Steven Courtemanche <Steven.Courtemanche@nrc.gov>
10/23/2008 11:27 AM

To Duane White <Duane.White@nrc.gov>
cc "Dante.Huntsman@inl.gov" <Dante.Huntsman@inl.gov>
bcc
Subject NMED Record 080278

The inspector reviewed the above document and noted some glaring errors, some of which I caused (Par ma faux, par ma faux, par ma grave faux). I have attached her document and agree with the contents. Basically, a dose of 3550 Gray would kill a patient and my letter of August 21, 2008, should have the readings in centigray. Additional changes in the record not covered by the attachment are:

Under Medical Event Information:

(1) Change "Brachy, Manual Afterloader" to just "Brachy, Manual" There was no afterloader involved in the procedure. The operation is done entirely by hand.

(2) Decrease all doses received/prescribed by a factor of 100, eg. 125600 becomes 1256.

Under Device/Associated Equipment Information:

Change "Manual Afterloader" to "Manual Brachytherapy Sources"

Documents Non-Publically Available with information on the event:

ML082960197 (Licensee Event Report)
ML082960197 (Inspection Report)
ML082960187 (Inspection cover letter)

Escalated enforcement action is still being considered and the NMED Record can not be closed at this time. Corrective actions by the licensee are being considered and determined whether they are adequate to address the perceived problems.

----- Message from Sandra Gabriel <Sandra.Gabriel@nrc.gov> on Thu, 23 Oct 2008 11:05:03 -0400 -----

To: Steven Courtemanche <Steven.Courtemanche@nrc.gov>
Subject: Recommended changes to narrative portion of NMED item 080278

NMED Item Number: 080278

Narrative: Last Updated: 10/23/2008

Bridgeport Hospital reported that two patients received underdoses during Cs-137 manual brachytherapy treatments for cancer of the cervix. The medical events were discovered on 5/7/2008. One patient was prescribed to receive 3001 and 2552 cGy (rad; right point A and left point B) on 12/10/2007, but was delivered 1256 and 1231 cGy (rad; right point A and left point B). On 1/2/2008, that patient was prescribed to receive 1887 and 2020 cGy (rad; right point A and left point B), but was delivered 1042 and 1116 cGy

(rad; right point A and left point B). The second patient was prescribed to receive 2276 and 2672 cGy (rad; right point A and left point B) on 1/9/2008, but was delivered 948 and 1296 cGy (rad; right point A and left point B). On 1/30/2008, that patient was prescribed to receive 2292 and 2232 cGy (rad; right point A and left point B), but was delivered 876 and 988 cGy (rad; right point A and left point B). The cause was human error involving incorrect implementation of a new method to input geometric data into the treatment planning computer. This resulted in use of an incorrect magnification factor in the dose calculations. The patient's referring physician and radiation oncologist were informed. The patients were informed and received additional treatment.