PDR advance copy per
J. Rattyé

 June 13, 1995

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-95-025B

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 Region IV staff in Arlington, Texas on this date.

Facility
Department Of The Army
Madigan Army Medical Center
Tacoma,Washington 98431-5000
Dockets: 03003003 License No: 46-02645-03

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: IRIDIUM-192 BRACHYTHERAPY MISADMINISTRATION

This is an update to information previously reported in PNO-IV-95-025 and PNO-IV-95-025A on June 5 and 9, 1995, respectively. On June 12, 1995, the licensee reported identification of another misadministration involving a manual brachytherapy treatment using iridium-192 to the Headquarters Operations Officer. The misadministration occurred on February 3, 1995, although the event was only discovered by the licensee this week during a comprehensive review of selected brachytherapy treatments performed at the licensee's facility from 1993 through May 1995. The review was initiated by the licensee in response to its determination that a misadministration involving a brachytherapy treatment using iridium-192 occurred on May 9, 1995. The latter misadministration was reported to the NRC on June 2, 1995. On June 8, 1995, the licensee reported to the NRC the discovery of three additional misadministrations which occurred on February 9 and August 23, 1994, and January 11, 1995. Each of the misadministrations involved brachytherapy treatments using iridium-192 and appear to be the result of common direct cause(s).

The misadministration reported by the licensee on June 12 involved a treatment performed on February 3, 1995, for which the authorized user physician prescribed a dose of 1,500 centigray (cGy) for the patient's biliary tract. Based on its recent recalculation of the dose, the licensee has determined that a dose of 2,050 cGy was delivered (26.8% greater than prescribed). The licensee expects no adverse effects to the patient as a result of the overdose.

Region IV initiated a reactive inspection on June 6, 1995, in response to the licensee's initial notification on June 2, 1995. Although the inspection is ongoing, NRC's initial assessment of the misadministrations indicates that one direct cause of the errors was the use of inappropriate data with the treatment planning computer system used to calculate dose rates and develop treatment plans. Region IV will continue its inspection at the licensee's facility during the week of June 12, 1995.

The state of Washington will be informed.

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Region IV received notification of this occurrence by telephone from the Headquarters Operations Officer and the licensee.

Region IV has informed NMSS.

This information herein has been discussed with the licensee and is current as of 3:00 p.m. CDT, June 12, 1995.

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