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PARKVEN

March 14, 1994

13-01284-02

U.S. Nuclear Regulatory Commission Region III 801 Warrenville Road Lisle, IL 60532-4351

Dear Nuclear Regulatory Commission:

Enclosed is our Reply to Notice of Violation, which is in response to the letter and notice dated February 22, 1994, from B.J. Holt, Chief, Nuclear Materials Inspection Section 1.

At Parkview we always want to use radiation and radioactive materials in keeping with all the best practices of radiation safety and to adhere to every regulation relating to medical use of radioactive materials.

If we can provide any additional information, please let us know.

Sincerely yours,

John F. Agnew, Ph.D.

John Fagner AM

Radiation Safety Officer

Robert A. Rankin Administrative Director

pc: David S. Ridderheim
President, Parkview Hospital

Larry Sheetz, Senior Vice President

Professional Services

9404050123 940322 PDR ADOCK 03001593

REPLY TO NOTICE OF VIOLATION

PARKVIEW MEMORIAL HOSPITAL 2200 Randallia Drive Fort Wayne, IN 46805

NRC License No. 13-01284-2

On December 21, 199 cesium-137 therapeutic tube sources were inserted into a patis undergoing cancer treatment but the radiation survey was not erformed immediately, in violation of NRC regulations.

A substantial number of cesium procedures are done each year at Parkview, and so the staff involved are well versed in the procedures. Afterloading instruments are fixed into the patient in an Operating Room, and after Recovery, films for dosimetry purposes are taken in Xray. The actual loading of radioactive materials is done later in the patient's room on floor 4 East. A physics staff person (physicist or dosimetrist) is always present at the time of insertion and performs the radiation surveys required.

However this particular case was unusual, in that the Authorized User wanted to delay inserting the radioactive materials until 6:00 pm, which is after all the physics staff have gone for the day. And so it was that the inserts were prepared by a physics person, but the Authorized User took them up to the patient's room and inserted them at 6:00 pm. The physics staff member then performed the radiation survey the first thing next morning, about 13 hours later. The survey was of the patient, the local area, and all the adjacent areas, and there were no unusual readings and no misplaced or lost sources. The survey was clearly not done "immediately", and is contrary to usual practice.

The natter was discussed at a meeting of all the physics section on February 7, 1994, and again at a meeting of the entire physics group with the Radiation Oncologists on February 16, 1994. At that time a policy decision was made that in the rare instance that an Authorized User wants to load the sources after hours, a physics person will accompdate by either staying late or coming back in to do the radiation surveying.

With this policy, there should certainly be no repeat of the delay in the radiation survey of a brachytherapy patient. We should be considered in compliance with the regulation as of February 16, 1994.