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INSTITUTE OF RADIOLOGY
WASHINGTON UNIVERSITY
MEDICAL CENTER

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RADIATION ONCOLOGY CENTER

PUBLIC

May 19, 1994

Mr. Roy J. Caniano
Chief, Nuclear Materials Safety Branch
United States Nuclear Regulatory Commission
Region III
801 Warrenville Road
Lisle, Illinois 60532-4351

RE: License No. 24-00167-11
Docket No. 030-02271

Dear Mr. Caniano:

As required by 10 CFR 35.33 (a) (4) and complying with your letter of May 12, 1994, I have sent these letters to the patients involved in these incidents in my capacity as Chairman of the Radiation Safety Committee at Washington University Medical Center.

I hope this will be satisfactory.

Best regards.

Sincerely yours,

Carlos

Carlos A. Perez, M.D.
Director, Radiation Oncology Center and
Chairman, Radiation Safety Committee
Washington University Medical Center (WUMC)

jm:cap\radsaf.doc
Encl.

Copy: John Eichling, Ph.D., Radiation Safety Officer, WUMC

4511 Forest Park Boulevard
Saint Louis, Missouri 63108
314/362-9700 or 9701 FAX: 314/362-9797

Rec'd 5-31-94

320

Washington
WASHINGTON·UNIVERSITY·IN·ST·LOUIS
School of Medicine

Division of Radiation Safety

May 18, 1994

Mrs. JoAnn N. Kloecker
515 High Hampton Road
St. Louis, Missouri 63124

Dear Mrs. Kloecker:

I am writing to you as Chairman of the Radiation Safety Committee. As you will remember, a minor equipment malfunction occurred on February 26, 1993 while you were undergoing internal radiation therapy during your hospitalization at Barnes Hospital. The brief equipment error resulted in a small added amount of radiation (less than 280 millirems) to your leg that was in our medical judgment of no consequence to you. For perspective, the effective radiation dose due to the equipment error was less than the annual effective dose that we all receive, on the average, due to naturally occurring radiation sources. In fact, the added effective dose was substantially less than the allowable radiation dose to the developing child of a pregnant radiation worker, e.g., a medical technologist or nurse.

We told you about the incident when it occurred. A federal agency that regulates the type of radiation treatment that you received, the United States Nuclear Regulatory Commission, has notified us that we should inform you in writing about this incident.

I sincerely apologize for troubling you so late with this matter. I wish to assure you again that the additional amount of radiation attributed to the equipment malfunction was very small and that, based on our medical judgement and experience, it will cause you no harm whatsoever.

Washington University School of Medicine
at Washington University Medical Center
Campus Box 8131, 660 S. Euclid Ave.
St. Louis, MO 63110-1093
(314) 362-2988 FAX: (314) 362-3333
(Location: 510 S. Kingshighway)

I am enclosing a copy of our official report to the US Nuclear Regulatory Commission. If you have any questions regarding this letter or our report, please feel free to contact me or my staff.

Sincerely,

Carlos A. Perez

Carlos A. Perez, M.D.
Chairman, Radiation Safety Committee
Washington University Medical Center (WUMC)

jm:radsaf.doc
Encl.

Copy: Andrew Galakatos, M.D. Gyn/Oncology, WUMC
Perry W. Grigsby, M.D., Radiation Oncology, WUMC
John Eichling, Ph.D., Radiation Safety Officer, WUMC
Roy J. Caniano, Chief, Nuclear Materials Safety Branch,
US Nuclear Regulatory Commission
Jeffrey Williamson, Ph.D., Radiation Oncology, WUMC

Washington
WASHINGTON·UNIVERSITY·IN·ST·LOUIS
School of Medicine

Division of Radiation Safety

May 18, 1994

I am writing to you as Chairman of the Radiation Safety Committee. As you will remember, a minor equipment malfunction occurred on January 7, 1993 while you were undergoing internal radiation therapy during your hospitalization at Barnes Hospital. The brief equipment error resulted in a small added amount of radiation (less than 20 millirems) to your leg that was in our medical judgment of no consequence to you. For perspective, the effective radiation dose due to the equipment error was less than the annual effective dose that we all receive, on the average, due to naturally occurring radiation sources. In fact, the added effective dose was substantially less than the allowable radiation dose to the developing child of a pregnant radiation worker, e.g., a medical technologist or nurse.

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Carlos A. Perez

Carlos A. Perez, M.D.
Chairman, Radiation Safety Committee
Washington University Medical Center (WUMC)

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US Nuclear Regulatory Commission
Jeffrey Williamson, Ph.D., Radiation Oncology, WUMC

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WASHINGTON UNIVERSITY
MEDICAL CENTER

RADIATION ONCOLOGY CENTER

DATE: May 19, 1994

TO: WHOM IT MAY CONCERN

FROM: Jeffrey F. Williamson, Ph.D.
Assoicate Professor and Chief, Brachytherapy Physics Service

RE: Correction to NRC Report of 6 October 1993
MicroSelectron/LDR malfunctions of 8 January 1993 and 26 February 1993
Washington University Broad Scope License 24-00167-11

Paragraph 2, line 7 of the 6 October 1993 letter, which reports two incidents of MicroSelectron/LDR unprogrammed source ejection to NRC, incorrectly states that the events occurred on 18 January and 12 April 1993. The incidents actually occurred on 8 January 1993 at 3:55 AM for [redacted] and on 26 February 1993 at approximately 5:45 AM for [redacted] Please correct your files.

c: NRC Region III
John O. Eichling, Ph.D.
Perry W. Grigsby, M.D.
Carlos A. Perez, M.D.
James A. Purdy, Ph.D.
Reportable Event File

JFW/cld

510 South Kingshighway Boulevard
Saint Louis, Missouri 63110