

**September 1, 2023 – March 11, 2024 RAM NMED Events**

**5 total events**

**1 – Struck Troxler Gauge**

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| <b>1.</b> | On September 6, 2023 a Troxler gauge, model 3411, was hit by a vehicle while on a job site. This gauge contained a 9 millicurie Cesium-137 source and a 44 millicurie Americium 241:Be source. The area was secured, and the PA DEP responded to the site. The owner/RSO retrieved the sources with long handled pliers and secured them in the transportation box for the gauge. The area and gauge were surveyed, and smears were taken for contamination. The case was also surveyed and the owner/RSO has contacted a consultant/vendor to leak test the sources and arrange for disposal. |
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**1 – Lost / Missing Source**

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| <b>1.</b> | On September 19, 2023 a licensee vehicle was involved in an automobile accident during which a nuclear density gauge ejected from the vehicle. The State Police recovered the device. The licensee reported to the scene and recovered the device. There was no damage to the gauge itself. The only damage incurred was to the transportation box. The side handle was ripped off as a result of the accident. The DEP has been in contact with the licensee. |
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**1 - Shutter Failure**

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| <b>1.</b> | On January 18, 2024, the licensee’s radiation safety officer (RSO) was completing shutter checks and leak tests on a Berthold, model LB-300 W fixed gauge, containing sealed source with 8 millicuries of Co-60. During the checks the shutter’s shear pin broke and he was unable to close the shutter. The vessel that this gauge is on is not entered very often and is not readily accessible. A licensed contractor will be on site within a month to repair the gauge. If they are not able to repair the gauge on-site, the gauge will be placed in storage until it can be sent for repair. The DEP has been in contact with the licensee. |
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**1 - Medical Event (Seed Implants)**

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| <b>1.</b> | On September 28, 2023 staff from the pathology department called the Radiation Safety Office to report that they had accidentally transected an I-125 seed used for Radioactive Seed Localization (RSL). The seed was in breast tissue and was transected during the pathology processing in the laboratory. The seed was a Best Medical International Model 2301 containing 169 uCi of Iodine -125 (I-125). Two staff members were involved, and they were told to sequester in the room until personnel from Radiation Safety could respond. Shortly after, Radiation Safety personnel performed surveys to determine the extent of the contamination. No personnel contamination was observed. All contamination was discovered in waste material and on the tissue samples. The transected seed was contained. The Radiation Safety Office took possession of the damaged seed and all radioactive waste. At the time of reporting, it is estimated that approximately 50% of the activity was lost to open contamination, which is greater than 1 ALI of I-125, and therefore reached the criteria for 22.2202 reportability. Workers had bioassays performed for thyroid exposure and all returned negative. |
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<b>1 - Medical Event (Y-90)</b>	
<b>1.</b>	On February 1, 2024 a patient was receiving a Lutetium-177 (Lutathera®) treatment. The written directive, signed by the AU, was for 200 mCi of Lu-177. However, the treating medical oncologist signed a 100 mCi dose alteration treatment plan order on the same day as the procedure. The patient received the 200 mCi dose that was recorded in the written directive instead of what was intended. It is believed that a miscommunication occurred between the AU and the treating oncologist. A full investigation into the cause of the event is underway by the licensee. The AU and the patient have been notified. No effects are expected to the patient. The DEP has been notified and is awaiting further updates.