

October 10, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-90-37

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: Newman Memorial Hospital
Shattuck, Oklahoma
License: 35-16717-01
Docket: 030-11681

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

SUBJECT: PATIENT PROVIDED VIAL CONTAINING RADIOPHARMACEUTICAL AND DISPATCHED TO ANOTHER HOSPITAL FOR DIAGNOSTIC SCAN

NRC received a telephonic report Friday evening, October 5, 1990, from the Radiation Safety Officer at Woodward Hospital and Health Center, Woodward, Oklahoma (NRC License No. 35-21269-01), that a patient and his wife had arrived at the hospital emergency room bearing a shielded vial labeled as containing technetium-99m. An instrument survey performed by a technician at the hospital revealed technetium contamination on the patient, his wife, and the container. No contamination was found in the patient's automobile.

The patient and the vial containing the radiopharmaceutical had been dispatched to Woodward from Newman Memorial Hospital because the latter had no remaining reagent needed to prepare the dose for the required emergency lung scan. Newman had administered a 5.4 mCi dose to the patient, but the procedure was unsuccessful due to infiltration of the radiopharmaceutical. (The injected radiopharmaceutical failed to enter or remain in the vein of the patient and localized in his arm. This is the likely source of the contamination detected at Woodward.) Because a second attempt was necessary, Woodward was contacted by Newman personnel and requested to perform the scan. Woodward responded that although they had the reagent, they were running low on technetium and might not have enough to conduct the scan.

The need for the emergency scan arose while the experienced nuclear medicine technician was absent from the Newman facility. An x-ray technician, who had only limited experience with nuclear medicine procedures, agreed to perform the procedure and released the patient to the Woodward hospital.

Newman Memorial faxed a report of the event to the Region IV office on October 8 wherein they committed to limit nuclear medicine services to normal business hours when the experienced nuclear medicine technician is present.

Neither the licensees nor the NRC plan to issue a press release.

The Region IV office received initial notification of this occurrence from the NRC Operations Center at approximately 9:00 p.m. CDT. The information presented herein has been discussed with both licensees and is current as of 3:00 p.m., October 9, 1990. The state of Oklahoma, NMSS, and the patient have been notified.

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(5520: 10/1990 @ 8:10
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