"Steven Courtemanche" <SRC@nrc.gov>
07/05/2006 02:53 PM

To <DHUN@inel.gov>
cc "Michele Burgess" <MLB5@nrc.gov>
bcc
Subject Closure information for NMED Event No. 060265

On June 28, 2006, you requested additional information on the above NMED Event.

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

The licensee stated that they put in place three corrective actions. (a) Measurements would be made of the digitized prescription points. The distance between the points should not greatly exceed 4 centimeters. (b) A checklist would be institutted to include confirmation that the magnification factors were inputted into the system. c) Spreadsheet will be created so that the data can be checked independently. If the independent check shows a dose different by more than 10 percent, then all of the data will be checked for errors.

The above information was found in the licensee's report of a medical event found at ML061300154.

(2) Who is the manufacturer of the HDR?

The manufacturer of the HDR is [redacted].

(3) What is the model and serial numbers of the HDR?

The model number of the HDR is [redacted] and the serial number (on the console) is 32194.

A medical consultant was hired to review the event, so that portion of "Other Information" needs to be changed to "Y". His letters can be found at ML061510141 and ML061710194.

Under "Medical Event Information", the patients were informed of the event as per the licensee's report mentioned above. Please change to "Yes."

The NRC is planning an inspection of the circumstances behind the event and the licensee's corrective actions but does not feel it is necessary to keep the NMED Event open. Unless you require additional information, please close this event.