Date 08/25/87

30-1910

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 III staff on this date.

Facility: Parkview Memorial Hospital 2500 East State Blvd. Fort Wayne, Indiana License No. 13-01284-03

Licensee Emergency Classification: Notification of an Unusual Event Alert Site Area Emergency neral Emergency X not Applicable

Subject: THERAPEUTIC MISADMINISTRATION

On August 24, 1987, the Licensee notified Region III (Chicago) that a 75 year old male patient had received a therapeutic radiation exposure (500 rads) to the wrong hip.

The patient was to receive 250 rads/day to the right hip; however, during the pre-treatment planning (simulation) a technologist inadvertently placed treatment marks on the patients left hip rather than the right side. The patient was then taken to the therapy room where another technologist noted the treatment marks on the left hip area and treated the left hip area. Prior to the third (3rd) treatment day, the patient advised the technologist that they were treating the wrong hip. The technologist then checked the patient's chart and realized that the wrong hip was treated.

(The treatments were halted when this error was discovered on August 24, 1987.)

The patient has been examined by a physician, and no clinical side effects were noted.

Region III will dispatch an inspector to review the circumstances of the misadministration. An NRC medical consultant will be retained to review the medical aspects of the case.

The State of Indiana will be notified.

Region III was notified of the misadministration at 4:30 p.m. (CDT), August 24, 1987. This information is current as of 8 a.m., August 25, 1987.

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