Region I Office
Division of Nuclear Materials Safety
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Telephone Conversation Record

Date: May 20, 2014
License No.: 47-17725-02
Docket No.*(no hyphens)*: 03029017
Mail Control/Report No.: Event Number 50121
Licensee Name: Beckley Appalachian Regional Hospital
Participant(s) Name/Title: Jennifer Bailey, Director of Medical Imaging
Work Telephone No.:(304) 255-3363
Business Cellphone No.:
NRC Representative Name/Title: Robin Elliott, Health Physicist

Subject: Wrong form of radioactive isotope administered for cardiac stress test
(This is the title that will be used in ADAMS)

Discussion:

Jennifer called the HOO at 16:25 on 5/19/14 to report that on 5/18/14 at 10:30 a patient was provided MDP (25 mCi Tc-99m) which is used for bone scans vice cardolite (31 mCi Tc-99m) for a cardiac stress test. The wrong dose was administered due to technician error. Both the prescribing physician and patient were informed. I contacted Jennifer and explained that this was not an event that required notification to the NRC but certainly required follow up on their part and would be reviewed during inspection. I asked that she review the package insert for MDP to ascertain the dose delivered to the patient from the 25 mCi injection to see if she agreed that it would be less than 5 rem effective dose equivalent or 50 rem to an organ or tissue. I told her if she agreed, she could call the operations center to have the event retracted. She plans to do this tomorrow. She indicated that the incident is under review and corrective actions are being developed. I also pointed her to 10 CFR 35.3045 and explained how it is unlikely to obtain the doses required for a medical event from diagnostic procedures as opposed to therapeutic procedures in general.

Action Required: Follow up on corrective actions taken at next inspection.

SUNSI REVIEW

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SUNSI Review Completed by: RElliott 5/21/14

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