RI - DNMS Licensee Event Report
Disposition

	Licensee: Lorton Community +CSPHG				
Event Description: Waste Sent to Landfill					
License N	No: 45-2305761 Docket No: 03030263 MLER-RI: 2007-023				
Event Da	ate: OQ 18107 Report Date: OQ D-1107 HQ Ops Event #:				
1.	REPORTING REQUIREMENT				
1	10 CFR 20.1906 Package Contamination 10 CFR 30.50 Report				
	10 CFR 20.2201 Theft or Loss 10 CFR 35.3045 Medical Event				
	10 CFR 20.2203 30 Day Report License Condition				
	other Waste alarm from hospital waste				
2.	REGION I RESPONSE				
	Immediate Site Inspection Inspector/Date				
	Special Inspection Inspector/Date				
	Telephone Inquiry Inspector/Date				
	Preliminary Notification/Report Daily Report				
	Information Entered in RI Log Review at Next Inspection				
	Report Referred To:				
3.	REPORT EVALUATION				
	∑ Description of Event				
	Levels of RAM Involved Calculations Adequate				
	Cause of Event Additional Information Requested from Licensee				
4.	MANAGEMENT DIRECTIVE 8.3 EVALUATION				
	Release w/Exposure > Limits Deliberate Misuse w/Exposure > Limits				
	Repeated Inadequate Control Pkging Failure>10 rads/hr or Contamination>1000x Limi	its			
	Exposure 5x Limits Large# Indivs w/Exp>Limits or Medical Deterministic Effe	ects			
	Potential Fatality 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)				
	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					
None					
□ Non-Pu	ublic Inspector Signauture: [Cultural Date:]/25/	67			
Public-SUNSI REVIEW COMPLETE Branch Chief Initials:					
Location of File: G:\Reference\Blank Forms\LER FORM.wpd Rev. 02/25/05					

Date: 9/21/07 U.S. NUCLEAR REGULATORY COMMISSION Time: 1:25 p.m. TELEPHONE CONVERSATION RECORD 03020223 Docket No(s). Mail Control License No(s). 45-23057-01 or Report No(s). Name of Licensee: Norton Community Hospital Name of Participant(s): Roger Coleman-Chief tech James Nunn-Physics Associates, consultant (276)679-9600 Telephone No. (540)563-0165 or (540)353-2597 (cell) Waste sent to landfill Subject: (NOTE: This will be used as the Documents Title in ADAMS) On September 18, 2007, waste believed to be from the above licensee Summary: set off a monitor at the Wise County Transfer Station in Norton, VA. Both the licensee and their consultant, James Nunn, believe that the waste came from patient bandaging at Norton Community Hospital. Exposure readings at the Station from the waste declined from about 4 mR/hr to background over approximately 30 hours, making it likely that the waste was Tc-99m. When inspectors from the State of Virginia surveyed the waste at the hospital, they found small pieces of bandaging like band aids and gauze which were radioactive. Mr. Coleman believes that nuclear medicine patients at the hospital are removing bandaging from injection sites and disposing of them in hospital waste. He considers it likely that this has been going on for a while, but that the transfer station only recently installed a radiation monitor to detect contamination. The licensee plans to institute patient instructions to return all bandages to nuclear medicine for disposal. They also plan internet inservices for nurses instructing them to collect patient items from the patient rooms that might be contaminated, and call nuclear medicine to pick them up. It is also planned that Mr. Nunn will in service personnel at the transfer station. Mr. Coleman will forward a report on these actions to NRC. Action Required:

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Sensitive

Prepared & SUNSI Review Completed By: RWM1 / RA / Date: 9/21/07

U.S. NUCLEAR REGI	Date: 9/24/07			
TELEPHONE CON	Time: 8 am			
Mail Control or_Report No(s).	License No(s). 45-23001-01	Docket No(s). 03020156		
Name of Licensee:	Mountain View Regional Medical Ce	nter		
Name of Participant(s):	Matthew Roberts-Chief tech Richard McKinley			
Telephone No.	(276)679-9100			
Subject: (NOTE: This will be used as the Documents Title in ADAMS)	Radioactive waste disposal			
Summary: According to Mr. Roberts, nuclear medicine waste is stored for decay and the last waste that was removed for disposal was removed on August 6, 2007. The last in house I-131 patient was Aust 16, 2007, a that waste is still in storage. Nurses on the floors have been in service on separating waste from radioactive patients and holding it for nucleimedicine. Mr. Roberts agreed to counsel patients about disposing of bandaging in the hospital.				
Action Required:				
Document Availability:	x Publicly Available	Non-Publicly Available		
x Non-Sensitive	Non-Sensitive Copyright Sen	nsitive Sensitive Copyright		
Immediate Release	x Normal Release	Delay Release Date		
Prepared & SUNSI Review Completed	RA / Date: 9/24/07			

Nuclear Regulatory Commission Attention: Richard McKinley

Fax: 1-610-337-5269

September 24, 2007

Investigation on Nuclear Medicine Incident

Norton Community Hospital was contacted by the Wise County Landfill personnel on September 20, 2007 in regards to a positive Geiger Reading from one of our trash dumpsters. A Geiger Counter was taken out to the dumpster and the trash was checked. One bag showed radioactivity in the 700 microRem/hour range. The article of trash that showed activity was a band-aid that had a spot of blood on it. This was determined to have been removed by a patient and thrown in the trash post nuclear medicine injection. This bandage was removed and placed in a secure area to decay to background activity.

ACTION PLAN:

- Patients who undergo nuclear medicine procedures will be educated in regards to their injection site. The injection site will be bandaged with a 2x2 swab and covered by Coban wrap. The patient will be instructed to leave the wrap on the injection site until the time of the procedure at which point the NM technologist will remove the bandage. This bandage will be checked for activity and if radioactive will be placed in the radiation waste area for storage until decayed to background.
- 2. A new instructional sheet will be given to the patient which explains the steps that must be taken to ensure radiation safety concerning their specific examination.
- 3. A Netlearning educational program for staff that cares for Nuclear Medicine patients will be implemented on a mandatory basis.
- 4. Current Geiger counter monitoring will occur at the 0.1 mRem/hour setting in order to detect even minimal radioactivity of any contaminated patient material.
- 5. Self-monitoring of our trash dumpsters for the next two weeks to ensure that all trash is at or below background activity levels.

It is the goal of Norton Community Hospital to provide high quality nuclear medicine procedures that ensure the safety of our staff, patients and community. It is our hope that the above measures will minimize the possibility of such a reoccurrence.

If you have any further questions, please contact Bryan Mullins, Imaging Director at 276-679-9665 or G.Thomas Haines, MD, RSO at 276-679-9668. Thank you.

Bryan Mullins, Director Imaging Services

G. Thomas Haines, MD, RSO