



"Steven Courtemanche"
<SRC@nrc.gov>
06/15/2007 11:45 AM

To "Dante C Huntsman" <Dante.Huntsman@inl.gov>
cc
bcc
Subject Re: Closure Information for NMED Event No. 070074

The Licensee Event Report [ML071300432] was examined by an NRC inspector and three areas of unintended dose, i.e., greater than 50 Rem and greater than 50% of the intended dose were examined. Rectum Area Number 3 was planned to receive a dose of 930 cGy and received 2472 cGy; Vaginal Mucosa Area No. 1 was planned to receive 411 cGy and received 1484; and Vaginal Mucosa Area No. 2 was planned to receive 265 cGy and received 1414 cGy. According to the chart, no unintended area received a dose of 3000 cGy or greater.

>>> Dante C Huntsman <Dante.Huntsman@inl.gov> 06/15/2007 12:45 PM >>>
Steven,

One last question on this event. Any estimates on what the unintended site received. Did it received the 3000 cGy (rad)?

Dante

"Steven Courtemanche" <SRC@nrc.gov>
06/15/2007 08:38 AM

To
<DHUN@inl.gov>
cc
"Michele Burgess" <MLB5@nrc.gov>
Subject
Closure Information for NMED Event No. 070074

On April 10, 2007, you requested additional information on the above NMED Event.

(1) What was the cause of the event?

As stated in your revision to the report, the cause of the event was human error. The licensee did not measure the plastic tube to ensure that it was 24 centimeters long.

(2) What corrective action(s) were taken by the licensee to prevent a recurrence?

As stated in your revision to the Event Report, additional training was provided to the personnel involved in the procedure and procedural

changes were made. The procedural changes included: Disposing of plastic tubes used for a procedure requiring 20-centimeter tubes once the procedure is completed and measuring the tubes to ensure they are the proper length before use.

(3) What was the activity of the source?

The total activity of the sources in the Fletcher suite and ovoid tandem was 68 millcurie Radium equivalent. (A throw-back activity to when only radium was used to treat patients.)

Since the inspection is closed and we are requiring no further information from the licensee, this event report may be closed unless you require further information.