This Event is not for public disclosure per Agreement State Request until 8/8/2002.

August 7, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-040

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	**Licensee Emergency Classification**
Centura Health Penrose	___ Notification of Unusual Event
St. Francis Hospital	___ Alert
Colorado Springs, CO	___ Site Area Emergency
License No.: 197-02	___ General Emergency
Colorado Agreement State Licensee	_x_ Not Applicable

SUBJECT: MEDICAL MISADMINISTRATION

DESCRIPTION:

On August 6, 2002, the Colorado Department of Public Health and Environment (CDPHE) notified the NRC Operations Center that a medical misadministration involving the use of a high dose rate (HDR) unit occurred on August 2, 2002, at Centura Health Penrose St. Francis Hospital, located in Colorado Springs, Colorado.

A medical physicist from Colorado Associates Medical Physics notified the CDPHE on August 2, 2002, of the medical misadministration. Apparently, an incorrect catheter length was entered into the software of the HDR unit, causing the source not to be inserted to the desired treatment area. This resulted in the patient receiving zero therapy dose. However, since the source had left the shielded unit housing, the patient did receive a dose to an undesired site. The CDPHE has requested additional information from the licensee regarding the event.

Region IV received notification of this occurrence from NRC's Operations Center on August 6, 2002.

Region IV has informed NMSS, STP, OEDO, and RIV SLO,

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