30-09792

Date: December 3, 1992

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN39263

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:
Indiana University
School of Medicine
Indianapolis, Indiana

License No. 13-02752-08

Licensee Emergency Classification
____General Emergency
____Site Area Emergency
____Alert
____Unusual Event
__X__N/A

Subject: THERAPY MISADMINISTRATION

On November 13 and 14, 1992, a 31-month-old patient received cobalt-60 teletherapy treatment to reduce swelling caused by a brain tumor. The prescribed dose was 300 rads to the brain area to be given in two treatments of 150 rads each. The actual dose delivered was 600 rads in two treatments of 300 rads each.

While planning the treatment, the dosimetrist calculated the treatment time for 300 rads per treatment rather than 150 rads per treatment. The error was not detected, and thus, the patient received two treatments of 300 rads each for a total dose of 600 rads.

The calculations and treatment plan were reviewed prior to the treatment by three additional individuals, and all failed to identify the error. A factor in the error was that 300 rads per treatment is considered a normal dose for brain tumors.

The error was discovered on December 2, 1992, during a review of the treatment plan by a student therapy technologist.

Region III (Chicago) will schedule a special inspection to review the circumstances surrounding the misadministration.

The State of Indiana was notified. The information in this preliminary notification has been reviewed with licensee management.

08-018

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The licensee notified the NRC Operations Center of this misadministration at 7:58 a.m. (EST) on December 3, 1992. This information is current as of 11 a.m. on December 3, 1992.

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