Region I Office
Division of Radiological Safety and Security
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Telephone Conversation Record

Date: 5/1/2023

License No. 47-01458-01

Docket No.(no hyphens): 03003375

Mail Control/Report No. 2023001

Licensee Name: United Hospital Center

Participant(s) Name/Title: Owais (Mohammed) Rafique, Asst. VP Specialty Practices; Kelly Stoneberg, Radiation Safety Officer (RSO); Yin Huang, Authorized Medical Physicist (AMP); Jim Israel, AMP

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NRC Representative Name/Title: Anne DeFrancisco, Branch Chief; Jason VonEhr, Senior Health Physicist; Jonathan Pfingsten, Senior Health Physicist

Subject: Follow-up on Reported Event

Discussion: A teleconference was held between the radiation safety staff, radiation oncology, and management of United Hospital Center (UHC) and NRC Region I staff to discuss the current status of follow-up the April 19, 2023, reported event (EN56477).

The licensee made immediate reports for three separate issues stemming from a stuck out HDR source event: licensee personnel overexposures, patient underdose for a single fraction, and safety equipment malfunction.

During this call, the NRC and licensee discussed the status of follow-up written reports due May 4th for the medical event (15 day written report under 10 CFR 35.3045(d)) and May 19th for the equipment malfunction (30 day written report under 10 CFR 30.50(c)(2)). The licensee previously contacted the HOO with an update retracting the reported suspected licensee personnel overexposure on the basis of dosimetry results.

The manufacturer was planning to replace the drive A assembly and source cable in the coming days (see below about the changes to the source exchange); the suspect equipment will be sent for further investigation.

Additional discussions were focused on the licensee's future plans concerning the steps the licensee would take prior to restarting the HDR program. The current plan was to perform a source removal, rather than exchange (on account of the anticipated timeline to restart the program), and keep the program on hold until:

- New AU authorized for 35.400 and 35.600 receives device specific training from the manufacturer;
- Find root cause of equipment failure from manufacturer;
- Re-training and equipment testing with the manufacturer;
- Re-evaluate policies, procedures, and competencies;
- Plan to do a time-out prior to HDR to verify use of dosimetry.

The licensee has performed an evaluation to determine the unintended dose to the patient. The licensee confirmed that the patient and referring physician will receive a copy of this information.

Action Required: Await written follow-up, conduct programmatic reviews under routine inspection, disposition issues as appropriate

SUNSI REVIEW

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