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Date: April 9, 1993

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN39321

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:	<u>Licensee Emergency Classification</u>
Mercy Memorial Medical Center	<input type="checkbox"/> General Emergency
St. Joseph, Michigan	<input type="checkbox"/> Site Area Emergency
	<input type="checkbox"/> Alert
License No. 21-04177-01	<input type="checkbox"/> Unusual Event
	<input checked="" type="checkbox"/> N/A

Subject: MISADMINISTRATION DUE TO MISPLACED BRACHYTHERAPY SOURCE

On February 16, 1993, a 23-millicurie cesium-137 sealed source dropped unobserved onto a patient's bed while it was being placed in a brachytherapy device and it was not discovered until 15 hours later.

The incident was not identified as a misadministration until it was noted by a Region III (Chicago) inspector performing a routine review of brachytherapy records during an inspection which began March 26, 1993. The records noted only a "dislodged source" during the treatment. No further evaluation had been performed.

The patient was being treated for cervical cancer using brachytherapy applicators which were vaginally inserted. The source apparently fell out of one of the devices used to place the sources into the applicator.

The source was discovered by a nurse changing a pad on the bed. The nurse did not recognize the source and placed it by hand in a small cup, then reported it to her supervisor. The radiation therapy staff then retrieved the source and properly inserted it in the treatment applicator for the balance of the treatment period. The patient's physician determined that no modification of the treatment plan was needed.

The source apparently was close to the patient's legs during the time it was on the bed. The licensee is preparing a radiation dose evaluation of the dose to the patient's legs and buttocks area and is in the process of making required notifications pursuant to 10 CFR 35.33.

Further Region III inspection on April 6-8, 1993, determined that the patient had received a potentially significant radiation dose to her legs and buttocks. This evaluation was determined by additional information on the position of the patient during the treatment and by an interview with the nurse involved who had been previously unavailable. An NRC medical consultant has been retained to evaluate the medical aspects of the incident.

An evaluation by Region III determined that the radiation exposure to the nurse who discovered and picked up the source would not have exceeded NRC exposure limits.

The State of Michigan will be notified. The information in this preliminary notification has been reviewed with licensee management.

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Region III initially learned of this incident during an inspection beginning March 26, 1993, with additional information obtained on-site April 6-8, 1993. This information is current as of 1:00 p.m. on April 9, 1993.

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