May 30, 2003

THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 6/3/03.

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-029

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 the Region IV staff on this date.

Facility
Phoenix Baptist Hospital & Medical Center
Phoenix, Arizona
License No.: 070-146
Arizona Agreement State Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: MEDICAL MISADMINISTRATION

DESCRIPTION: On May 29, 2003, the Arizona Radiation Regulatory Agency (the Agency) notified NRC's Operations Center of a reported medical radiopharmaceutical misadministration involving iodine-131. The event is a medical misadministration based on Arizona's current regulation for the medical use of radioactive material.

Phoenix Baptist Hospital & Medical Center, an Arizona licensee, notified the Agency on May 27, 2003, that a patient had been administered 0.99 gigabequerel (27 millicurie) of iodine-131 instead of the prescribed 0.2 gigabequerel (5 millicurie) dose. The licensee reported that the initial investigation indicated that Medi-Physics Inc. had mistakenly sent a 0.99 gigabequerel (27 millicurie) dose designated for another hospital located in Phoenix to the licensee and that the licensee's 0.2 gigabequerel (5 millicurie) dose had been sent to the other hospital. The licensee stated that the dose had been assayed and noted to differ from the requested 0.2 gigabequerel (5 millicurie) dose. However, the dose was administered to the patient anyway. The patient had a thyroid ablation procedure conducted previously. No adverse effects are anticipated. The patient and referring physician have been notified. The Agency and licensee are continuing to investigate this event.

Region IV received notification of this occurrence from NRC's Operations Center on May 30, 2003. Region IV has informed OEDO, NMSS, OSTP and the Region's SLO and PAO.

This information has been discussed with the State and is current as of 10:00 a.m. (CDT) on May 30, 2003.

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