

**BLUE RIDGE NUCLEAR PHARMACY**

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Event # 36504

On Monday, December 12, 1999 at approximately 3:45 PM I received a phone call from one our customers, Lewis-Gale Hospital asking where their shipment containing 15 mCi of I31-Iodine was. A quick review of our dispensing records verified that the order had been received, prescriptions written and dispensed. A search of the storage cabinet did not turn up the package in question so the hospital was asked to make sure that it had not been delivered. The technologist indicated that this had been done and the package was not in their possession. I then called the pharmacist, Mr. Cowan Edwards, who verified that he had indeed written the prescriptions and packaged the dose for delivery and placed it in the storage cabinet. Mr. Edwards thought that the driver had taken the package on his morning run. I then called the driver, Mr. Richard Teague at home. Mr. Teague stated that there had been no box containing I31-Iodine for Lewis-Gale Hospital in the cabinet when he left on his morning run.

I then contacted the NRC office using their toll-free telephone number to inform them that we had a shipment which was missing. I gave the person on the phone all the information I had regarding the package and indicated that we were still conducting our investigation. I was assigned an event number to refer to with any additional information I had.

I next called Mr. John Yonce, supervisor for Associated Courier in Charlotte, NC. to see if one of his drivers had inadvertently picked up this package along with our usual return shipments of expired 99-Mo Generators. Mr. Yonce stated that a new driver had made the run to our facility that morning and had picked up the package by mistake. The package was still in the vehicle and secured. Mr. Yonce stated that he would instruct the driver to bring the package with our routine shipment the next morning. I then called the NRC to inform them that the package had been located and confirm that the material had never been out of a controlled area. I was instructed to write this brief description of this incident and place it in our files but because the material was not missing for over 48 hours and was never out of direct control, this was all that was necessary.

The following morning, the package arrived and the material was placed back in our inventory.

Respectfully Submitted;

A handwritten signature in black ink that reads "Robert W. Beightol".

Robert W. Beightol, B.S., Pharm.D., BCNP, FASHP
Pharmacy Manager, RSO