NRC FORM 591M PART 3
(10-2003) 10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

Docket File Information

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE	2. NRC/REGIONAL OFFICE
The Bryn Mawr Hospital **130 South Bryn Mawr Avenue** **Bryn Mawr, Pennsylvania 19010** REPORT NOS 2005-002	**U.S. Nuclear Regulatory Commission** **Region I, 475 Allendale Road** **King of Prussia, Pennsylvania 19406-1415**

3. DOCKET NUMBER(S)	4. LICENSE NUMBER(S)	5. DATE(S) OF INSPECTION
03003094	37-07722-04	December 22, 2005
6. INSPECTION PROCEDURES USED	**7. INSPECTION FOCUS AREAS**	**8. INSPECTOR**
87131	03.01(H), 03.06, 03.07	DJanda/SGabriel

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S)	2. PRIORITY	3. LICENSEE CONTACT	4. TELEPHONE NUMBER
02230	2	Marchello Barbarisi, M.D., RSO	610-526-8695

[X] Main Office Inspection — Next Inspection Date: April 2007

[ ] Field Office _____

[ ] Temporary Job Site _____

PROGRAM SCOPE

This was an unannounced, special inspection limited to a review of the circumstances surrounding two administrations of the wrong diagnostic radiopharmaceutical. In October 2005, licensee management contacted Region I to discuss these administrations and to confirm that they did not require reporting to the NRC as medical events. Both involved administration of Tc-99m MDP instead of the intended radiopharmaceutical. The injecting nuclear medicine technologist (NMT) was the same for both administrations. In the time frame that these events occurred (April 2003-April 2004), licensee management was aware of multiple problems with the NMT's performance and took actions to address these problems. The licensee terminated the NMT's employment in February 2005. The inspectors confirmed that neither administration met the definition of a reportable medical event.

The two administrations of the wrong diagnostic radiopharmaceutical occurred in 2003-2004, however licensee management stated that the Radiation Safety Committee (RSC) did not review them until an employee raised concerns in October 2005. The licensee's RSC discussed a written report summarizing the two administrations at a meeting on December 22, 2005. The licensee implemented a policy requiring documentation and review at the next RSC meeting of any administration of the wrong radiopharmaceutical, even if it is not reportable to the NRC.

The inspectors noted that a third administration of the wrong diagnostic radiopharmaceutical occurred in March 2005, involving a different injecting NMT. The health physics consultant prepared a written evaluation which was reviewed at the next RSC meeting. This administration did not meet the definition of a reportable medical event.

Within the scope of this inspection, no violations were identified.