

RI - DNMS Licensee Event Report Disposition

Licensee: Nuclear Cardiology Diagnostics
 Event Description: Missing Sources
 License No: 29-31017-01 [REDACTED] 03036847 MLER-RI: 2005-029
 Event Date: 4-12-05 Report Date: 4-19-05 HQ Ops Event #: _____

1. REPORTING REQUIREMENT

<input type="checkbox"/>	10 CFR 20.1906 Package Contamination	<input type="checkbox"/>	10 CFR 30.50 Report
<input checked="" 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 _____		

2. REGION I RESPONSE

<input type="checkbox"/>	Immediate Site Inspection	Inspector/Date	<u>4/26/5</u>
<input checked="" 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: _____		

REPORT EVALUATION

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

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
Decision/Made By/Date: _____			

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

SPECIAL INSTRUCTIONS OR COMMENTS

RAM WAS LOCATED ON SITE

Public Inspector Signature: [Signature] Date: 4/26/5
 Non-Public Branch Chief Initials: [Signature] Date: 6/22/5

IAN J. MOLK, M.D., F.A.C.C.
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Diplomates American Board
of Internal Medicine
Diplomates Subspecialty Board
In Cardiovascular Disease

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RECEIVED
REGION I

'05 MAY 16 08:46

DURHAM CENTER - SUITE 406-A • 4 ETHEL ROAD • EDISON, NEW JERSEY 08817

Administrator
USNRC
Region I
475 Allendale Road
King of Prussia, PA 19406-1415.

RE: REPORT OF MISSING SEALED SOURCES

FACILITY: Nuclear Cardiology Diagnostics
4 Ethel Road
Suite 406A
Edison, NJ 08817

NRC LICENSE: 29-31017-01
NJ RAM LICENSE: 20840/01

DATE: 4/19/2005

This is a report of missing radioactive sources. The sources are vial-type sources used for dose calibrator calibration. The sources are as follows:

Nuclide	Chemical/Physical Form	Activity	Calibration Date
Cesium-137	Sealed source, vial	225 microcuries	5/1/1986
Barium-133	Sealed source, vial	262 microcuries	6/26/1986

The activity of the Cesium-137 source on April 12, 2005 was 134 microcuries, which is 10 times the quantity in Appendix C to part 20. The activity of the Barium-133 source was 74 microcuries, which is less than 10 times the quantity in Appendix C to part 20.

On Tuesday April 12, 2005, the sources were thrown into non-radioactive waste container by the nuclear medicine technologist during a cleaning of the hot lab. The technologist did not realize that this happened until Friday April 15, 2005 during my review of the radiation protection program.

On Friday April 15, 2005, I called the waste hauler to ask for the final destination of the trash. On Tuesday, April 19, 2005 I was informed that the material was sent to the Edgeboro Landfill in Central New Jersey.

The exposure rate from the Cesium-137 was 0.6mR/h at 30cm and 0.054mR/h at 1 meter. The bag containing the waste was placed in a dumpster. There would be no exposure greater than 2mrem in any one hour under these circumstances.

There is no likelihood of that the sources will be recovered because, they are now buried under tons of trash that has be deposited at the landfill since Wednesday April 13,2005.

To ensure against a recurrence of the loss or theft of licensed material, the RSO, President of the group and the medical physicist consultant have interviewed the nuclear medicine technologist about this incident and have instructed the technologist about the procedures for handling radioactive material, the use of the survey meter including the check source, and the importance of surveying everything that leaves the hot lab. A replacement Cesium-137 has been ordered for quality control of the dose calibrator. Only unit

A call was made the NRC Operations Center on April 19, 2005. It was recorded as Event Investigation number 41611.

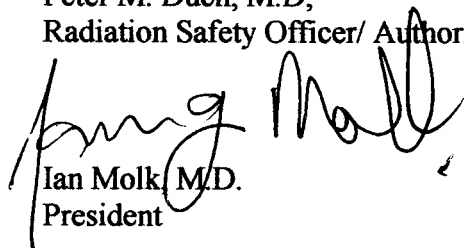
April 19, 2005 the medical physics consultant described the incident to a representative of the NRC, Region 1.

On April 22, 2005 the sources were found in the radioactive trash in the hot lab at Nuclear Cardiology Diagnostics. The sources were put into storage.

Respectfully submitted,



Peter M. Duch, M.D.
Radiation Safety Officer/ Authorized User



Ian Molk, M.D.
President