PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-III-83-20 Date: 3/18/83

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 the staff on this date. 30-2028

Facility: St. John's Hospital
22101 Moross Road
Detroit, MI 48236
Lic. No. 21-03210-01

Licensee Emergency Classification:
_____Notification of Unusual Event
_____Alert
_____Site Area Emergency
_____General Emergency
__X__Not Applicable

Subject: POSSIBLE OVEREXPOSURE FROM FIVE Cs-137 SEALED THERAPEUTIC IMPLANT SOURCES TOTALING 138 MILLICURIES

On March 17, 1983, the licensee notified Region III (Chicago) of a possible overexposure of an estimated 400 rads to the skin of the radiation therapist from five therapeutic treatment tubes containing a total of 138 millicuries of cesium-137 (Cs-137).

Two patients in adjacent rooms of the hospital were undergoing therapeutic treatment with Cs-137 sealed implant sources. One patient was to have the implants removed at 8:00 a.m. on 3/17/83 and the other at 4:00 p.m. on 3/17/83. At 8:00 a.m. the radiation physicist removed the Cs-137 from the one patient, performed surveys, and returned the sources to storage. When the radiation therapist arrived, the physicist informed him that the sources had been removed. The therapist, assuming that the sources had been removed from both patients, removed applicator tubes from both patients and put them in his pocket. (The tubes from one patient were empty. The tubes from the second patient still contained the sources). The therapist carried these sources in his pocket for about one hour (8:30 to 9:30 a.m.) and then put them in his desk.

The physicist later reminded the therapist of the implants to be removed from the patient at 4:00 p.m. At this point (about 12:00-12:30 p.m.) they both realized what had occurred.

Based on radiation surveys and initial calculations, the licensee estimates the therapist received a skin exposure of about 400 rads in the area of the thigh from the sources in the pocket of the labcoat in which they had been placed. Technologists working in the area of the desk may have received a maximum of 200 millirems to the whole body while the sources were in the desk.

The licensee is continuing its evaluation of the incident and will furnish a followup report to RIII. The licensee has sent all the film badges that may have been exposed to its film badge supplier for processing.

DMB: IE34

Rev. 1/19/83

A Region III Radiation Specialist will be at the licensee's facilities on March 18, 1983 to review the overexposure incident.

The State of Michigan has been informed.

The licensee does not plan to make a news release at this time. Region III will issue a news announcement if warranted by the March 18 inspection findings.

Region III was advised of this by a telephone call from the licensee at 1:00 p.m. (CST) on March 17, 1983.

This information is current as of 8:00 a.m. (CST) on March 18, 1983.

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1/10/83