DCS No: 03009588020191
Date: February 1, 1991

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-91-10

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:
Washington Hospital Center
110 Irving Street, N.W.
Washington, D.C. 20010
DN 30-09588

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

Subject: TELETHERAPY THERAPEUTIC MISADMINISTRATION

On February 2, 1991, at 1:40 p.m. the licensee informed Region I of a teletherapy therapeutic misadministration that occurred about 1:00 p.m. A 74 year old, male patient was to be administered 250 rads to the brain for cancer treatment. The technologist identified the patient, however, the technologist used another patient chart without verifying the name or the picture of the patient on the chart. No patient treatment area markers, such as tattoos, were used. Using the wrong chart, the technologist proceeded to set up a 5.0 centimeter by 6.5 centimeter field size and initiated treatment of the patient's larynx. The thyroid of the patient was not blocked from exposure to the teletherapy beam. While the patient was undergoing treatment to the larynx, the technologist realized that the wrong organ was being treated. The technologist immediately terminated the patient treatment. The licensee estimated that 57 rads were delivered to the larynx as 100 rads were to be delivered to the larynx in 1.38 minutes and the treatment was terminated after 0.79 minutes. After termination of the larynx treatment, the patient was given the proper treatment of 250 rads to the brain.

Corrective action by the licensee included prompt recognition by the technologist that the wrong procedure was performed and termination of the treatment and additional training for the technologist in the proper identification procedures for treatment plan verification.

NRC Region I is contacting an NRC medical consultant to provide clinical assessment of this misadministration. The Region I staff will examine the circumstances behind the incident during the next inspection of the program.

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