HOSPITAL

EVENT NUMBER: 24451

LICENSEE: LEAHY CLINIC MEDICAL CENTER
CITY: BURLINGTON REGION: 1
COUNTY: MIDDLESEX STATE: MA
LICENSE#: 20-05766-02 AGREEMENT: N
DOCKET: 30-1879

NOTIFICATION DATE: 10/19/92
NOTIFICATION TIME: 10:57 [ET]
EVENT DATE: 10/14/92
EVENT TIME: 11:00[EDT]
LAST UPDATE DATE: 10/19/92

NOTIFICATIONS

GENE KELLY RDO

NRC NOTIFIED BY: Dr. HERBERT MOWER (RSO) EMD LAWCE
HQ OPS OFFICER: TIM McGINTY

EMERGENCY CLASS: NOT APPLICABLE
10 CFR SECTION:
LADM 35.33(a) MED MISADMINISTRATION

EVENT TEXT

MEDICAL MISADMINISTRATION AT LEAHY CLINIC MEDICAL CENTER IN BURLINGTON, MA.

DR. MOWER, THE RSO AT LEAHY CLINIC MEDICAL CENTER (LOCATED @ 41 MALL ROAD, BURLINGTON, MA, 01805), REPORTED A MEDICAL MISADMINISTRATION. THE EVENT OCCURRED AT ABOUT 1100 EST ON 10/14/92, AND THE LICENSEE ATTEMPTED TO NOTIFY THE REGION ON 10/15/92 @ 1500 EST (THEY LEFT A MESSAGE VIA THE REGION 1 COMMERCIAL SWITCHBOARD AND EXPECTED A CALL BACK). THE RSO WAS OUT OF TOWN AT A MEETING AND ONLY NOW REALIZED THAT THE MISADMINISTRATION WAS YET TO BE REPORTED.

THE EVENT CONCERNED A HIGH DOSE RATE REMOTE AFTER LOADER, FROM WHICH 700 RADS WERE PRESCRIBED FOR A PATIENT WITH A TUMOR IN THE MAIN STEM BRONCHUS AREA. THE HIGH DOSE RATE REMOTE AFTER LOADER WAS APPARENTLY PROGRAMMED INCORRECTLY, AND THE 6 Ci IRIDIUM-192 SOURCE WAS RETRACTED FROM THE CATHETER 7mm INSTEAD OF 70mm AS DESIRED FOR PROPER PLACEMENT OVER THE TUMOR. THIS RESULTED IN DELIVERY OF THE DOSE TO THE WRONG AREA, HOWEVER NO ADVERSE EFFECTS TO THE PATIENT ARE EXPECTED. THE PATIENTS PHYSICIAN WAS NOTIFIED, HOWEVER THE PATIENT WAS NOT INFORMED. (THE PATIENT IS TERMINAL).

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