April 1, 2024 – August 30, 2024 RAM NMED Events	
7 total events	
1 – Equipment Failure	
1.	On July 31, 2024, the licensee reported damage to a QSA 880D (Serial # D14778, Source Serial # FC2203), camera containing 38 Ci of Ir-192. The licensee was on site performing weld inspections for a client. After the second exposure, the source did not return to the shielded position. The technicians on site called the Radiation Safety Officer (RSO) and established a restricted area around the source. They also notified the client to keep their personnel away from the area. The RSO arrived on site and was able to retrieve the source. The licensee staff determined that the technicians on site did not receive any overexposure. The RSO received 451 mR during the source retrieval. The badges have been sent to Landauer for verification. The equipment was taken out of service for repair.
2 – Lost / Missing Source	
1.	Timeline of the Event: On June 14, 2024, the Department was notified of a lost nuclear density gauge. On June 17, 2024, the licensee provided updated information regarding this incident. The updated information includes the location of the event, the discovery time and the local police information. On June 24, 2024, the licensee notified the Department that the car and gauge were recovered. On June 14, 2024 at 2:30am, an employee of the licensee reported to police that their vehicle, with a nuclear density gauge in it, was stolen earlier that day. Local police are aware of the incident. On June 24, 2024, the car and gauge were recovered. The gauge was still inside of the vehicle with no damage or evidence of tampering. Survey meter readings of the gauge showed normal levels and it was returned to the licensee. Representatives of the of a local Fire Company accompanied the licensee to retrieve the gauge. The gauge was a Troxler 3440 with containing Cesium 137, 9 millicuries; Americium 241:Be, 44 millicuries.
2.	On July 17, 2024 an employee of the licensee reported to police that a nuclear density gauge was stolen from their vehicle between 6:30-10:50 pm. Local police are aware of the incident. On July 19, 2024, an announced reactive inspection was initiated after the department received information from the licensee, that one of their portable gauges was stolen. The gauge was stolen from a vehicle, present across the street from the employee's residence. It was discovered missing that morning at 2:10 am. The employee stated that the vehicle was locked, and the gauge had been secured with a chain and lock in the rear of the station wagon. A black moving blanket was used to cover the gauge. Company equipment and a personal item were also stolen. Local law enforcement was contacted at 2:23 am. They arrived, took a statement, and stated that a detective would follow up. The gauge was a Troxler 3440 with containing Cesium 137, 9 millicuries; Americium 241:Be, 44 millicuries. To date the device has not been found.
4 – Medical (I-131 Administrations)	
1.	The reportable event occurred on April 17, 2024. A therapeutic dosage of 100mCi sodium iodide I-131 was intended to be delivered. At the end of the day while performing routine surveys, the 100 mCi capsule was found in its original shipping container. It was determined that the patient received a 4 mCi diagnostic sodium iodide I-131 capsule rather than the 100 mCi therapeutic capsule. Since the patient returned to receive the therapeutic dosage within a few hours and the total activity administered to the patient was within +/- 20% of the written directive no permanent functional damage or negative effects on the patient are expected. The licensee submitted a written report to the Department on May 3, 2024, in accordance with 10 CFR 35.3045(d).

2-	On April 19th, 2024 the licensee discovered a reportable event from *December 28, 2022. A patient received a diagnostic scan that was performed using 1mCi of I-131. This scan was performed without a written directive being prepared. Immediately upon discovery, the authorized users and technologists received training to remind them that they are required to verify the prescribed dosage to be administered against a prepared written directive. The licensee's system was modified to remind the employees to verify the prescribed dosage in the written directive against the dosage about to be administered. No harm is expected to the patient.
3-	On April 19th, 2024 the licensee discovered a reportable event from *December 29, 2022. A patient received a diagnostic scan that was performed using 1 mCi of I-131. This scan was performed without a written directive being prepared. Immediately upon discovery, the authorized users and technologists received training to remind them that they are required to verify the prescribed dosage to be administered against a prepared written directive. The licensee's system was modified to remind the employees to verify the prescribed dosage in the written directive against the dosage about to be administered. No harm is expected to the patient.
4-	On April 19th, 2024 the licensee discovered a reportable event from *January 31, 2023 a patient received a diagnostic scan that was performed using 4Mci of I-131. This scan was performed without a written directive being prepared. Immediately upon discovery, the authorized users and technologists received training to remind them that they are required to verify the prescribed dosage to be administered against a prepared written directive. The licensee's system was modified to remind the employees to verify the prescribed dosage in the written directive against the dosage about to be administered. No harm is expected to the patient.
	*Events 2 through 4, in this section, were discovered and reported all at the same time