| Hospital | Event Number: 42474 |
|---|---|
| Rep Org: COMMUNITY HOSPITALS OF INDIANA<br>Licensee: COMMUNITY HOSPITALS OF INDIANA<br>Region: 3<br>City: INDIANAPOLIS State: IN<br>County: MARION<br>License #: 130600901<br>Agreement: N<br>Docket:<br>NRC Notified By: ANDREA BROWNE<br>HQ OPS Officer: JOE O'HARA | Notification Date: 04/05/2006<br>Notification Time: 13:31 [ET]<br>Event Date: 11/08/2005<br>Event Time: [CST]<br>Last Update Date: 04/05/2006 |
| Emergency Class: NON EMERGENCY<br>10 CFR Section:<br>35.3045(a)(3) - DOSE TO OTHER SITE > SPECIFIED LIMITS | Person (Organization):<br>ANNE MARIE STONE (R3)<br>GREG MORELL (NMSS) |

**Event Text**

NOTIFICATION OF A MEDICAL EVENT - DOSE TO INCORRECT AREA OF BODY

Community Hospitals of Indiana reported that a high dose rate (HDR) remote afterloader treatment field was incorrectly performed. On November 8, 2005, Community Hospital East in Indianapolis, Indiana performed a HDR treatment on a terminally ill lung cancer patient. Community Hospital East applied the correct dose to the patient. However, a catheter used to carry the source into the patients body was inserted into the patients airway without a cap on the end. As a result of the cap not being in its proper place on the catheter, the source was placed approximately 7 mm higher than originally intended per the physicians written directive. As a result, the field which was irradiated was greater by approximately 7 mm. Immediately following the treatment, the error was noted and the physician was informed. The physician noted that the area which was irradiated was within her area of concern and that everything was "o.k." This treatment was conducted to relieve patient symptoms rather than cure the disease. The patient succumbed to the disease approximately two weeks later. The treatment and its results were documented by the licensee in its Radiation Safety Committee Meeting minutes.

During a routine inspection of its records on 4/4/06, a Region III NRC Inspector noted that this event appeared to be a medical event and should be reported. As a result of that guidance, the licensee is reporting the event.