July 11, 1988

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-88-56

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 IV staff on this date.

FACILITY: Sioux Valley Hospital
Sioux Falls, South Dakota
Docket: 30-03249

Licensee Emergency Classification:
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

40-12378-01

SUBJECT: THERAPEUTIC MISADMINISTRATION

The licensee telephoned Region IV with a notification of a therapeutic misadministration. The licensee had discovered on July 8 that when a cesium-137 brachytherapy sealed source was removed from a patient undergoing gynecological treatment that the source was found to be 30 milligrams instead of the intended 20 milligrams. The source had been implanted on July 6 as part of a series of treatments. At the time of notification, the licensee had not calculated the dose that the patient had incurred, but the licensee had estimated that there should be no significant health impact due to the use of a stronger source than was prescribed. (The treatment series will be modified to account for the additional dose.)

The licensee reported that the misadministration was attributed to busy conditions in the hospital and that a physician who accompanied the technician to the hot lab to secure the source removed the wrong source and that the technician did not verify the appropriateness of the source obtained by the physician.

Neither the licensee nor the NRC plans to issue a press release.

The state of South Dakota has been informed.

Region IV received notification of this occurrence by telephone from the Radiation Safety Officer of Sioux Valley Hospital at 5:00 p.m. on July 8, 1988. Region IV informed NMSS.

CONTACT: Dale A. Powers, FTS 726-8195.

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