

DCD

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: Indiana University School of Medicine
Indianapolis, Indiana
License No. 13-02752-08

Licensee Emergency Classification:
Unusual Event
Alert
Site Area Emergency
General Emergency
☒ Not Applicable

03009792

Subject: TELETHERAPY MISADMINISTRATION

On April 10, 1989, the licensee reported a teletherapy misadministration to Region III (Chicago). A 68-year-old male patient was undergoing a radiation treatment program in late March 1989 and received a total of 2700 rads dose to his right hip, instead of the left hip and groin area, as prescribed. The treatments were concluded on March 27, 1989 and consisted of 9 exposures of 300 rads each using a cobalt-60 teletherapy device.

The licensee reported that a miscommunication between technologists resulted in the treatment to the wrong leg. The error was discovered during a "case review" of completed therapy cases.

The licensee is continuing the treatment schedule by treating the correct leg.

Region III (Chicago) will review the circumstances of the misadministration during an inspection in late April. An NRC medical consultant will be retained to review the medical aspects of the case.

The State of Indiana was notified.

Region III was notified of this event at 2 p.m. (CDT), April 10, 1989. This information is current as of 11 a.m. (CDT), April 11, 1989.

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