

February 1, 2026 – August 31, 2026 RAM NMED Reportable Events	
9 Total Reportable Events	
2 – Damaged Portable Gauge Device	
1.	A Troxler Model 4640-B nuclear density gauge (Serial Number 001153) containing a 9 millicurie Cs-137 source was run over by a roller. The density tech that was responsible for the gauge was doubling as a roller operator during the shift. The gauge was placed on the ground between readings. The operator got on the roller and proceeded to move the machine which came in contact with the gauge. The licensee had a company representative onsite with a meter and obtained readings of 0.6mR/hr at 10cm. The licensee also contacted the manufacturer, Troxler. A rep with Troxler said that the readings would be 30mR/hr at that distance if the tungsten shield of the gauge was breached. The licensee believes that only the case was damaged. Following the manufacturers' guidance, they wrapped the device in insulation, placed it in a metal job box in the back of their truck and transported it back to their yard in Centre County until morning. No overexposures occurred and the gauge arrived and was secured at their shop at 10:03 pm that evening. The following day, the gauge was transported to North East Technical Services, Inc. in Maryland for disposal.
2.	A Troxler Model 3430 (S/N 28741) nuclear density gauge containing an 8 millicurie Cs-137 source and a 40 mCi Am/Be source was run over by a passing vehicle on the dead-end road where it was placed. It was subsequently dragged several feet before stopping. A flagger attempted to stop the vehicle but couldn't. The gauge was stuck under the front bumper of the car, and the plastic casing/electronics were clearly damaged, however the rod and handle were not affected. The technician immediately pulled the gauge out from the car, retracted the source from the backscatter position (still in the gauge body) to the shielded position, and moved it to the side of the road before calling the field manager. The licensee field manager then arrived onsite with a survey meter. Surveys were performed of the gauge outside the transportation case, inside the case, and the area where the gauge was struck and relocated to after impact. A wipe of the outside of the gauge where the shutter is located was taken and no external contamination was present. The gauge outside the case was reading 4 mR/hr on contact, case with the gauge inside was reading 2 mR/hr on contact and 0.4 mR/hr at 1 meter. The road and roadside were background. The gauge was then transported back to the company headquarters to be sent to Troxler for repair.
1 – Industrial Radiography	
1.	On August 10, 2026, around 7:00pm, a radiographer was working at the licensee's permanent location and could not fully retract the source into the camera. The camera was a QSA Model 880 with a source assembly model QSA Model A424-9 and contained approximately 22 Ci of Ir-192. The source would not go into the locked position or back out of the S-tube, and the gamma alarm was only flickering. The source was stuck an inch or so from the locked position, so it was partially in the shielding, and not fully retracted. They were able to disconnect the crank and pull the source back into the locked position. They put lead bags and lead plate against the front outlet port for the rest of the night. Since then, the camera seems to be operating correctly, and the issue was with the crank. The licensee spoke with the manufacturer (QSA) and the maintenance technician they both seemed to think it was an issue with the crank. The licensee installed a new drive cable assembly on August 12, 2026. They sent the old drive cable assembly to QSA on

	August 12, 2026 for inspection and repair if possible. The licensee estimates that the radiographer on duty received 3.5 mR during the 14-hour shift.
3 – Shutter Event	
1.	On July 21, 2026, a licensee discovered that a fixed gauge shutter was stuck open. The gauge was a Global Gauge Corporation (formerly E.S.C. Resources, Inc.) Model SH-6000 containing 2 Ci of Am-241. The gauge access area was shut down, the area was secured, and access was restricted. Global Gauge Corporation responded to troubleshoot the device and completed repairs on July 28, 2026. The cause of the shutter failure was determined to be a failed solenoid switch. The defective solenoid switch was replaced, and the shutter was tested and verified to be functioning properly before the gauge was returned to service on July 28, 2026. Radiation surveys confirmed that radiation levels in accessible areas remained within expected limits, no personnel exposures occurred, and access controls remained in place until repairs were completed and proper shutter operation was verified.
2-	On July 1, 2026, at 10:00am, the licensee's Safety Representative and a contracted Technical Specialist from a consulting firm notified the RSO that the coating weight gauges' shutter mechanisms were malfunctioning. The gauges were Metso Automation Model 300 NDS gauges containing 2 Ci of Am-241 each. The shutters would not close when a user attempted to utilize the Human-Machine Interface (HMI) and click "Close Shutter". The maintenance department arrived approximately 30 minutes later. The air system was then placed in the closed position, ceasing air pressure to the devices. Upon the air being suspended, the shutters immediately closed on the devices. Both a solenoid and valve were replaced in a timely fashion; this returned proper functionality to the shutters. At no point were any individuals exposed to the primary beam of the devices.
3-	On August 19, 2026, Global Gauge Corporation arrived at the licensee's facility to perform a calibration of the licensee's gauge. During the calibration process, Global Gauge Corporation discovered that the shutter was malfunctioning. This same gauge recently experienced a shutter malfunction that was reported as Shutter Event 1 above. The gauge was removed from service, shutter verified closed and secured in temporary storage. Global Gauge Corporation plans to transport the gauge back to their facility to repair or rebuild the gauge.
9 – Medical In Nature	
1.	A licensee reported a medical event involving a patient receiving another patient's dosage. The patient was scheduled to receive Tc-99m Sestamibi on 3/31/2026, but the nuclear medicine technologist (NMT) accidentally administered 37 MBq (1 mCi) of I-131. The NMT picked up the paperwork for another patient's I-131 dosing but accidentally called the Tc-99m patient's name. The NMT explained the exam and went over the written directive, and consent paperwork with the patient. The patient signed the written directive and consent for treatment, even though all paperwork had the other patient's name on it. At approximately 11:15 EDT, the NMT incorrectly administered the I-131 pill to the patient. Upon making copies of the documents to give to the patient, the NMT realized his mistake and then notified the patient, his supervisor, and Radiation Safety. Upon review of the event by the authorized user physician chose to administer the patient with the originally scheduled Tc-99m Sestamibi and associated imaging. The patient was then released from the hospital. Radiation Safety estimated the effective dose at 84.77 cSv (rem) and the thyroid dose at 165.46 cSv (rem). The direct cause was human error, combined with deviation from policy for proper patient identification. Additional deviations were also discovered during an investigation. When the written directive for the I-131 was reviewed by Radiation Safety, it was observed that the written directive had not been signed prior to treatment. All nuclear medicine

	supervisors will provide a document review of patient identification protocols to all NMT's across their licenses. That review would also include NMT's who support Radiation Oncology. The RSO also stopped all verbal approvals of written directives on 4/2/2026. The nuclear medicine supervisor attempted to bring the patient back in for follow up scanning to determine an accurate radiation dose to the patient; the patient declined. Follow up bloodwork was ordered by the authorized user at the request of the RSO. Protocol for diagnostic doses of I-131 requiring written directives was reviewed and revised to explicitly state the written directive must be signed prior to any administration. The patient and referring physician were notified of the incident.
2.	A patient underwent a vaginal hybrid intracavitary implant for re-irradiation of recurrent cervical cancer. The treatment was performed using Ir-192 in a Nucletron Flexitron Model 136149A02 HDR Unit (6.8 Ci source strength). The original treatment was for 5 fractions at 600 cGy per fraction, and this was her 2nd treatment. The plan was for placement of 3 needles into/around the tumor with a multichannel vaginal cylinder. Once under anesthesia, the implant was placed and secured with perineal immobilization and fixation of needles to cylinder. Imaging confirmed appropriate placement of the applicator. Following the second check, the applicator was connected to the HDR. No concerns were raised about applicator positioning at that time. Prior to delivery, the patient was heard coughing on the patient monitoring system. The CRNA raised concerns about patient breathing and entered the room for approximately 10 minutes to optimize breathing and ultimately placed nasal airway. Upon questioning the respiratory issues, no concerns from CRNA were expressed over patient coughing/heaving/gagging that could increase intraperitoneal pressure and displace the applicator. The AU did not verify this themselves. The treatment was delivered. Upon completion of the treatment, it was noted by AU that the applicator was partially displaced from the vagina, approximately 5cm from intended position. They suspect it moved when the patient coughed before treatment, but it could have moved during treatment. Intended treatment area did not receive prescribed dose of 600 cGy. Small area (~8cc) of vaginal wall received prescribed dose of 600 cGy where no dose had been prescribed. The patient recovered from anesthesia, and the event was disclosed to patient and family. The AU does not expect adverse effects.
3.	On July 23, 2026, a patient was receiving prostate treatment with Theragenics Cs-131 seeds (3.31 mCi seed). 76 seeds were brought to the operating room to implant 48 seeds, as described in the written directive. During the treatment, the Authorized User noticed that the applicator did not deploy seed #47 as intended. The mic applicator became disengaged from the needle hub during the procedure. As a result, seeds #46 and #47 were not implanted as intended. Radiation surveys were conducted, and the two seeds were located. Imaging performed after the treatment indicated that 45 seeds were implanted. Since 48 seeds were brought into the operating room, the additional 3 seeds should have remained unimplanted. Only two (seeds #46 and 47) were discovered – one seed was unaccounted for. The Authorized Medical Physicist immediately conducted surveys of the operating room, equipment, patient transport bed, linens, trash, and surrounding areas in an attempt to locate the missing seed. The seed was not located.