

RI - DNMS Licensee Event Report Disposition

Licensee:	KIVARKIS Y. YOUNAN, MD, PA				
Event Description:	Mis-delivered RADIATION material shipment				
License No:	29-30919-01	Docket No:	03036592	MLER-RI:	2004-068
Event Date:	11/30/2004	Report Date:	(MC) 12/6/04	HQ Ops Event #:	NA

1. REPORTING REQUIREMENT

<input type="checkbox"/>	10 CFR 20.1906 Package Contamination	<input type="checkbox"/>	10 CFR 30.50 Report
<input type="checkbox"/>	10 CFR 20.2201 Theft or Loss	<input type="checkbox"/>	10 CFR 35.3045 Medical Event
<input type="checkbox"/>	10 CFR 20.2203 30 Day Report	<input type="checkbox"/>	License Condition
<input type="checkbox"/>	Other <u>NONE</u>		

2. REGION I RESPONSE

<input type="checkbox"/>	Immediate Site Inspection	Inspector/Date	
<input type="checkbox"/>	Special Inspection	Inspector/Date	
<input type="checkbox"/>	Telephone Inquiry	Inspector/Date	
<input type="checkbox"/>	Preliminary Notification/Report	<input type="checkbox"/>	Daily Report
<input checked="" type="checkbox"/>	Information Entered in RI Log	<input checked="" type="checkbox"/>	Review at Next Inspection
<input type="checkbox"/>	Report Referred To:		

3. REPORT EVALUATION

<input checked="" type="checkbox"/>	Description of Event	<input type="checkbox"/>	Corrective Actions
<input checked="" type="checkbox"/>	Levels of RAM Involved	<input type="checkbox"/>	Calculations Adequate
<input type="checkbox"/>	Cause of Event	<input type="checkbox"/>	Additional Information Requested from Licensee

Not specified but STANDARD

4. MANAGEMENT DIRECTIVE 8.3 EVALUATION

<input type="checkbox"/>	Release w/Exposure > Limits	<input type="checkbox"/>	Deliberate Misuse w/Exposure > Limits
<input type="checkbox"/>	Repeated Inadequate Control	<input type="checkbox"/>	Pkging Failure > 10 rads/hr or Contamination > 1000x Limits
<input type="checkbox"/>	Exposure 5x Limits	<input type="checkbox"/>	Large# Indivs w/Exp > Limits or Medical Deterministic Effects
<input type="checkbox"/>	Potential Fatality	<input type="checkbox"/>	Unique Circumstances or Safeguards Concerns

If any of the above are involved:

<input type="checkbox"/>	Considered Need for IIT	<input type="checkbox"/>	Considered Need for AIT
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Decision/Made By/Date:

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

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

6. SPECIAL INSTRUCTIONS OR COMMENTS

<u>Review during next inspection</u>

☒ Public

Inspector Signature:

Date:

☒ Non-Public

Branch Chief Initials:

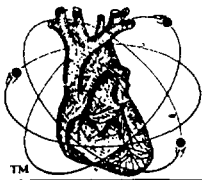
Date:

Location of File: G:\Reference\Blank Forms\2004 LER FORM.wpd

Rev. 02/01/05

NON PUBLIC: SISP REVIEW COMPLETE

with h12 from public



NCS

RECEIVED
REGION 1

NC SYSTEMS, INC.
NUCLEAR CARDIOLOGY SYSTEMS
5660 AIRPORT BLVD., SUITE 101
BOULDER, CO 80301

'04 DEC -6 P1:55

INCIDENT REPORT

On 29 November 2004, Nuclear Cardiology System, Inc. (NCS) of 5660 Airport Blvd., Suite 101, Boulder, Colorado 80301, Materials License #COL 751-01, shipped the following radioactive materials, via Federal Express, to Clarmont Comprehensive Health Care, 1145 Bordentown Avenue, 2nd Floor, Parlin, New Jersey 08859, Materials License(s) NJSL-20812/01/000 and NRC 29-30919-01.

The materials shipped consisted of two (2) shipments of sealed, epoxy, solid sources for use incident to medical diagnosis. The sources were shipped consisted of two (2) ^{57}Co sources, one (1) ^{137}Cs source and one (1) ^{133}Ba source.

The incident occurred when the Federal Express delivery, on 30 November 2004, delivered the sources to the wrong office at the intended address. The delivered office, a dental practice, is located on the same floor but clearly not the correct organization. NCS learned that the materials had been delivered but not received by its staff at the site, the incident was reported to the State of New Jersey, Federal Express, and the NRC.

On 01 December 04, the sources were located, at the wrong office, and moved to the correct location. The State of New Jersey, the NRC and Federal Express were notified that the sources had been located.


ACTIONS:

1. Federal Express should provide proper training to its personnel on the safe handling, delivery, of Dangerous Goods.
2. NCS will, when possible, provide additional location identification such as Suite #, of the destination however, that would not have prevented this incident.

Note: If NCS had not had staff on-site the knowledge that the materials were "missing" would not have been immediately recognized.

The incident does not involve the intended recipient license as the materials were not received by the intended recipient until after the incident was closed.

Sincerely,



Charles H. Rose, RSO
License COL 751-01

Distribution:

Steve Sandin
NRC, Region I
Division of Nuclear Materials Safety
475 Allendale Road
King of Prussia, PA 19406-1415

Pat Oppenheimer
Manager
Federal Express
3670 Hacks Cross Rd., Bldg G
Memphis, TN 38125

William Csaszar
State of New Jersey
Division of Environmental Safety & Health
PO Box 415
Trenton, NJ 08625-0415

Mr. Charles Hockman, Director
Office of Hazardous Materials
400 Seventh Street, SW
Washington, DC 20590

Dr. Younan
Clarmont Comprehensive Health Care
1145 Bordentown Avenue, 2nd Floor
Parlin, NJ 08859

NCS: Compliance
Shipping/Receiving