

**BOTSFORD**  
CANCER CENTER

U. S. Nuclear Regulatory Commission  
Region III  
Material Licensing Section  
2443 Warrenville Road  
Suite 210  
Lisle, IL 60532-4352

Margaret Syrian, M S  
Botsford Cancer Center  
Suite 120  
27900 Grand River Avenue  
Farmington Hills, MI 48336  
January 28, 2011

Dear Sir or Madam,

Please see attached report of incident that was verbally reported to you Jan. 19, 2011.  
Report No. 46553  
Contact: Bill Hoffman

Best Regards,



Margaret Syrian, MS  
Staff Physicist  
Botsford Cancer Center  
(248) 473 - 4802

RECEIVED FEB 7 2011

**Incident Report**  
**Botsford Cancer Center**

Licensee Name: Botsford General Hospital  
28050 Grand River Avenue  
Farmington Hills, MI 48336-5933

License Number: 21-08892-01  
Docket No. 030-02077

Report No. 46553  
Contact: Bill Hoffman  
Date: 1/19/2011

Name of the prescribing physician: James Fontanesi, M.D.

Description of the incident:

The HDR (High Dose Rate), remote after loading, brachytherapy treatment was planned and approved by the physician for a patient. The plan of the treatment was to irradiate the prostate area for 1200 cGy utilizing 15 channels and an Ir-192 source for a total time of 707.33 seconds.

Staff members evacuated the room. The HDR room door was closed. The treatment of the patient was started in the HDR room as planned. A staff member was still present in the room when the HDR machine was started remotely. After 1.855 minutes (111.3 sec) of the patient treatment when channel four was in progress the HDR machine stopped because the room door was opened from inside. This happened when the staff member exited the room explaining he/she had not realized that the patient's treatment had started.

Why the incident occurred:

Staff member was not physically observed in the treatment room upon the final check of the room. Individual was obscured by the patient's position and placement of equipment in the room.

The effect on the individual who received the administration:

Progress of the patient's treatment was noted so the time the staff member had remained in the treatment room could be determined. Staff member's position was verified and the distance from the level of the implant to the individual's seated position was measured. Noting the source strength a calculation of the estimated dose was performed. This estimate is the upper limit as the source is considered as a point source and the exposure is in air. The Botsford Cancer Center medical physicist and radiation safety officer verified the calculation. At the end of the day the radiation level was also measured for the time the staff member had been in the room. The staff member was informed later that morning that his/her exposure had been minimal (< 10 mrem).

Corrective action taken or planned to prevent a recurrence:

Risk management meeting took place on 1/21/2011. It was proposed that a final physical and verbal check of personnel, made by the physicist or physics staff member be added to the HDR Prostate Treatment Worksheet.

Certification that the licensee notified the individual:

Certification that the licensee notified the individual is supported by the statement made by the individual to that effect on the Employee Incident Report filled out by the individual on 1/19/2011.

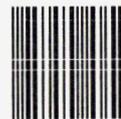
Prepared by: Margaret Syrian, MS  
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