PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-98-053

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 Region III staff (Lisle, Illinois) on this date.

Facility
Community Hospitals Of Indiana, Inc
Indianapolis, Indiana
License No: 13-06009-01

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

Subject: LOSS OF IODINE-125 SEEDS

On November 4, 1998, the licensee notified the NRC that three seeds each containing 376 microcuries of iodine-125 (I-125) were lost (i.e., 1128 microcuries total).

On November 3, 1998, I-125 seeds were implanted into a patient. After the implant, the licensee staff counted eight spare seeds that remained in a "sterilizer pig" that was used to sterilize the seeds before the procedure. Normal procedure requires a dosimetrist to inventory any spare seeds, perform an ambient exposure rate survey of the area, and transfer the spare seeds to a transport pig used to bring the seeds back to the Radiation Oncology Department. Apparently, the dosimetrist did not place the eight spare seeds into the transfer pig before leaving the room. Therefore, the spare seeds remained in the sterilizer pig. A radiation survey did not detect the spare seeds because they were shielded within the sterilizer pig.

After the dosimetrist left the room, an Operating Room Technician (ORT) cleaned the sterilizer pig by rinsing the contents into a sink. The ORT was not trained to recognize the seeds as radioactive material.

During the morning of November 4, 1998, the dosimetrist remembered he had forgotten to transfer the spare seeds to the transport pig. Five of the eight spare seeds were found in the sink's drain trap. The licensee performed surveys of the sink and removed accessible pipes, but could not find the three missing seeds. The licensee believes the event would not lead to a dose in excess of regulatory limits because the seeds were most likely flushed down the drain.

NRC Region III (Chicago) will conduct an inspection within 30 days to review the circumstances surrounding this event.

The State of Indiana and the NRC Office of Nuclear Materials Safety and Safeguards have been notified. The information in this preliminary notification has been reviewed with licensee management.

The licensee notified the NRC Operations Center of this incident at 11:01 a.m. (ET) on November 4, 1998. This information is current as of 3:00 p.m. (CT) on November 4, 1998.

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