DCS No: 030013259401O6
Date January 7, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9403

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region I staff on this date.

Facility:
Washington Hospital Center
110 Irving Street, N.W.
Washington, DC 20010-2975

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Docket No.: 030-01325
License No.: 08-03604-03
Event No.: NONE
Event Location Code: HOS

Subject: REPORT OF A DOSE TO THE WHOLE BODY IN EXCESS OF REGULATORY LIMITS

On January 6, 1994, the licensee notified NRC that a technician received a dose to the whole body in excess of regulatory limits at their facility in September 1993. At the end of November 1993, the licensee collected and sent to the personnel monitoring device (dosimetry) vendor for processing the whole body and extremity badges for September, October and November 1993. The licensee was notified on December 10, 1993 by the dosimetry vendor that the September 1993 whole body film badge for one individual indicated a 5390 millirem dose and the extremity thermoluminescent dosimeter (TLD) for the same individual indicated a 5830 millirem dose. The vendor commented that the film badge did not show damage resulting from exposure to heat or light. The licensee was notified by the dosimetry vendor on December 18, 1993 that the October 1993 whole body badge indicated a 2700 millirem dose and the extremity TLD indicated a 1570 millirem dose to the same individual. The November 1993 dosimetry indicated a 30 millirem whole body dose and a 90 millirem extremity dose.

The licensee determined that the technician labeled monoclonal antibodies with Technetium-99m (Tc-99m) on one occasion in September 1993 and on one occasion in October 1993 under the supervision of a physician. They believe that the high exposures were a result of these two individual procedures. The licensee stated that the physician is authorized to use Tc-99m radiopharmaceuticals in humans; however, he is not authorized to perform the labelling procedures using Tc-99m. The licensee stated that their Radiation Safety Committee took action to preclude further research use of radioactive materials by the physician and technician.

Region I will conduct an inspection of the licensee's facilities and program on January 10 and 11, 1994. The Region is prepared to respond to media inquiries.

The District of Columbia has been informed.

This information is current as of 11:30 a.m., January 7, 1994.

CONTACT: David G. Mann (215) 337-5237
Jenny M. Johansen (215) 337-5304

DCS No: 03001325940106
Date January 7, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9403

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