RI - DNMS Licensee Event Report
Disposition

Licensee: TOME J. UBINAS Radiation Oncology Ctr
Event Description: Leaking Source

License No: 52-25487-01 Docket No: 030-35220 MLER-RI: 2006-014
Event Date: 3-29-06 Report Date: 4-3-06 HQ Ops Event #:

1. REPORTING REQUIREMENT

- [ ] 10 CFR 20.1906 Package Contamination
- [ ] 10 CFR 20.2201 Theft or Loss
- [ ] 10 CFR 20.2203 30 Day Report
- [X] Other 10 CFR 35.67, 35.3067
- [ ] 10 CFR 30.50 Report
- [ ] 10 CFR 35.3045 Medical Event
- [ ] License Condition

2. REGION I RESPONSE

- [ ] Immediate Site Inspection — Inspector/Date
- [ ] Special Inspection — Inspector/Date
- [ ] Telephone Inquiry — Inspector/Date
- [ ] Preliminary Notification/Report
- [✓] Information Entered in RI Log
- [ ] Report Referred To:
- [ ] Daily Report
- [ ] Review at Next Inspection

3. REPORT EVALUATION

- [✓] Description of Event
- [✓] Levels of RAM Involved
- [✓] Cause of Event
- [✓] Corrective Actions
- [✓] Calculations Adequate
- [ ] Additional Information Requested from Licensee N/A

4. MANAGEMENT DIRECTIVE 8.3 EVALUATION

N/A

- [ ] Release w/Exposure > Limits
- [ ] Repeated Inadequate Control
- [ ] Exposure 5x Limits
- [ ] Potential Fatality
- [ ] Deliberate Misuse w/Exposure > Limits
- [ ] Pkging Failure>10 rads/hr or Contamination>1000x Limits
- [ ] Large# Indivs w/Exp>Limits or Medical Deterministic Effects
- [ ] Unique Circumstances or Safeguards Concerns

If any of the above are involved:

- [ ] Considered Need for IIT
- [ ] Considered Need for AIT

Decision/Made By/Date:

5. MANAGEMENT DIRECTIVE 8.10 EVALUATION (additional evaluation for medical events only)

N/A

- [ ] Timeliness - Inspection Meets Requirements (5 days for overdose / 10 days for underdose)
- [ ] Medical Consultant Used-Name of Consultant/Date of Report:
- [ ] Medical Consultant Determined Event Directly Contributed to Fatality
- [ ] Device Failure with Possible Adverse Generic Implications
- [ ] HQ or Contractor Support Required to Evaluate Consequences

6. SPECIAL INSTRUCTIONS OR COMMENTS

review during next inspection

☐ Non-Public

☒ Public-SISP REVIEW COMPLETE

Inspector Signauture: Date: 5/4/06

Branch Chief Initials: Date: 5/4/06

Location of File: G:\Reference\Blank Forms\LER FORM.wpd

Rev. 02/25/05

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Penny

TOME & UBINAS RADIO ONCOLOGY CENTER

To: Hector Bermudez
Fax: 404-562-4955
Phone:
Re:

From: Luis Rivera, RSO NRC License #52-2548-01
Pages: 2 including cover
Date: 4/3/6
cc: Director, Office of Nuclear Material Safety + Safeguards

☑ **Urgent** ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Comments:

Tome and Ubiñas Radio Oncology Center
NRC license # 52-25487-01

Date: April 3, 2006

Re: Report of a leaking source

This report of a leaking source is pursuant to 10 CFR 35.67 and the reporting requirements as described in 10 CFR 35.3067.

Model Number: STM 1251

Serial Number: n/a

Radionuclide: I-125

Estimated Activity: apparent activity of 0.340 mCi on 03/29/06

Result of the Test: Survey instrument readings and subsequent wipe test result revealed the presence of more than 0.005 microcuries.

Date of the test: 3/29/06

Action Taken: An I-125 seed (model STM 1251) jammed in the Mick applicator during a transperineal prostate seed implant. Survey meter readings indicated the source was in the applicator. Water was flushed through the applicator into a basin in an attempt to retrieve the seed. While the seed did not flush into the basin, survey meter readings of the water in the basin revealed radioactivity. At this point we proceeded with the assumption of a ruptured source (subsequent wipe tests confirmed our assumption). The Mick applicator and the water basin were then immediately removed from use and isolated. A second mick applicator was used to finish the procedure and as such the written directive for the patient was met. The operating room was isolated to verify that there was no spread of radioactive contamination. No one was permitted in the room. All personnel that were present in the room were surveyed for radiation. All results were negative. Subsequent wipe tests of the areas adjacent to the contaminated applicator were negative for contamination. A survey of the patient's urine at the end of the procedure was negative for radiation. The patient was sent home with a catheter. He returned the following day for catheter removal. A survey of the urine in the catheter was negative for radiation.