THE PLAIN DEALER

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March 9, 1992

FREEDOM OF INFORMATION ACT REQUEST
FOIA-92-117
Rec'd 3-11-92

Mr. Donnie Grimsley
Director FOIA and Publication Services
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555
FAX: 301-492-4994

Dear Mr. Grimsley:

Under the provisions of the federal Freedom of Information Act, I request that your office produce for my inspection and/or photocopying all documents that in any way whatsoever pertain to the following incidents and inspections. I have included the licensee name, a short description of the incident or inspection, and, where possible, an inspection or docket number.

1). Rochester General Hospital, Monroe County, N.Y. Between January 1988 and August 1988, 19 patients received overdoses of Co-60 because someone altered data in a computer program in April 1988.

2). Bartholomew County Hospital, Columbus, Ind. On 5-19-87, a 59-year-old woman being treated for neck cancer was killed when a 3,000 lb shield head of a teletherapy machine fell on her.

3). Syncor Corp., Allentown, Pa. NRC issued an order 6-22-88 after six mislabeling incidents over a 16-month period led to 14 misadministrations.

4). West Houston Medical Center, Houston, Texas. On 5-17-88, a patient scheduled to receive 30 microcuries of I-131 for a diagnostic scan of thyroid got 30 millicuries instead, resulting in 30,000-rad dose. Technologist involved did

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not know the difference between millicuries and microcuries.

5). Mercy Hospital, Wilkes-Barre, Pa. On 5-8-85, a patient received an injection of Tc-99m from the chief of nuclear medicine that was meant for another patient. The misadministration was intentionally not reported to the NRC, according to a subsequent OI investigation.
Docket No. 30-02971, 30-15110

6). Pittsburgh Testing Laboratory, Cleveland, Ohio. During August 1984 inspection, NRC found radiography being performed by unqualified individuals.
Docket No. 030-05985

7). Lakeview Hospital, Wauwatosa, Wisconsin. On 7-31-80, NRC was informed that patients had routinely received double doses of prescribed radiopharmaceuticlas for diagnostic scans since 1976. Most done for brain, bone, liver, spleen and lung scans in which Tc-99m was used on 20 to 30 patients a month.

8). St. Joseph's Hospital, Albuquerque, New Mexico. On 12-1-80, [illegible]spital RSO reported to New Mexico Environmental Protection Division that between 12-8-77 and 10-15-79 numerous patients developed complications from I-125 seeds licensed by the state. Severe adverse reactions noted in prostate cancer patients.

9). Medical College of Ohio, Toledo, Ohio. From April 12, 1982 to April 16, 1982, a female patient being treated for cancer of the uterus had four cesium-137 sources placed in her, three

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of which delivered overdoses. Patient began experiencing radiation-induced complications on 8-2-82. NRC special inspection on 4-19-82 to 4-23-82.

10). University of Cincinnati Hospital, Cincinnati, Ohio. On 12-30-83, hospital reported that about 50 people had been exposed to radiation from an iridium-192 source after it was shuttled between the university hospital and another in Cincinnati

11). Syncor International, Blue Ash, Ohio. On 5-18-84, Syncor and Nuclear Pharmacy Inc., of Chicago, received faulty devices from Medi-Physics Inc. to use in preparation of Tc-99m doses. Resulted in 16 misadministrations. Syncor fined $8,500 on 8-23-84.

12). Tripler Army Medical Center, Honolulu. On 6-17-86, a 54-year-old female patient received a dose of 3.09 mci of I-131, instead of the prescribed dose of 50 uci for a thyroid imaging procedure.

13). Bloomington Hospital, Bloomington, Ind. On 10-12-84, NRC received allegation that five diagnostic misadministrations had occurred but had not been reported. Hospital RSO obstructed inspection and misled inspectors by telling hospital employees to lie about misadministrations.
Docket No. 030-01644

14). Maryview Hospital, Portsmouth, Va. On 4-9-86, a patient suffering from kidney cancer was misadministered a dose of phosphorus-32.
Docket No. 030-03347
Inspection No. 45-10831-02/86-01

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15). University of Cincinnati Medical Center, Cincinnati, Ohio. On 9-4-84, NRC was notified that a patient being treated for a brain tumor had had leakage in I-125 implant, resulting in an exposure of 2,087 rads to the thyroid.
Docket No. 30-02764
Inspection No. 30-02764/84-02

16). University of Cincinnati, Cincinnati, Ohio. Between 6-15-91 and 6-21-91, one strand containing three Ir-192 bracytherapy seeds was found to be missing. Material was apparently disposed of in standard trash and dumped in a landfill.
Docket No. 030-02764
EA No. 91-097
Inspection No. 030-02764/91001(DRSS)

Again, I would like to stress that I am asking for all documents that in any way related to these incidents and inspections.

As a reporter for The Plain Dealer, I ask that you waive any search and copying fees as the release of this information is in the public interest.

I greatly appreciate your help in obtaining this information. Feel free to ring me at 216-344-4808 anytime with questions.

Again, thanks.

Truly,

Dave Davis