10CFR 35.33(a)

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Community Hospitals Indianapolis

Community Hospital East

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US Nuclear Regulatory Commission
Region III
801 Warrenville Road
Lisle, IL 60532-4351

Aug. 16, 1996

Materials License 13-06009-01

030-01625

Dear Sirs:

In accordance with 10 CFR 35.33 this a written report of a brachytherapy misadministration. The NRC Operations Center was notified by phone on 8/16/96.

LICENSEE: Community Hospitals, Indianapolis
PRESCRIBING PHYSICIAN: Morgan Tharp, MD
DATE OF MISADMINISTRATION: 8/16/96
DESCRIPTION OF EVENT: Treatment area described in directive misplaced by 2.7 cm inferiorly .
CAUSE OF EVENT: Length of dummy sources not corrected for length of catheter hub.
EFFECT ON PATIENT: No adverse effect. Volume of tumor not included in field will be corrected at next fraction.
IMPROVEMENTS TO PREVENT RECURRENCE: A table will be prepared with a listing of all dummy sources and their corrected length.
ACTION TO PREVENT RECURRENCE: Table of dummy vs length placed in QC manual.
NOTIFICATION: The patient was notified by Dr. Tharp of the error on 8/16/96.
CONTENT OF NOTIFICATION: Patient informed that we had undertreated area of tumor, that the dose difference would be corrected during the next treatment. No adverse effect was expected from the extension of the treatment area past the intended lower boundary.

If more information is required, please contact me at 317-355-5865.

Sincerely,

Andrea D. Browne

Andrea D. Browne, Ph.D.
Radiation Safety Officer

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AUG 26 1996