

June 16, 2000

**PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE** PNO-IV-00-015

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region IV staff in Arlington, Texas on this date.

**Facility**

Sioux Valley Hospital Association  
Sioux Valley Hospital Association  
1100 South Euclid Ave.  
Sioux Falls, South Dakota 57117-5039  
Dockets: 03003249  
License No: 40-12378-01

**Licensee Emergency Classification**

Notification of Unusual Event  
Alert  
Site Area Emergency  
General Emergency  
X Not Applicable

Subject: MEDICAL MISADMINISTRATION

At 13:52 (EDT) on June 15, 2000, Sioux Valley Hospital Association (licensee) provided a telephonic report to the NRC Operations Center regarding a medical misadministration that occurred on April 4, 2000. This misadministration was identified by a Region IV inspector who was performing a routine inspection on June 15.

On April 4, 2000, a patient undergoing treatment for thyroid cancer did not receive the prescribed 3.7 gigabecquerels (100 millicuries) of sodium iodide I-131 as stated in the applicable written directive. Interviews with licensee representatives revealed that a nurse in the licensee's Patient Appointment Center, which scheduled the procedure and ordered the radiopharmaceutical, misinterpreted the written instruction "100 mCi I-131 followed by a whole body scan" to mean "I-131 whole body scan." A diagnostic administration of 157.62 megabecquerels (4.26 millicuries) of I-131 was ordered and subsequently administered for the whole body scan. A technologist who administered the dose also assumed that the prescribed dosage of "100 mCi" was in error and modified the written directive to match the dosage that was ordered and received at the time the dose was administered. The whole body scan results were reviewed two days later and the error in dosage was identified. Licensee representatives informed the inspector that the planned treatment would be scheduled at a future date. The patient was informed of the dosage error. The licensee's consultant reviewed the incident at the time of its occurrence and advised licensee representatives that the error was a recordable event and not reportable to NRC.

The state of South Dakota has been informed. Region IV received notification of this occurrence by telephone and has confirmed the information with the licensee. Region IV has informed OEDO and NMSS.

This information has been discussed with the licensee and is current as of 11:00 a.m. (CDT) on June 16, 2000.

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