April 19, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-021A

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
Memorial Medical Center - Baptist Campus
2800 Napoleon Ave.
New Orleans, LA 70115

State of Louisiana Licensee
License No.: LA-0349-L01
Event Report ID No.: LA020007

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

SUBJECT: CORRECTION (**BOLD**) - MEDICAL MISADMINISTRATION

DESCRIPTION: The Louisiana Department of Environmental Quality notified the NRC Operations Center that three medical misadministrations had occurred in March 2002.

On April 12, 2002, it was discovered that at the beginning of March 2002, three patients undergoing treatment to the prostate received 70 centigrays (70 rads) to their knees, thighs, and scrotum. All three patients were to receive therapy doses to the prostate. While planning the therapies, apparently the **dosimetrist** put a Nucletron source positioning simulator (Part # 111.094) together the wrong way. The design of the simulator allows it to be put together backwards. The correct distance for the procedures was 1408 millimeters, but the actual distance was 1117 millimeters. As of now, there appear to be no observable effects to the patients. All three patients were notified and have agreed to have the therapy reperformed at the correct site. The facility uses a Nucletron Vectrave HDR with a 0.37 gigabequerel (10 curies) source of Iridium-192. The activity during the patient therapies was 0.29 gigabequerel (8.06 curies) for one patient, 0.20 gigabequerel (5.45 curies) for another, and 0.18 gigabequerel (4.8 curies) for the third patient. The licensee's policy was changed so that the physicist will check the position simulator before each use. Further details will be placed in the NMED database as soon as the details are available.

Region IV received notification of this occurrence from NRC's Operations Center on April 17, 2002. Region IV has informed NMSS, OEDO, STP, and the Region's SLO and PAO.

The State reported on April 18, 2002, that it was the Nucletron technician and not the dosimetrist that put the simulator together backwards as originally reported. On April 19, 2002, the State reported that the original report was correct. This information has been discussed with the State and is current as of 10:00 a.m. (CDT) on April 19, 2002.

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