"White, Duane"
<Duane.White@nrc.gov>
07/10/2009 07:45 AM

To Robert L Sant <Robert.Sant@inl.gov>
cc Dante C Huntsman <Dante.Huntsman@inl.gov>, Thomas W Smith <Thomas.Smith@inl.gov>
bcc
Subject RE: 090580 PAO

History: This message has been replied to.

Robert,

For this event, since it does not currently provide the dose to the patient information that was given in error, I think we should indicate at the end of the narrative that the NRC has requested information regarding the actual dose that was given in error (does not have to be worded exactly like this).

Duane
(301) 415-6272

From: Robert L Sant [mailto:Robert.Sant@inl.gov]
Sent: Thursday, July 09, 2009 6:14 PM
To: White, Duane
Cc: Dante C Huntsman; Thomas W Smith
Subject: 090580 PAO

We just entered event 090580 as a Potential AO based on EN 45184. The narrative is as follows:

Gamma Knife Center of the Pacific reported that a patient received a gamma knife treatment to the wrong site on 7/2/2009. The gamma knife treatment was prescribed for multiple brain metastatic sites using an 8-mm collimator. The prescribed dose was 2,400 cGy (rad). The treatment was prescribed for seven discrete sites in the brain. After the second discrete site had been treated, it was determined that an 18-mm collimator had been used instead of the 8-mm collimator. Following the discovery, the collimator was changed to the 8-mm collimator. Treatment to the remaining five discrete sites was administered with the 8-mm collimator. Both the physician and patient were notified of the incident. It was stated that the previous patient had been treated with the 18-mm collimator as prescribed. Corrective actions included sending a notice to all authorized users, neurosurgeons, and medical physicists that they should each independently check collimator size prior to each treatment.