June 13, 2003

THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 6/17/2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-030

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	**Licensee Emergency Classification**
Sister of Charity of the Incarnate Word	
(St. Joseph's Hospital)	___ Notification of Unusual Event
1919 LaBranch	___ Alert
Houston, Texas 77002	___ Site Area Emergency
	___ General Emergency
License No. L02279-000	_X_ Not Applicable

SUBJECT: MEDICAL EVENT

DESCRIPTION: On June 12, 2003, the Texas Department of Health, Bureau of Radiation Control (the Bureau) notified NRC's Operations Center of a reported medical event. This event is categorized as a therapy event based on the State of Texas' current regulation for the medical use of radioactive material.

The Sister of Charity of the Incarnate Word (St. Joseph's Hospital), a State of Texas licensee, notified the Bureau on June 12, 2003, of a therapy event. The licensee reported that on June 11, 2003, at the beginning of the 6th treatment, the medical physicist discovered a geographic location error in the source placement. This error occurred using a nominal 111 gigabequerels (3 curie) iridium-192 source in a GammaMed Plus (HDR device) on a patient being treated for breast cancer. The medical physicist determined that an input error had also occurred on the five previous treatments. Measurements that were put into the HDR device were mistakenly entered in centimeters, not millimeters as specified in the written directive. The individual steps for the 20 millimeter source should have been in 1 millimeter increments, not 1 centimeter increments. As a result of the incorrect entry the iridium-192 source was actually never in the patient's body. The medical physicist has estimated 70 Gray (7,000) rads) superficial dose to the skin at a depth up to 1 centimeter and a deep dose (beyond 1 centimeter) of 30 Gray (3,000 rads). The patient has developed a small red spot which is being monitored by the hospital for potential blistering. The referring physician and patient have been notified. Both the patient and the hospital have agreed to re-start therapy treatment. Corrective actions to prevent a recurrence of this event will follow with the licensee's 15-day report of the incident. The Bureau is continuing to investigate this event.

Region IV received notification of this occurrence from NRC's Operations Center on June 12, 2003. Region IV has informed NMSS, OEDO, STP, and Region IV's PAO and SLO.

This information has been discussed with the State and is current as of 10:45 a.m. (CST) on June 13, 2003.

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