December 12, 2002

This event is not available for public disclosure per Agreement State request until 12/17/02

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-02-043

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 III staff on this date.

Facility
Iowa Methodist Medical Center
Des Moines, Iowa
License: 0310-1-77-HDR
(Agreement State Licensee)

Licensee Emergency Classification
___Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: Brachytherapy Misadministration - HDR

DESCRIPTION:

On December 12, 2002, the Iowa Department of Public Health (IDPH) notified the NRC Operations Center that a medical misadministration involving the use of an iridium-192 high dose-rate remote afterloader unit (HDR) had occurred on December 3, 2002, at the Iowa Methodist Medical Center in Des Moines, Iowa.

The licensee discovered the misadministration on December 11, 2002 and notified IDPH on December 12, 2002. The treatment plan required 20 steps with a stepping distance of 0.5 centimeter using a Nucletron microSelectron HDR. The therapy procedure incorrectly used a stepping distance of 1.0 centimeter, resulting in a dose to an unintended site. The licensee is investigating the cause of the stepping distance deviation and the magnitude of the delivered dose.

The patient and referring physician were notified of the misadministration by the licensee. The licensee will submit a 15-day written report to IDPH.

The NRC Office of Nuclear Material Safety and Safeguards and the NRC Office of State and Tribal Programs were notified of the incident.

IDPH reported this event to the NRC Operations Center on December 12, 2002. This information was discussed with IDPH and is current as of 3:00 p.m. CST on December 12, 2002.

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