| August 27, 2025 – January 31, 2026 RAM NMED Reportable Events | |
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| **5 Total Reportable Events** | |
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| **2 – Leaking Source** | |
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| **1.** | On November 21, 2025, the licensee was performing a routine sealed source leak test and discovered that a Cs-137 vial reference standard (Model No. RV-137-200U, Serial No. 1710-68-8) was leaking. The licensee used a Capintec CRC 55tW well counter to determine that the source was leaking or contaminated. The source container was wipe tested on the inside and found to also be contaminated. The dose calibrator dipper was very slightly contaminated and also removed from service. All other equipment associated with the source was wipe tested and found to be free of contamination. The source was immediately removed from service. The sealed source was replaced in the original lead container and placed into gloves and a plastic bag along with all associated wipes and dose calibrator dipper. The licensee will package the material and send it to Eckert and Ziegler for disposal. The estimated activity of the source was 170 µCi, and the leak test results were 0.0139 µCi. |
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| **2.** | A Licensee reported a leaking Cs-137 E-Vial source (NAS serial #A6820) that contained an activity of 3.99 MBq (107.9 µCi) and an original activity of 7.63 MBq (206.2 µCi; calibrated 6/1/1997). During a quarterly physics audit and visual inspection performed on June 3, 2025, it was noted that the bottom of the Cs-137 reference source was fractured. The source was isolated, and leak tested by Universal Consultants, Incorporated. Results revealed 9.01 kBq (0.2436 µCi) at the bottom of the source. The source was encapsulated in mylar/latex and sealed to prevent contamination. Wipe tests found contamination within the lead container and on the dose calibrator dipper (bottom section). Radiation surveys and wipe tests throughout the facility's Hot Laboratory and Nuclear Medicine Department revealed no evidence of contamination. The Licensee stated that the failure was attributed to 28 years of use, being removed and inserted into the lead shield and dose calibrator for daily use. They ordered a replacement Cs-137 E-Vial source. The Licensee used the leaking encapsulated source for required daily calibrations until the new source was received on June 30, 2025. The leaking source was then pulled from use and stored in a shielded, secured environment pending disposal. They properly disposed of the source on October 13, 2025, through Bionomics, Incorporated. The Licensee updated their policy manual concerning reportability of leaking Cs-137 E-Vial sources and reporting incidents to DEP. |
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| **1 - Loss or Potential Loss of a Source** | |
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| **1.** | On December 10, 2025, the Department was notified that the licensee may have lost two sealed sources with serial numbers 110790 and 113504. It is thought the loss likely occurred between June 2 and June 20, 2025, during clean-up activities in a maintenance area where the two 100-millicurie Americium-241 sources may have been inadvertently disposed of in a roll-off container. The sources were used in Filtec Model FT-50 fill gauges. Their most recent leak test was completed, and passed, on June 1, 2025.<br><br>**Update 1:** After interviewing staff at the facility, we learned that the licensee had three Filtec FT-50 gauges in storage – two sourced, and one unsourced. When the storage area was cleaned out, the gauges were likely put in a roll off dumpster that was sent to a local scrap recycling center in Greensburg, PA. On December 22, 2025, the local scrap recycling center recovered one (1) gauge with S/N 113504 with the source inside and intact.<br><br>**Update 2: T**he local scrap recycling center discovered a second gauge. The second gauge does not have a source, and the serial number plaque is no longer attached. The Licensee continues to work with a consulting firm & the local scrap recycling center to continue to locate the other missing source.<br><br>At this time, the Department is in contact with the licensee, awaiting more information regarding any possible overexposures or contamination, and will update this document as soon as more information is provided. |
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| **2 – Medical In Nature** | |
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| **1.** | On December 12, 2025, a patient received a Y-90 TheraSphere treatment. The prescribed dose was 131.08 mCi. The patient received a dose of 72.4 mCi. It is preliminary believed that the administration tubing set or microcatheter defect caused a delay in administration leading to clog in line, however this is still being investigated. No effect on the patient occurred. |
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| **2.** | On December 22, 2025, the Pathology Assistant (PA) accidentally bisected an I-125 seed used for Radioactive Seed Localization (RSL) in breast tissue during the pathology processing in the laboratory. The seed was a Best Medical International Model 2300 Series (S/N 61498-8) containing 169uCi of I-125. The PA removed the two sections from the tissue with forceps and placed them in a vial within a shielded lead pig and contacted the Nuclear Medicine (NM) department. The NM employee surveyed the area, equipment used, and the PA. The specimen container, absorbent liner the tissue was sectioned, and 6 of the 11 specimen slides showed contamination. These items were packed into another container and taken back to NM department. Area surveys of the room and personnel showed no evidence of contamination. The RSO and ARSO were notified of the event. The facility attempted to measure the remaining activity of the 2 pieces of seed. The dose calibrator detected a greater activity than the decayed activity. The decayed activity of the seed was 169uCi. The dose calibrator detected 188uCi. The dose calibrator background of I-125 detected 2uCi. The RSO stated the greater reading may be due to the very low activity and the I-125 only having an energy of 35kev. Wipes were performed on the broken seed sections with no removable activity noted. The wipes detected only 12cpm after correcting for background (bkg=212cpm). These results lead the RSO to believe that the pathology encapsulated the released I-125. This loose contamination is greater than 1 ALI of I-125 (40uCi) and reaches the criteria for notification to the NRC for 10 CFR 20.2202(b)(2). |
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