"Steven Courtemanche" <SRC@nrc.gov>
12/28/2007 07:40 AM

To <DHUN@inel.gov>
cc "Michele Burgess" <MLB5@nrc.gov>
bcc
Subject Additional information for NMED Event No. 070612

On December 11, 2007, you requested additional information on the above NMED Report item.

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

The licensee made revisions in its setup procedures, i.e. The catheter is not to be connected to the HDR until after the CT scans are completed, and training to all personnel in the revised procedures.

(2) What are the model and serial numbers of the HDR unit?

The model of the HDR unit is a [redacted] and its serial number is still being looked up by the licensee.

(3) Who was the manufacturer of the unit?

The manufacturer of the unit was [redacted].

(4) What was the determined dose given to the patient (The report stated that the patient was given 2000 rad more than prescribed, but what was prescribed?)

The amount prescribed was 340 rem. Exact numbers were not given by the licensee. There was a 0.5 cubic centimeter area within the treatment volume that received "greater than 2500 rem" though, I suspect, not much greater and a 1.0 cubic centimeter area that received "in excess of 2000 rem. There was also a radiation dose of 680 rem to an unintended area. All of these exposures qualify as medical events.

An enforcement panel has yet to be held for this inspection, so NRC management would like the action kept open. When I determine what the serial number for the unit is, I will send a sseparate e-mail. Information regarding your questions were found at ML072980395.