DCS No: 03011384900921
Date: September 21, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-90-82

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 I staff on this date.

Facility:
Cooper Medical Center
Camden, New Jersey
License No. 29-08285-02
Docket No. 030-11384

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Subject: CESIUM-137 BRACHYTHERAPY MISADMINISTRATION

On September 21, 1990 at 12:30 p.m., the Cooper Medical Center Radiation Safety Officer notified NRC Region I of a brachytherapy misadministration which had occurred on September 17, 1990.

The patient was scheduled to receive a brachytherapy treatment which involved the use of Cesium-137 sealed sources. The sources were loaded into a Fletcher-Suit vaginal applicator. The radiation oncologist prescribed a treatment which would deliver a total of 3000 rads to a predetermined point (treatment area). The dosimetrist determined that the source loading prescribed by the radiation oncologist would not deliver the prescribed 3000 rads to the treatment area. Therefore, the dosimetrist derived another treatment plan with a different source loading. The treatment plan was approved by the radiation oncologist. The physicist went to load the sources and obtained what he believed to be the correct prescription. However, the physicist took the original prescription rather than the new. This resulted in a misadministration in which the patient received a dose of 1464 rads instead of the prescribed 3000 to the treatment area. This is a difference of approximately 50% less than the prescribed treatment dose. No further brachytherapy treatments are prescribed for the patient. The patient is scheduled for surgery. The Radiation Safety Officer said that the misadministration had been identified on September 21, 1990, when the chief dosimetrist was recording all treatment information onto another permanent log, and noted that the total implant time did not agree with the noted source activities. The licensee is continuing to evaluate the incident and will provide the NRC with a written report.

Region I will review this incident in a future inspection.

The State of New Jersey has been notified of this incident.

The information is current as of 2:30 p.m., September 21, 1990.

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