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January 25, 2016

U.S. Nuclear Regulatory Commission Region III
2443 Warrenville Rd
Suite 210
Lisle, IL 60532-4351

Attn: Geoffrey M. Warren

Re: License No. **21-13562-01**, Crittenton Hospital Medical Center

In accordance with 10CFR35.3045(d), we are providing a written report following the discovery of the medical event on January 11, 2016 (reported on January 12, 2016).

Thank you for you cooperation with this matter. If you have any questions or require additional information please contact our consulting physicist, Michelle L. Kritzman, at (734) 662-3197.

Respectfully,

Terry Hamilton
Interim President & CEO
Crittenton Hospital Medical Center
Rochester, Michigan

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Report and Notification of a Medical Event

Event Number: 51648
Licensee: Crittenton Hospital Medical Center
Prescribing Physician: Annie Kalapparambath, M.D.

Event: On January 11, 2016, a patient was scheduled for a lymphoscintigraphy study. The prescribed dosage range is 0.5-1.0 mCi of Tc-99m filter Sulfur Colloid. The technologist inadvertently assayed the unit dosage for a gastric emptying study. The activity at 10:45 was 2.4 mCi unfiltered sulfur colloid . The unit dosage was then taken out to be injected by Dr. Kalapparambath. The injection was made subareolar and consisted of one shallow injection. Once the mistake was discovered, Dr. Kalapparambath was immediately notified along with the department supervisor. A call was place to our physicist at MPC who was out of the office. She was notified by 8:30 a.m. on Tuesday January 12. Dr. Kalapparambath immediately notified the referring physician. They referring physician spoke to the patient about the use of the unfiltered sulfur colloid. The surgery continued as scheduled with accurate results for this type of procedure. Follow-up phone calls were placed to the referring physician and patient on January 18.

Why event occurred: The technologist assayed the wrong unit dosage for injection during a scheduled lymphoscintigraphy study. Due to the full schedule and concentrating on the next few items that needed to be completed, the technologist didn't stop to check the dosage chart detailing the hospital protocol for lymphoscintigraphy studies. The technologist didn't catch the fact that the dosage was out of range of the prescribed amount after the dosage was assayed.

The effect on the individual who received the administration: There is no negative effect to the patient. The patient was sent to the OR for a lumpectomy as scheduled.

Action to prevent recurrence: The nuclear medicine technologists were reminded of the importance reviewing the prescribed dosage list prior to administration of a unit dosage.

Annie Kalapparambath

Annie Kalapparambath, M.D.
Radiation Safety Officer

Terry Hamilton

Terry Hamilton
Interim President & CEO

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DO NOT RELEASE TO THE PUBLIC, CONTAINS PRIVACY INFORMATION

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Terry Hamilton
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Rochester, Michigan

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FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Attn: Geoffrey M. Warren	William Bell, Jr.
COMPANY:	DATE:
NRC	1/27/2016
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
(630) 515-1078	Four (4)
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
(248) 652-5111	License No. 21-13562-01
RE:	YOUR REFERENCE NUMBER:
Event Number 51648	N/A

URGENT X FOR REVIEW PLEASE COMMENT PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

To Mr. Geoffrey M. Warren:

Thank you for your assistance with our Event response.

Have a Blessed Day