



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

AUG 2 1994

Docket: 030-02872  
License: 35-00376-02

St. John Medical Center  
ATTN: George Kendall  
Senior Vice President  
1923 South Utica Avenue  
Tulsa, Oklahoma 74104-6502

SUBJECT: NOTIFICATION OF ADMINISTRATION OF RADIOPHARMACEUTICALS TO THE  
WRONG PATIENTS

This refers to your letters dated June 9, 1994, which provided notification of three instances in which diagnostic dosages of radiopharmaceuticals were administered to the wrong patient. In each instance, the patient who was administered the radiopharmaceutical was not scheduled by his/her referring physician for a nuclear medicine examination.

Based upon information presented in your letters and discussions held during a telephone conversation between Ms. Linda Kasner of this office and Dr. Keith Jones of your staff on July 12, 1994, it is our understanding that two patients were administered 10 millicurie doses of technetium-99m labelled Cardiolite on May 13 and 26, 1994, and that in a third instance, a patient was administered dosages of 10 and 30 millicuries of technetium-99m labelled Cardiolite on July 12, 1994. (The licensee's second letter dated June 9, 1994, documented the latter incident.)

St. John Medical Center reported the incidents in accordance with the provisions of 10 CFR 20.2203(a)(2)(iv), which requires that a licensee submit a written report describing the circumstances associated with any event which results in an individual member of the public receiving a radiation dose in excess of the limits established in 10 CFR 20.1301. Each of the above noted radiopharmaceutical administrations resulted in the respective patient receiving an effective dose equivalent in excess of 100 millirem, the dose limit established in 10 CFR 20.1301 for individual members of the public.

Normally, an event or incident that results in an individual member of the public receiving a radiation dose in excess of the limits established in 10 CFR 20.1301 would be considered a violation of NRC regulations. However, the errors involving administration of technetium-99m labelled Cardiolite, in diagnostic dosages, to the wrong patients is not being cited as a violation of 10 CFR 20.1301 in this case. Pending rulemaking to resolve the issue that the provisions of 10 CFR Part 35 should be applied in such cases, the NRC will exercise discretion and is not issuing citations for violations of 10 CFR 20.1301 involving radiation exposure to a medical patient, including

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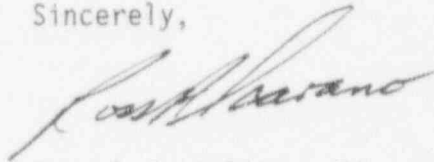
the wrong patient, which is caused by an error in the administration of radiation or radioactive material to that patient.

Notwithstanding the above, errors involving failures to follow procedures established to prevent the administration of radiation or radioactive material to the wrong patient may be considered a violation of NRC requirements or the conditions of your NRC license and may be the subject of future enforcement action. Therefore, you are encouraged to review these incidents to determine their root cause and whether any violations of your procedures occurred, and to implement corrective actions as appropriate. Your response to these incidents will be reviewed during a future inspection.

No response to this letter is required. Should you have any questions regarding this letter, please contact Ms. Linda Kasner at (817) 860-8213.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter will be placed in the NRC Public Document Room.

Sincerely,



Samuel J. Collins, Director  
Division of Radiation Safety  
and Safeguards

cc:  
Oklahoma Radiation Control Program Director

bcc:  
DMB - Original (IE-07)  
LJCallan  
WLFisher  
LLKasner  
FA' enslawski, WCFO  
GFSanborn, EO  
MRShaffer  
MCHernandez  
NMIB  
MIS System  
RIV Files (2)

RIV:C:NMIB <i>JK</i>	EO <i>EA</i>	DD:DRSS <i>[scribble]</i>	D:DRSS <i>[scribble]</i>	
LLKasner <i>JK</i>	GFSanborn	DRAScarano	SJCollins <i>[scribble]</i>	
07/29/94	08/1/94	08/1/94	08/1/94	

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