

Hospital	Event Number: 45249
Rep Org: YALE - NEW HAVEN HOSPITAL Licensee: YALE - NEW HAVEN HOSPITAL Region: 1 City: NEW HAVEN State: CT County: License #: 06-30445-01 Agreement: N Docket: NRC Notified By: MIKE BOHAN HQ OPS Officer: JOHN KNOKE	Notification Date: 08/06/2009 Notification Time: 12:11 [ET] Event Date: 08/05/2009 Event Time: [EDT] Last Update Date: 08/06/2009
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(1) - DOSE <> PRESCRIBED DOSAGE	Person (Organization): MEL GRAY (R1DO) ANGELA MCINTOSH (FSME)

Event Text

DOSAGE TO PATIENT WAS POTENTIALLY DIFFERENT FROM PRESCRIBED DOSE DUE TO EQUIPMENT MALFUNCTION

"Two patients were scheduled for treatment using a Leksell GammaKnife Model C/B-2 stereotactic radiosurgery unit on August 5, 2009. This model uses an Automatic Positioning System (APS) to automatically change patient position during the treatment. The APS reported positioning error codes to the treatment console and the operators called Elekta, the manufacturer's US representative for help. They were told to undock the patient and reinitialize the APS system and then to complete treatment. This happened again during the second patient treatment and the local Elekta service person was called to inspect the unit.

"The service representative arrived after the completion of treatment to the second patient and it was noted then that while trying to drive the APS system back to it's nominal position, one of the axis indicators was off by 5 mm. It is not known if this happened during the treatment, so this is a provisional report until a thorough analysis can be performed. The console logs have to be analyzed by the manufacturer's representatives to see if the error occurred during treatment and as a result of an APS malfunction."

A Medical Event may indicate potential problems in a medical facility's use of radioactive materials. It does not necessarily result in harm to the patient.