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NRC PROPOSES TO FINE TORRINGTON'S COMMUNITY HOSPITAL $2,500 FOR NUCLEAR MEDICINE ERRORS

The Nuclear Regulatory Commission has proposed a $2,500 civil penalty against Community Hospital, Torrington, Wyoming, for failure to implement required quality assurance measures and for falsifying records.

The failures led to overdoses of radioactive drugs for two patients that went undiscovered for more than a year. The hospital and an independent medical consultant hired by the NRC concluded that health risks to the patients from the overdoses were negligible.

The two patients received doses of radioactive sodium iodide on September 6 and November 7, 1994, that were 30 percent and 40 percent greater than the doses prescribed by their doctors. The errors were not discovered until an NRC inspection was completed on February 26 of this year. The NRC also determined that the medical technician who made the errors deliberately falsified hospital records indicating that the doses given to the patients were as prescribed by their doctors.

NRC Regional Administrator L. Joe Callan said in a letter to the hospital administrator: "Although the actual consequences to the patients may have been negligible, this case is of significant regulatory concern in that the hospital did not implement a Quality Management Program which was effective in ensuring that radioactive material was administered in accordance with authorized users' instructions and that deviations . . . were not promptly identified and corrected."

When the errors were discovered, Community Hospital immediately suspended nuclear medicine procedures involving sodium iodide and subsequently decided to terminate its NRC license to perform nuclear medicine. A mobile service provider is now performing nuclear medicine at the hospital. As a corrective measure, the hospital also reviewed its policies and procedures and took disciplinary action against the medical technician involved.

Community Hospital has 30 days to pay the fine or file a protest.

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