

FEB - 9 1994

Docket No. 030-13632

License No. 06-14734-01

Mount Sinai Hospital
ATTN: Paul Stillman
Senior Vice President
500 Blue Hills Avenue
Hartford, Connecticut 06112

Dear Mr. Stillman:

Subject: Routine Inspection No. 030-13632/93-001

This letter refers to your December 29, 1993 correspondence, in response to our December 1, 1993 letter.

Thank you for informing us of the corrective and preventive actions for Item A and the corrective actions for Items B and C. These actions will be examined during a future inspection of your licensed program.

In your response to Items B and C, you did not include your preventive actions to ensure these violations do not recur. Please provide this information.

Your cooperation with us is appreciated.

Sincerely,

Original Signed By:
Jenny M. Johansen

Jenny M. Johansen
Medical Inspection Section
Division of Radiation Safety
and Safeguards

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cc:
Public Document Room (PDR)
Nuclear Safety Information Center (NSIC)
State of Connecticut

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REGION I

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MOUNT SINAI HOSPITAL

December 29, 1993

Docket No. 030-13632

License No. 06-14734-01

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

SUBJECT: Reply to a Notice of Violation Pursuant to Routine Inspection No. 030-13632/93-001

TO WHOM IT MAY CONCERN:

This written statement is in reply to a Notice of Violation dated December 1, 1993 received by Mount Sinai Hospital, Hartford, Connecticut:

- A. The cesium-137 brachytherapy sources which had been stored in the brachytherapy storage area were moved to Radiology Room 3 in preparation for alternative use of the area. These sources were subsequently transferred for disposal. The transfers were organized by Dr. Gary Marolt, Physicist for Mount Sinai Hospital. An amendment request was inadvertently omitted.

The cardiac room on the third floor had been in use for years for thallium-201 cardiac studies. This area has always been treated as an area of radioactive materials use, with daily area surveys and weekly wipe tests. A drawing of the area had not been included in our license either inadvertently, or because the materials used did not require an NRC license. In any event, a license amendment request should have been filed since the advent of use of technetium-99m sestamibi in addition to thallium-201.

Dr. Marolt is no longer our consulting physicist. We became aware that there was a problem prior to the visit of the NRC inspector through a management audit conducted by our new physics consultant. Management has been made aware of the necessity of filing amendments upon changing areas of use. We have filed a request for a license amendment to reflect the changes. Full compliance will be achieved as of the date we receive our license amendment.

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- B. The lack of leak testing of our cesium-137 brachytherapy sources at the proper six month intervals and prior to transfer for disposal resulted from the same process described above.

We became aware that there was a problem prior to the visit of the NRC inspector through a management audit conducted by our new physics consultant. Leak tests will be conducted on a timely basis, effective immediately. Since the brachytherapy sources are now in the disposal site, no further action will be taken.

- C. Upon decontamination of the patient room following unsealed source I-131 therapy over 30 millicuries on May 29, 1993, we had carefully surveyed the room using a radiation detection survey instrument, but had not performed the required wipe test for removable contamination.

Since more than ten half lives have passed since the incident, no corrective action can be taken. To avoid further violations, the nuclear medicine staff has been instructed in techniques for room decontamination following I-131 inpatient therapy procedures. We are currently in full compliance.

We hope this satisfies your request for a response to the Notice of Violation. Please contact us if you require additional information.

Sincerely,



Paul Stillman
Senior Vice President

PS/pg

cc: Regional Administrator, Region I