"Steven Courtemanche" <SRC@nrc.gov>
08/19/2005 08:48 AM

To <DHUN@inel.gov>
cc "Michele Burgess" <MLB5@nrc.gov>
bcc
Subject Closure information for NMED Event No. 050326

On July 18, 2005, you requested information on the above NMED Event.

(1) Corrective actions were listed to take place in the future. Need to know if corrective actions were implemented or still pending. Corrective actions have been implemented. Technologists and physicians have received aditional training on any procedures requiring a written directive. Individuals involved have also been reminded that a written directive is required to be completed, reviewed and signed prior to the administration of any radiopharmaceutical requiring a written directive. Licensee has determined that the root cause of the event was both the technologist and the physician did not follow the procedures involving the administration of doses requiring a written directive.

(2) What was the determined dose given to the patient? This information can not be determined. The licensee does not have the data on the initial size of the thyroid and its uptake percentage to determine the biological half-life of the iodine-131 in the body.

An inspection into the incident was conducted by Region I staff on June 16, 2005. The region believes that further information on this event is not forthcoming and that the event should be closed.