

Department of Radiology
Alaska Regional Hospital
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31 Mar 2008

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Health Physicist
Division of Materials Safety
U.S. Nuclear Regulatory Commission, Region IV
611 Ryan Plaza Drive, Suite 400
Arlington TX 76011-8064

RECEIVED
APR 2 2008
DNMS

Re: License # 50-18244-01

Dr. Katanic,

The corrective action plan we were operating under, vis-à-vis our Junior Technologist and brachytherapy program has come to a premature end with the dismissal of the Junior Technologist. For reasons that are confidential to the Human Resources department followed by a minor incident involving shoddy discharge of his duties around an I-131 thyroid cancer ablation case, he was discharged from employment at this hospital.

Investigation of the incident confirmed that there was no loss of control of byproduct material and the patient was discharged at an appropriate time with the appropriate instructions. The problem was in the paperwork which I have attached. The failure to completely and properly fill out the form indicates a relapse of the sort of casual and inconsistent approach to his duties that we had hoped to remediate through our corrective action plan.

This letter constitutes notice that we have terminated that corrective action plan. When we are fortunate enough to hire a new Technologist, we will have a similar but hopefully abbreviated program of enhanced supervision of the new Junior Technologist's activities on the brachytherapy cases. I say hopefully abbreviated because the program will go on until we observe consistent satisfactory performance.

Thank you for your advice and patience during this process.

Cordially,

Bradley K. Cruz, MD
Radiation Safety Officer

03/25/2008

To whom it may concern:

I am a Nuclear Medicine Technologists working at Alaska Regional Hospital. On 3/19/2008, at apx 1445 hrs., I performed on oral I-131 Radiotherapy Ablation on an inpatient. The patient was given a 100 mCi I-131 per oral (1 capsule), and instructions to help minimize radiocontamination in the room. Room surveys were then performed and documented.

On the afternoon of 03/20/2008, I performed a one meter patient reading as is standard 24 hrs after dosing to ensure that the patient falls below the 7 mR/hr that is required prior to being discharged. The Patient's 1 meter reading was 3.9 mR/hr. I documented this on our written directive that was taped to the outside of the patients door. Background and gieger counter calibration readings were also taken & documented. 3meter, bedside, door, hallway, and rm 549 readings were taken and recorded, but not yet documented on the written directive. I then informed my supervisor that the patient's 1 meter reading was 3.9 mR/hr. and paged Dr. Chung, our radiation oncologist, to inform him of the reading. Based on this reading the patient was discharged later that day.

On 03/24/2008, my supervisor, Peter Stokinger, cleared the room and noticed that the 3.9 mR/hr 1 meter reading had been documented in the wrong column on the written directive. This form can not contain "white out", so what would usually be done in this situation is to line through the reading in the wrong column and initial, and record appropriately OR fill out a new written directive correctly and get all the appropriate signitures. The latter being the preferred method.

The patient was NOT discharged without the manditory 1 meter reading showing an acceptable level. The patient was informed of this level as the readings were being taken and can bear witness. My supervisor and nursing staff also are aware that I was in the patients room taking the readings.

Sincerely,

 CNMT

ALASKA REGIONAL HOSPITAL
INPATIENT I-131 THERAPY WRITTEN I
WORKSHEET AND ROOM SURV

[2 pages]

Chung, Richard T MD
Alaska Regional Hosp

Room # 548 Date Ordered: 3/17/08 Authorized User: Richard Chung MD
Patient Name: [REDACTED] Dose Ordered: 100 mCi p.o. for: 3/19/08
date

Patients ID identified by:
Initials RC states own name photo ID ID bracelet
 relative states own birthdate states own SSN

Informed Consent:
Initials RC Informed consent obtained and instructions provided to patient/family on how to keep exposure to other individuals ALARA (as low as reasonably achievable) NRC reg. guide 8.39 Table 2

Patient not pregnant based on:
Initials RC hysterectomy celibacy negative pregnancy test male
 normal menses < 2 weeks ago past child bearing age pt had environmental radiation

Patient Dose:
Initials PMB Dose measured and administered 104.2 mCi Time of administration 1445

Room Prep
Initials RC Trash bags set up Valuables removed Room 549 empty and labeled
 entire floor faucet handles bathroom floor toilet lid TV remote
 telephone table top bed controls pillow chair
No chair

THE PLAN OF TREATMENT IS IN ACCORDANCE WITH THE WRITTEN DIRECTIVE

AUTHORIZED USER: [Signature] DATE: 3/19/08

*****EXPOSURE RATE (mR/hr)*****

Time/Date	[1] midline bedside	[2] midline 1 meter	[3] midline 3 meters	[4] doorway	[5] hallway	[6] Rm 549
1445 / 03-19-08	92	22	1.9	0.39	0.3	0.22
1425 / 03-20-08	3.4					

DATE	BKG READING	SURVEY METER #	CK SOURCE READING	TECH. INIT.
3/19/08	0.03	242990	1.3 mR/hr	PMB
3/20/08	0.03	242990	1.3 mR/hr	PMB
3/24/08	0.06	242990	1.3 mR/hr	[Signature]