PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-94-005

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 II staff on this date.

Facility
Alexandria Hospital
Alexandria, Virginia
License No: VA-023-01

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: BRACHYTHERAPY MISADMINISTRATION

At 2:23 p.m. on January 28, 1994, the licensee notified the NRC Operations Center of a misadministration during a brachytherapy procedure that occurred on January 27, 1994.

At 2:00 p.m. on January 27, 1994, upon completion of the treatment of a patient with 10 Curies of Iridium 192 using a Nucletron High Dose Rate Remote Afterloader (HDR), the licensee found that the HDR had been programmed to deliver the dose at the end of the catheter rather than at 12 centimeters from the end of the catheter as specified in the treatment plan. The error resulted in the 500 Centigray dose being delivered to the the periphery of the lung instead of the trachea. Subsequently, the correct area was treated. The patient has been informed and the licensee did not expect adverse effects to the patient as a result of the misadministration.

Region II will perform a special inspection to review the circumsatance surrounding the event.

The NMSS Misadminstration/ Medical Consultant Coordinator has been informed.

The Commonwealth of Virginia has been informed.

This information is current as of 11:00 a.m. on January 31, 1994.

Contact: C. Hosey (404)331-5614
D. Collins (404)331-5586

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January 31, 1994

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