MUNSON MEDICAL CENTER
MUNSON HEALTHCARE

November 17, 2014

Ryan Craffey, Health Physicist
US NRC Region III
2443 Warrenville Road, Suite 210
Lisle, IL 60532-4352

Dear Mr. Craffey,

Re: Event Notification Number: 50543

Below is the information required by 30.50(c)(2).

(i) Description of event: After implanting a patient with Palladium-103 (Pd-103) seeds [Theragenics Corporation Theraseed Model 200], the Mick applicator (applicator) was removed from the operating room by a nurse. The nurse would not normally remove the applicator from the operating room, but this time there was a second patient scheduled for treatment and the applicator was scheduled to be used as a back-up. The nurse was trying to be helpful by getting the applicator to the cleaning room for quicker turn-around. The physician (Authorized User) had not removed the magazine of four remaining seeds from the applicator, nor had the medical physicist (MP) performed a survey of the equipment before the nurse removed the applicator from the operating room. The applicator was transported to the OR cleaning area. A cleaning technician started to clean the applicator, but noticed it was no disassembled. She asked the surgical technician from the implant for assistance. The surgical tech recognized the magazine needed to be removed from the applicator and placed in the lead storage pig. He removed the magazine over or near the wash basin. The surgical technician commented later that the magazine was more difficult to remove than previous magazines. It appears that the applicator plunger was moved sometime between the last seed implant and magazine removal, thus pushing a seed partially out of the magazine. The majority of the seed was retained in the applicator needle, but a portion was broken off during magazine removal and was lost. When the MP realized approved procedures were not followed, he tried to account for the seeds and determined part of one was missing. He used fluoroscopy of the magazine and a well counter to detect if the missing was in the applicator or magazine. This is when he determined that a seed had broken and part of it was missing.

(ii) The location of the event: The second floor OR cleaning room at Munson Medical Center.

(iii) Material: Palladium-103 seed, nominal activity 1.5 mCi. The portion of the seed lost had an activity of approximately 0.5 mCi.

(iv) Date and time of event: October 15, 2014 around 0945 EST.

(v) Corrective actions: Training of OR personnel (including nurses, surgical technicians, cleaning technicians) by MP. Training will include new policy that only the AU and MP

will handle implant materials (magazines/seeds, applicator, and pig). If other personnel see the implant materials out of sight of AU or MP, the implant materials are not to be touched, and the AU or MP are to be notified. Additionally, the implant material is to remain on the sterile work table in OR until released by the MP. Training is scheduled for November 19, 2014. This practice will be reiterated during the time out preceding each case.

(vi) Individual exposure: The broken piece of seed was unable to be located and is presumed to have washed down the wash basin drain. The larger piece was retained. The cleaning technician may have received a very small hand exposure.

Sincerely,

Dennis J. Aurand

Dennis Aurand, MS, DABR®
Diagnostic Medical Physicist
Radiation Safety Officer
daurand@mhc.net
phone: 231.392.8612
fax: 231.935.3204

Form # 4522 (11/10)

MUNSON HEALTHCARE

FAX COVER SHEET

PLEASE DELIVER TO:	Ryan Craffey	**DATE:**	November 17, 2014
RECIPIENT'S PHONE:	630-829-9655	**FAX:**	630-515-1259
SENDER:	Dennis Aurand	**DEPT:**	RSO, Radiology
SENDER'S PHONE:	231.392.8612	**FAX:**	231.935.3204
SUBJECT:	Event Notification Number: 50543		

The following document(s) are transmitted for delivery to the above named individual and consist of 3 page(s), including the cover sheet.

If you have any questions, please contact the above sender.

1105 Sixth Street
Traverse City, MI
49684-2386
(231) 935-5000