DCS No: 03001287940621
Date: June 22, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9438

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 I staff on this date.

Facility:
William W. Backus Hospital
326 Washington Street
Norwich, Connecticut 06360

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

Docket No.: 030-01287
License No.: 06-11734-02
Event No.:
Event Location Code: HOS

SUBJECT: MEDICAL MISADMINISTRATION REQUIRING MEDICAL INTERVENTION

The Region I Office was notified at 2:30 p.m. on June 21, 1994, of a therapeutic misadministration that had occurred at the William W. Backus Hospital in Norwich, Connecticut.

The written prescription dated June 16, 1994, was given to the Chief Nuclear Medicine Technologist for ordering the required seeds. The Chief Nuclear Medicine Technologist ordered the seeds from a commercial nuclear pharmacy. The order was placed by phone. The technologist insists the order was placed correctly and that the pharmacy made a mistake and sent 112 seeds with activities of 4.49 millicuries per seed instead of 0.43 millicuries per seed. The seeds were logged in correctly on June 20, 1994, after their receipt.

On June 21, 1994, at 7:15 a.m. the seeds were taken out by the dosimetrist from the storage area. He did note the entry in the log book as 112 seeds with activities of 4.49 millicuries per seed.

The dosimetrist thought that the entry of 4.49 millicuries per seed was in error and "corrected" it by changing the entry to 0.449 millicuries per seed.

He took the seeds to the operating room and the surgeon implanted the seeds into the patient around 10:30 a.m.

The dosimetrist, while reviewing the records of receipt of seeds noted the error at about 12:30 p.m.

The surgeon and the patient were notified and a decision to remove the seeds was made. By about 3:00 p.m. most of the seeds were removed and approximately 42 seeds still remained inside the patient.

While removing the seeds, one of the seeds was punctured and some personnel in the operating room were contaminated. The licensee has collected the contaminated blood and other material.

The patient is still hospitalized.

Inspectors from Region I have been dispatched to the facility.

IE-34

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The State of Connecticut has been notified. The Region I Office of Public Affairs is prepared to respond to media inquiries. This information is current as of 9:00 a.m. June 22, 1994.

Contact: Jenny Johansen
(610) 337-5304

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