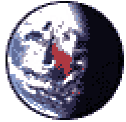

Duane White
<Duane.White@nrc.gov>
11/12/2008 10:43 AM

To Thomas W Smith <Thomas.Smith@inl.gov>
cc Dante C Huntsman <Dante.Huntsman@inl.gov>, Robert L Sant <Robert.Sant@inl.gov>
bcc
Subject RE: FW: 080672 P AO

Tom,

I had the Medical Radiation Safety Team look at the Texas report you provided me and they still do not consider this event a medical event. Again the main reason is that the written directive went through the review and authorization process and therefore the patient was given what was prescribed, which is in accordance with the regulation. The MRST feel that this event falls more into the practice of medicine.

Therefore, we need to change this event record to read:
NRC Reportable Event: N
Abnormal Occurrence: N

Thanks,
Duane
(301) 415-6272

From: Thomas W Smith [mailto:Thomas.Smith@inl.gov]
Sent: Wednesday, November 05, 2008 10:57 AM
To: Duane White
Cc: Dante C Huntsman; Robert L Sant
Subject: Re: FW: 080672 P AO

Duane:

We have received some more info (attached) from Texas regarding this event. They have decided that this is indeed a medical event (see page 3 of 5). Are you sure that NRC wants to declare that this was not a medical event?

Tom

Duane White <DuaneWhite@nrc.gov>

10/30/2008 10:51 AM

To Thomas W Smith <Thomas.Smith@inl.gov>
cc
Subject FW: 080672 P AO

Tom,

For this event, we declared that it was not a medical event and therefore not an AO. See the attached email for our reasons. Please update this event record accordingly.

Thanks,

Duane
(301) 415-6272

From: Thomas W Smith [mailto:Thomas.Smith@inl.gov]
Sent: Monday, October 27, 2008 12:49 PM
To: Duane White
Subject: 080672 P AO

Duane:

We marked NMED 080672 as a P AO. However, it may turn out that this event is not reportable - we are waiting for more info from Texas to make a final determination on whether the "signed written directive" was valid. If so, we will remove the P AO marking.

South Texas Radiology Imaging Centers reported that a patient was mistakenly administered 0.14 GBq (3.8 mCi) of I-131 on 9/2/2008, instead of the prescribed 1.11 GBq (30 mCi) of Tc-99m for a routine bone scan. In placing the order for a nuclear medicine study, the referring physician's receptionist had first checked "Bone Scan – Total Body," but then drew a line through that entry and marked "I-131 Whole Body Scan." The appropriateness of the study for the patient was not verified by the referring physician, nuclear medicine technologist, or authorized physician user. The error was discovered on 9/4/2008, 48 hours after administration, when the patient returned to the center for imaging. There is confusion whether the incident meets reportability based on the fact that the administration was performed in accordance with a signed written directive. However, the authorized physician user's final report stated that a total body scan with Tc-99m was intended. The estimated dose to the patient's thyroid is 4,940 cSv (rem). Investigation continues on the incident.

Tom

----- Message from Angela McIntosh <Angela.McIntosh@nrc.gov> on Thu, 30 Oct 2008 08:02:11 -0400 -----

To: Duane White <Duane.White@nrc.gov>
Subject: RE: 080672 P AO

Duane, we determined it not to be an AO, because it is not a medical event, since the patient received what was prescribed. It is also not an AO under the AO human exposure criteria, because the person involved was a patient, and not a radiation worker nor a member of the public. It is likely an NRC violation of some sort, but it is neither a medical event nor an AO.

Angela

From: Duane White
Sent: Wednesday, October 29, 2008 3:18 PM
To: Angela McIntosh

Subject: FW: 080672 P AO

Angela,

I forgot, but did we determine if the event in which a patient receive a whole body scan as directed on the written directive but, this was not the test that the AU intended to give the patient (see email below)

Duane
(301) 415-6272

From: Thomas W Smith [mailto:Thomas.Smith@inl.gov]
Sent: Monday, October 27, 2008 12:49 PM
To: Duane White
Subject: 080672 P AO

Duane:

We marked NMED 080672 as a P AO. However, it may turn out that this event is not reportable - we are waiting for more info from Texas to make a final determination on whether the "signed written directive" was valid. If so, we will remove the P AO marking.

South Texas Radiology Imaging Centers reported that a patient was mistakenly administered 0.14 GBq (3.8 mCi) of I-131 on 9/2/2008, instead of the prescribed 1.11 GBq (30 mCi) of Tc-99m for a routine bone scan. In placing the order for a nuclear medicine study, the referring physician's receptionist had first checked "Bone Scan – Total Body," but then drew a line through that entry and marked "I-131 Whole Body Scan." The appropriateness of the study for the patient was not verified by the referring physician, nuclear medicine technologist, or authorized physician user. The error was discovered on 9/4/2008, 48 hours after administration, when the patient returned to the center for imaging. There is confusion whether the incident meets reportability based on the fact that the administration was performed in accordance with a signed written directive. However, the authorized physician user's final report stated that a total body scan with Tc-99m was intended. The estimated dose to the patient's thyroid is 4,940 cSv (rem). Investigation continues on the incident.

Tom