case as a background, it was determined that the source was likely discarded in the laundry.
D. To prevent any future losses of I-125 seeds the facility inventory procedure was modified to eliminate the initial seed count in the nuclear medicine hot lab. All seeds will be counted in the surgical suite just prior to insertion.

The amount and type of nuclide contained in this seed presents no radiological hazard or exposure concerns to any member of the general public.

Thank you for your attention to this matter.

Sincerely,

(Rose)

RSO