

Helen Newberry Joy Hospital Nuclear Medicine Department
Memorandum for Record:
7/3/08

On 7/2/08 a MO99 generator was delivered to the Nuclear Medicine department by Federal Express. Upon receiving the package, check in was done by myself by first doing a visual inspection of the package and the package appeared O.K. with only a couple of minor tears less than 1 in. and not appearing to penetrate the cardboard. A successful battery test was done on the Geiger Mueller counter model 14C I used to check in the package. A reading of the check source was also noted and appeared fine. A background check of an area outside of the vicinity of the package was also done as is the protocol before checking in the package. I then put on gloves and began the package survey. The label on the outside of the box was a radioactive III symbol with a 148 GBq level of generator and a transportation index of 2.2 mR/h. The T.I. I recorded with the GM counter measured 3 mR/h. This level was noted higher than the 2.2 posted on the package. I next checked the outside of the box and measured 30 mR/h. Using the Ludlum well counter I measured a background count of 11,695 dpm's (disintegrations per minute). A wipe test of the package 3 areas 3in. x 5in. in diameter with a Q-tip showed a level of 23,985 dpm's considerably above acceptable limits.

I immediately informed Dr. Rowe the RSO and called Kevin Miller our physicist from Medical Physics Consultants for guidance. I was advised to call Fed Ex and inform the driver of the possibility of contamination. I talked to someone at the Fed Ex 1-800 number and they said they would call me back. I then called the Nuclear Regulatory Commission and spoke to Bob Gattone. He took down all of the information and advised me to make sure the Fed Ex driver and truck were checked for contamination and to isolate the package in question. He also instructed me to inform maintenance personnel as to what was going on and follow the proper procedures required. I called maintenance and left a message and posted a sign on the hot lab door reading "do not enter" and wrote the phone numbers of myself and the RSO if there were any questions. I was also told to find out where the package originated and get the information back to Bob Gattone at the NRC. I called the emergency number on the package and got someone at Chem Tech in Washington. They told me they handle emergency response for hazardous materials and they would let the proper companies know. I soon got calls from Tony Romzo from GE Healthcare and a message from Kevin Anderson at Lantheus Medical Imaging. I explained the situation to Tony and said that I had spoken with the NRC and needed to know the origin of the package he told me that it was Bristol Meyers Squibb and that Lantheus Medical Imaging was the place of origin. I was unable to contact Kevin Anderson at Lantheus Imaging but left him a message to call me. I called back Fed Ex and explained in further detail the serious nature of this event and it was important that I get a hold of the driver. I was then forwarded to a dispatcher and was told that the truck was an hour away. I informed the dispatcher of the incident and told her it was important that the driver and truck were surveyed for possible contamination. I then received a call from the ER at War Memorial hospital and I advised them what had happened and asked if they would call in a nuclear medicine technologist to survey this driver and his truck. Christy, the nuclear medicine technologist at War Memorial soon called and I explained

everything to her. I was then contacted by Roy Parker a physicist for Fed Ex. He wanted to be informed of the situation so I told him everything up to that point. I called Christy at War Memorial back later that evening and was told that the truck and driver were within normal limits of background radiation.

The next morning 7/3/08 I repeated the wipe test on the package using a new box of gloves. My reading of the package on this day came back within normal limits of background telling me there may have been cross contamination in the department. I called Kevin Anderson at Lantheus Medical Imaging and he concurred that this is what probably happened and that Lantheus was in fact the origin of the package. I then called Bob Gattone at the NRC and informed him of the results of the new wipe test and confirmed the origin of the package. The three of us confirmed that this was more than likely cross contamination of the gloves used in the original wipe test and the package was now safe for opening and future use of the product. The garbage in the room with the contaminated gloves was put in storage for 10 half lives and the package was checked in again with acceptable wipe tests done externally and internally. The package was put into lead storage and will be used as normal next week.

I contacted the hospital maintenance department and had them install a glove holder on the wall. This should help prevent cross contamination by keeping the box of gloves away from the drawing and waste disposal areas. No further action is required at this time.

Chad Bruno
NM Supervisor
Helen Newberry Joy Hospital
502 West Harrie St.
Newberry, MI 49868
906-293-9169