April 4, 1997

Ms. Colleen Cameron
Executive Director
St. John's Regional Medical Center
2727 McClelland Boulevard
Joplin, MO 64804-1695

SUBJECT: FOLLOW-UP OF A POTENTIAL BRACHYTHERAPY MISADMINISTRATION

Dear Ms. Cameron:

This refers to a follow-up of an unresolved matter regarding the applicability of the definition of "misadministration" in 10 CFR 35.2 as it pertains to a brachytherapy event that occurred at St. John's Regional Medical Center on October 22 and 23, 1996. The NRC has determined that the event did not result in a misadministration due to patient intervention.

The NRC's decision regarding this event was not based solely on whether or not the event was a consequence of patient intervention; rather, additional relevant facts were also considered such as if you: (1) monitored the placement of the sources and ribbon at a reasonable frequency; (2) correctly identified the displacement/dislodgement during the monitoring process; and (3) upon discovery of the source displacement/dislodgement, took prompt and proper action to secure the sealed sources. In this case, displacement of the ribbon was promptly detected shortly after the patient was served breakfast; and upon discovery of the displacement, your staff took prompt and proper actions to secure the sealed sources.

We have no further questions regarding the aforementioned brachytherapy event.

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 (PDR).

Sincerely,

Original Signed by Gary L. Shear

Roy J. Caniano, Acting Director
Division of Nuclear Materials Safety

License No. 24-01090-03
Docket No. 030-12728

cc: Jennifer Fisher, M.S., RSO

bcc: H. Clayton, EICS
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