RI - DNMS Licensee Event Report
Disposition

Licensee: Nari Medical Association, LLC

Event Description: Loss of Cs-137 Rad Source

License No: 24-30488-01 | Docket No: 03036822 | MLER-RI: 2006-030

Event Date: 06/24/06 | Report Date: | HQ Ops Event #:

1. REPORTING REQUIREMENT

- [ ] 10 CFR 20.1906 Package Contamination
- [x] 10 CFR 20.2201 Theft or Loss
- [ ] 10 CFR 20.2203 30 Day Report
- [ ] Other Reported - but not required to report due to low activity
- [ ] 10 CFR 30.50 Report
- [ ] 10 CFR 35.3045 Medical Event
- [ ] License Condition

2. REGION I RESPONSE

- [ ] Immediate Site Inspection — Inspector/Date
- [ ] Special Inspection — Inspector/Date
- [ ] Telephone Inquiry — Inspector/Date
- [ ] Preliminary Notification/Report
- [x] Information Entered in RI Log
- [ ] Report Referred To:
- [ ] Daily Report
- [ ] Review at Next Inspection

3. REPORT EVALUATION

- [x] Description of Event
- [x] Levels of RAM Involved
- [ ] Cause of Event
- [x] Corrective Actions
- [ ] Calculations Adequate
- [ ] Additional Information Requested from Licensee

4. MANAGEMENT DIRECTIVE 8.3 EVALUATION

NA

- [ ] Release w/Exposure > Limits
- [ ] Repeated Inadequate Control
- [ ] Exposure 5x Limits
- [ ] Potential Fatality
- [ ] Deliberate Misuse w/Exposure > Limits
- [ ] Pkging Failure>10 rads/hr or Contamination>1000x Limits
- [ ] Large# Indivs w/Exp>Limits or Medical Deterministic Effects
- [ ] Unique Circumstances or Safeguards Concerns

If any of the above are involved:

- [ ] Considered Need for IIT
- [ ] Considered Need for AIT

Decision/Made By/Date:

5. MANAGEMENT DIRECTIVE 8.10 EVALUATION (additional evaluation for medical events only)

NA

- [ ] Timeliness - Inspection Meets Requirements (5 days for overdose / 10 days for underdose)
- [ ] Medical Consultant Used-Name of Consultant/Date of Report:
- [ ] Medical Consultant Determined Event Directly Contributed to Fatality
- [ ] Device Failure with Possible Adverse Generic Implications
- [ ] HQ or Contractor Support Required to Evaluate Consequences

6. SPECIAL INSTRUCTIONS OR COMMENTS

Review at next inspection

- [ ] Non-Public
- [x] Public-SUNSI REVIEW COMPLETE

Inspector Signature: Date:

Branch Chief Initials: Date: 8/21/06

Location of File: G:\Reference\Blank Forms\LER FORM.wpd

Rev. 02/25/05

Dr. Ahmad Mossavi, M.D.
20 White Road
Shrewsbury, NJ 07702

INCIDENT - LOSS OF CS-137 ROD SOURCE

Reporting NRC: Not required based on the following:

10 CFR Part 20.2201 Reports of theft or loss of licensed material:

(a) *Telephone reports.* (1) Each licensee shall report by telephone as follows:

(i) Immediately after its occurrence becomes known to the licensee, any lost, stolen, or missing licensed material in an aggregate quantity equal to or greater than 1,000 times the quantity specified in appendix C to part 20 under such circumstances that it appears to the licensee that an exposure could result to persons in unrestricted areas; or

(ii) Within 30 days after the occurrence of any lost, stolen, or missing licensed material becomes known to the licensee, all licensed material in a quantity greater than 10 times the quantity specified in appendix C to part 20 that is still missing at this time.

Since the Appendix C of Part 20 is 10 μCi for Cs-137, the activity loss is only 0.102 μCi, it is not necessary to report to NRC. However, it is filed for future inspection.

Description of the licensed material involved:

Kind:	Cesium-137
Quantity:	0.000102 mCi
Chemical Form:	Cesium Chloride
Physical Form:	Rod Source
Source S. No:	BM 0837-010-2

Description of the circumstances under which the loss or theft occurred:

On June 24, 2006, during the routine quarterly audit conduct by our consultant health physicist Mr. Venkata K. Lanka, we have discovered that we misplaced the above described rod source used for calibrating gamma well counter. We searched every possible place within our nuclear medicine laboratory located at the 20 White Road, Shrewsbury, NJ 07702. We have searched for it in the remainder of our facility. We could not locate it.

Our records indicated that our Nuclear Medicine technologist, Mr. Seth Achamfour-Yeboah, last used with the well counter was April 18, 2006. While not in use, Mr. Achamfour-Yeboah stores the rod source in a blue colored leaded container and left the leaded container inside L-block shield.

We have checked with the our radioactive material unit dose delivery company, GE Health Care of NJ, 1 Nylon Place, Livingston, NJ, if the delivery person inadvertently picked up the blue leaded container and found that no delivery person took it by mistake.

We could not locate the above named rod source so far.

A statement of disposition, or probable disposition, of the licensed material involved:

We believe that it may have disposed into the radioactive waste disposal can along with gloves and/or absorbent papers. Our practice of disposal of waste prior to disposal is that our technologist checks with the Geiger Counter. Mr. Achamfour-Yeboah may have missed this while checking the waste prior to disposal.

Exposures of individuals to radiation, circumstances under which the exposures occurred, and the possible total effective dose equivalent to persons in unrestricted areas:

The exposure to any individual could be very minimal as the activity is very low. The possibility of any individual to get 100 mR is very unlikely.

Actions that have been taken, or will be taken, to recover the material:

1. We have thoroughly checked our nuclear medicine lab and other labs in my office.
2. Mr. Yeboah, Nuclear Medicine Technologist, checked every other possible place to recover the material.
3. We called the GE Health Care of NJ, 1 Nylon Place, Livingston, NJ, if the delivery person inadvertently picked up the blue leaded container and found that no delivery person took it by mistake.

Procedures or measures that have been, or will be, adopted to ensure against a recurrence of the loss or theft of licensed material:

1. All personal working at our nuclear medicine facility are informed of the incident and educated them of the need for storage of controlled material.
2. Strict instructions were issued for storing all radioactive material in the locked cabinet and not to leave them near to the Gamma Counter or behind the L-block.
3. Since the technologist involved did not pay attention (negligence) to the storage of the above licensed material, I have requested him not to work in his facilities any more.

Signed: 

Ahmad Mossavi, M.D.