Second Quarter 2001 Summary of Incidents, Complaints, Enforcement Actions *

Prepared by

Bradley Caskey, Helen Watkins, James Ogden
Incident Investigation
Cathy McGuire - Escalated Enforcement

Texas Department of Health
Bureau of Radiation Control
Division of Compliance & Inspection

Telephone: 512/834-6688

*

"Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). The text of these summaries will not appear in this report."

Copies of this report are available on the internet at
http://www.tdh.state.tx.us/ech/rad/pages/brc.htm

TABLE OF CONTENTS

Summary of Incidents for Second Quarter 2001 1

Summary of Complaints for Second Quarter 2001 13

Incidents Closed since First Quarter 2001 19

Complaints Closed since First Quarter 2001 21

Appendix A 23

Summary of Hospital Overexposures
Reported during Second Quarter 2001

Appendix B 25

Summary of Radiography Overexposures
Reported during Second Quarter 2001

Appendix C 27

Enforcement Actions for Second Quarter 2001

SUMMARY OF INCIDENTS FOR SECOND QUARTER 2001

I-7742 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7743 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7744 - Source Abandoned Downhole - Schlumberger - Sugar Land, Texas

On April 16, 2001, the Licensee notified the Agency of the abandonment of a 1.7 curie cesium-137 density source and a 16 curie americium-241/beryllium neutron source at a depth of 12,050 feet. A logging tool, containing the sources, became stuck on March 22, 2001. Repeated attempts to retrieve the tool were unsuccessful. The tool and the sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed

I-7745 - Abandoned Source - ProTechnics - Houston, Texas

On April 12, 2001, the Licensee notified the Agency that a 180 microcurie well logging source was abandoned down hole on March 22, 2001. The source was abandoned at a depth of 10,018 feet and immobilized, by red dyed cement, to a depth of 9,980 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7746 - Dose Irregularity - Nycomed Amersham Imaging - San Antonio, Texas

On April 27, 2001, the Licensee notified the Agency of a dispensing error that occurred on April 13, 2001. The wrong radiopharmaceutical was dispensed and administered. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. A report of the error by the pharmacy has been forwarded to the Texas State Board of Pharmacy for possible action under state pharmacy rules.

File Closed.

I-7747 - Medical Event - University of Texas Medical Branch - Galveston, Texas

On April 18, 2001, the Registrant notified the Agency that a medical event occurred when a patient was treated with external beam radiation on April 9, 2001. An Agency investigation determined that the wrong patient was treated. Approximately, one minute into the treatment the therapist realized that the wrong patient was being treated and immediately stopped the treatment. The therapist failed to properly identify the patient before treatment. The attending physician was notified and he made the decision not to notify the patient. The treatment plan was modified to allow the patient to receive the prescribed treatment. Corrective actions include: therapists not involved with the patient will not modify settings on the accelerator console prior to treatment; therapists must verify the prescribed orders in the chart with the console settings; two therapists must verify that patient identification and treatment protocol are correct prior to beginning treatment; and the Registrant will conduct monthly meetings on preventative measures. The Registrant was cited for three violations.

File Closed.

I-7748 - Equipment Malfunction - Rockwood Industrial Services- Houston, Texas

On April 19, 2001, the Licensee notified the Agency that a 65 curie iridium-192 source could not be retracted into the shielded position of a radiography device on April 16, 2001. The radiography crew realized the source was not retracted upon performing a survey. The crew adjusted the restricted area and contacted the radiation safety officer (RSO). The RSO disconnected the source guide tube, picked up the guide tube using six-foot manipulating tongs, and shook the source out. Since the connector on the source was not broken off, the RSO was able to reconnect the pigtail and retract the source into the shielded position of the radiography device. The Licensee determined the posi-lock was loose and not secured to the backplate. The device was sent to the manufacturer for repair. The highest exposure received during the recovery was 150 millirems. To prevent a recurrence, the Licensee provided the crews a two-hour training course concerning the incident.

File Closed.

I-7749 - Medical Event - University of Texas Medical Branch - Galveston, Texas

On April 18, 2001, the Registrant notified the Agency that a medical event had occurred involving a therapy treatment with external beam radiation on April 13, 2001. An Agency investigation verified that the wrong patient was treated. Approximately, one minute into the treatment the therapist realized that the wrong patient was being treated and immediately stopped the treatment. The therapist failed to properly identify the patient before treatment. The attending physician was notified and he made the decision not to notify the patient. The treatment plan was modified to allow the patient to receive the prescribed treatment. Corrective actions include therapists not involved with the patient will not touch the accelerator console prior to treatment; therapists must verify the prescribed orders in the chart with the console settings; two therapists must verify that patient identification and treatment protocol are correct prior to beginning therapy treatment; and the Registrant will conduct monthly meetings on preventative measures. The Registrant was cited for three violations.

File Closed.

I-7750 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7751 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7752 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7753 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7754 - Radioactive Material Stolen - Technical Welding - Pasadena, Texas

On May 10, 2001, the Licensee notified the Agency that radioactive material was stolen on May 9, 2001. A radiographer, while socializing at a local bar, left a radiographic exposure device, containing a 41 curie iridium-192 source, unattended and not physically secured against unauthorized removal. The darkroom was also left unlocked, and the exposure device was unsecured within the darkroom. This resulted in a loss of control of radioactive material when the radiographic exposure device was stolen. The radiographer was cited for failure to block and brace the device during transport and for failure to immediately notify the radiation safety officer when he discovered the device was stolen. The radiographer was referred for escalated enforcement actions. The device has not been recovered.

File Inactive.

I-7755 - Damaged Gauge - Texas Department of Transportation - Knippa, Texas

On May 30, 2001, the Licensee notified the Agency that a nuclear density gauge had been damaged. The gauge was stored in a mobile laboratory that was parked at an aggregate production plant. The gauge was damaged when the lab was overturned by a storm and became partially submerged in flood water. The gauge's specimen chamber hinges were bent and the gauge was covered in mud. A leak test of the source was performed and no leakage was detected. The gauge is in storage pending disposition.

File Closed.

I-7756 - Radioactive Material Lost - ProTechnics / Federal Express - Midland, Texas

On May 30, 2001, the Licensee notified the Agency that a one millicurie barium-133 well logging source was lost on that date. The source, enclosed in a titanium source holder, was shipped from Houston to Midland via a commercial carrier. Upon arrival at its destination, the Licensee noticed the transport shield was open and the source missing. Apparently, during shipment, the holder had opened and had been insecurely reassembled. To prevent a recurrence, the manufacturer is modifying the transport shield design to have two independent methods of securing the source inside the container. An extensive search did not locate the source. No one is believed to have received excessive radiation exposure as a result of the incident.

File Inactive.

I-7757 - Equipment Malfunction - METCO - Houston, Texas

On May 7, 2001, the Licensee notified the Agency of a source that would not return to the shielded position on that date. The incident occurred in a permanent radiographic installation. The probable cause of the incident was, a control cable broke where it was worn at a constant stop area. The control cable was replaced and normal operation was achieved. The control cable was disposed of and not sent to the manufacturer for evaluation.

File Closed.

I-7758 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7759 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7760 - Source Disconnect - Texas QA Services, Inc. - Grand Praire, Texas

On May 6, 2001, the Licensee notified the Agency of a source disconnect that occurred on April 25, 2001. The Licensee believes the drive cable was not properly connected to the source pigtail. The source contained 36 curies of iridium-192. The radiation safety officer retrieved the source and received an exposure of about 40 millirems during the incident. To prevent a recurrence, the Licensee held a safety meeting that emphasized the importance of ensuring a positive source connection.

File Closed.

I-7761 - Radioactive Material Lost - Chorum Technologies - Richardson, Texas

On May 21, 2001, the General Licensee notified the Agency that two polonium-210, static eliminators, manufactured by NRD, LLC, were missing after facility reductions by the company. An Agency investigation determined that a total of five static eliminators were missing from the company's facilities. The Licensee is continuing to search company storage facilities, believing that the missing devices are probably located with stored equipment. To prevent a recurrence of this incident the Licensee has established a color coding system of remaining inventory.

File Inactive.

I-7762 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7763 - Lost Radioactive Material - Texas Instruments - Dallas, Texas

On May 17, 2001, the General Licensee notified the Agency that a polonium-210 static eliminator, manufactured by NRD, LLC, that was attached to a tool in the wafer fabrication facility, was lost. The machine was moved but its exact location is uncertain. The Licensee is continuing to search for both the missing equipment and the attached static eliminator.

File Inactive.

I-7764 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7765 - Radioactive Material Lost and Recovered - METCO - Houston, Texas

On June 2, 2001, the Licensee notified the Agency that a radiographic exposure device was lost, then recovered during the morning on that date. During preparation for a shift change, the device was placed in the bed of a company truck while films were being developed. One radiographer was assigned to secure the exposure device in another company truck for use by the day shift. All equipment but the exposure device was secured. The radiographer left the work site in the company truck enroute to the Licensee's facility. The remaining night shift personnel determined that the device was not onsite and contacted the radiographer who had departed. The device had been left in the bed of the truck, which did not have a tailgate. A search of the fabrication yard and the route to the facility located the device in a ditch between the Interstate Highway and it's access road. The device sustained damage when it fell from the truck. The back port plug was sheared off by the impact and the source pigtail was severely bent and crushed. Surveys of the device detected no high or abnormal readings. A leak test of the device indicated no leakage. The device was sent to the manufacturer for inspection and repair. After repairs, the device was returned to service. The radiographer did not wear his film badge and did not perform proper surveys during radiographic operations. His employment was terminated by the Licensee. The Licensee and radiographer were cited for failure to lock and secure the transport package in the transport vehicle to prevent accidental loss and for failure to ensure that the radiographer wore required personnel monitoring equipment.

File Closed.

I-7766 - Source Abandoned Down Hole - The Rosel Company - Liberal, Kansas

On June 15, 2001, the Licensee notified the Agency that a two curie cesium-137 well logging source wad been abandoned down hole in an oil well. Fishing attempts to retrieve the source were unsuccessful. The source was abandoned at an estimated depth of 7,650 feet. A cement plug was set and capped with red dye and a deflection device. The depth of the top of the cement plug was 7, 570 feet. A permanent plaque is being fabricated for attachment to the wellhead. The source was abandoned in accordance with the Railroad Commission of Texas Rule 35 and the Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7767 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7768 - Lost Gauge - Tolunay-Wong Engineers, Inc. - Houston, Texas

On June 13, 2001, the Licensee notified the Agency that a moisture density gauge, containing a 40 millicurie americium-241/beryllium source and a 10 millicurie cesium-137 source, could not be located during a routine inventory. The utilization log was checked and a meeting was held with the gauge operators. The gauge was not found. The Licensee believes the gauge may have been taken by a disgruntled employee whose employment was recently terminated. The Licensee was cited for failure to secure radioactive material from unauthorized removal and for allowing an individual without direct supervision and without accepted training to use radioactive material.

File Inactive.

I - 7769 - Stolen Density Gauge - Alpha Testing Inc. - Dallas Texas

On June 25, 2001, the Licensee notified the Agency that a nuclear density gauge, containing a 40 millicurie americium-241/beryllium source, was stolen from the back of a company truck. An employee, not yet authorized to use the gauge, logged out the gauge and secured it in the back of the truck. On the way to the job site, the employee stopped at a convenience store for coffee. When he returned to the truck, the gauge was missing. The Licensee reported the stolen gauge to the local police department and searched for the gauge in the immediate area around the convenience store. The gauge was not located. The Licensee was cited for allowing the use of radioactive material by unauthorized personnel and for failure to keep the gauge under constant surveillance to prevent unauthorized removal.

File Closed.

I-7770 - Leaking Sources - Spectro - Marble Falls, Texas

On June 14, 2001, the Licensee notified the Agency that two 100 millicurie iron-55 sources, contained in spectral instruments, had removable activity in excess of 0.005 microcuries, on May 22, 2001. The sources had 5.7 and 4.2 microcuries, respectively, of removable contamination. The sources were removed from the spectral instruments and placed in storage pending disposal. The contamination was confined to the face of the sources, the proportional counter windows, and the filter tray assemblies. The proportional counters and filter tray assemblies were decontaminated and disposed. All other interior components and exterior surfaces of the instruments were wipe tested and disposed of after assuring that no contamination was detected.

File Closed.

I-7771 - Unauthorized Disposal of Radioactive Material - Louis Daily, M.D. / Air & Sea Environmental / AmeriTech Resource Recovery - Houston / Houston / Center, Texas

On May 30, 2001, the Licensee notified the Agency of the transfer of a strontium-90 eye applicator to an unlicensed disposal firm. An Agency investigation determined that the eye applicator was transferred to the disposal firm on May 8, 2001, without Agency authorization. In turn the disposal firm transferred the eye applicator, as regulated medical waste, to an incinerator. The eye applicator was incinerated on May 15, 2001. Waste ash from the shipment was disposed of at local landfill. A survey of the incinerator indicated no radioactive contamination. The incinerator has a 100 percent efficient scrubber that removes all effluents, so no radiation was vented to the ambient air. The waste ash was disposed of in a trailer of approximately 30,000 pounds of ash. The Licensee and both unlicensed disposal firms were cited for unauthorized disposal of radioactive material.

File Closed.

I-7772 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7773 - * Health and Safety Code-Chapter 241.051(d)
File Closed.

COMPLAINT SUMMARY FOR SECOND QUARTER 2001

C-1555 - Unregistered Laser - Healthcare Associates of Irving - Irving, Texas

On April 17, 2001, the Agency received an anonymous complaint alleging an unregistered Class IV laser had been in operation for over one year. An Agency investigation determined that the allegation was valid. A Class IV laser had been placed in operation at the facility during October 1999. The facility was cited for failure to register the laser within 30 days of being placed in operation.

File Closed.

C-1556 - Uncredentialed Technologist - Southwest Podiatry Associates - Dallas, Texas

On April 10, 2001, the Agency received an anonymous complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs. A review of Agency records determined the address provided by the complainant was an administrative office only and no radiographs were performed at the location. The Registrant has operations at six other sites in Texas. Compliance will be verified at the sites during the Agency's next routine inspections.

File Closed.

C-1557 - Unregistered Laser - Skin Technology / Medical Equipment Designs - Irving/Grand Prairie, Texas

On April 26, 2001, the Agency received a complaint alleging that: an unregistered Class IV laser has been in operation at the facility for over 4 months; that a licensed Texas practitioner is not authorizing use of the machine; that at least one patient had been burned by the laser; and that the physician is not on-site during machine use. An Agency investigation determined the facility was unregistered. The laser equipment was provided by a provider of equipment. A licensed Texas practitioner was associated with the facility but did not see laser patients prior to or after treatment and did not authorize exposure of humans to laser radiation. The physician confirmed he was not on site during most laser procedures. The investigation could not confirm that any patient had been burned by lasers used at the facility. The facility was cited for: failure to register within 30 days of commencement of laser operations; and for failure to have a licensed Texas practitioner authorize deliberate exposure of humans to laser radiation. A report of the complaint was provided to the Texas State Board of Medical Examiners for possible actions under their rules and regulations..

File Closed.

C-1558 - Uncredentialed Technologists - ET Mobile Imaging - Lindale, Texas

On May 3, 2001, the Agency received an anonymous complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs during April 12 through April 26, 2001. An Agency investigation did not substantiate the allegation. Other violations found during the investigation were as follows: the beam limiting device of the mobile x-ray unit was not equipped with sufficient collimation; the light field was misaligned and did not coincide with the x-ray field; the Registrant failed to maintain a copy of the current regulations, current operating and safety procedures, and equipment performance evaluations and corrections; and the Registrant did not indicate on the current log, the model and serial numbers from the control panel of the x-ray machine used. The Registrant was cited for the violations.

File Closed.

C-1559 - Incomplete Installation Records - Bay Area Dental Supply / Michael W. Fuqua, DDS - Tynan / Harlingen / Weslaco, Texas

On May 11, 2001, the Agency received a complaint alleging a Registrant was performing unauthorized calibration of dental x-ray equipment, was not completing required forms and paperwork, and was not installing equipment in accordance with manufacturer's requirements. The Agency inspected both the Registrant and recent installations performed by the Registrant. The inspection of the Registrant determined that the Registrant had: failed to notify the Agency within 30 days of repair and component replacement on existing x-ray equipment; failed to provide copies of FDA Form 2579 to the Agency within 15 days of installation of diagnostic x-ray systems containing certified components; and failed to include on the daily log, the Registration number of facilities where services or installations had been performed. An additional inspection of another Registrant who had several pieces of equipment installed by the assembler indicated the assembly had been performed in accordance with manufacturer's instructions. However, seven other violations of Agency regulations were cited against that Registrant. Additionally, another former Registrant was determined to be performing calibrations of dental x-ray equipment without being registered and was cited for that violation.

File Closed.

C-1560 - Unregistered X-Ray Unit - Hanna Dental X-Ray Services - Mission, Texas

On May 15, 2001, the Agency received a complaint from a Registrant alleging a former radiation safety officer opened his own business and began operating under the registration number assigned to his former employer. An Agency investigation determined the former employee was no longer performing services using the former employer's registration number and had recently applied for a registration under his own name.

File Closed.

C-1561 - Unauthorized Distribution of Radioactive Materials - L & L Enterprises - Houston, Texas

On April 27, 2001, the Agency received an anonymous complaint alleging a firm without a radioactive materials license was distributing devices containing radioactive materials. An Agency investigation determined the Texas facility was a manufacturer's representative but was not involved in the distribution of the radioactive devices.

File Closed.

C-1562 - Unauthorized Use of Radioactive Material - P.A. Heart Center - San Antonio, Texas

On April 16, 2001, the Agency received a complaint alleging the unauthorized use of radiopharmaceuticals on March 30, 2001. The radiation safety officer, who was the only authorized user of radioactive material at the medical center, had terminated employment. The ordering of radiopharmaceuticals under the authorized user physician's name had continued for 52 additional procedures. An Agency investigation determined another physician was allowed to use radioactive material without first being listed as an authorized user. The Licensee was cited for the violation.

File Closed.

I-1563 - Uncredentialed Technologist - Medi-Clinic - Houston, Texas

On May 30, 2001, the Agency received an anonymous complaint alleging uncredentialed personnel were performing radiographs when credentialed personnel were sick or unavailable and personnel dosimetry was not returned to the supplier for processing. An Agency investigation determined that x-ray logs for the last year indicated that radiographs were all performed by a credentialed operator except for the possibility of five radiographs which did not adequately identify the equipment operator. All personnel monitoring badges had been returned to the supplier for processing and were processed for all badged individuals. The complaint was not substantiated.

File Closed.

C-1564 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1565 - NORM Dumping - Lajitas Resort - Lajitas, Texas

On June 8, 2001, the Agency received a complaint alleging a company was dumping naturally occurring radioactive materials (NORM) waste on the ground near wells being drilled at their facility. An Agency investigation determined the alleged NORM waste was soil from water and irrigation wells permitted by the Texas Natural Resource Conservation Commission. The soil removed from the wells contained background levels of NORM and remains on site. The allegation was invalid.

File Closed.

C-1566 - Regulation Violations - Toungate Plaza Medical Center - Garland, Texas

On June 6, 2001, the Agency received an anonymous complaint alleging an uncredentialed technologist was allowed to perform radiographs. An Agency investigation determined the technologist had current credentials and certifications.

File Closed.

I-1567 - Laser Injury - Texas Vein Center - Arlington, Texas

On June 12, 2001, the Agency received a complaint alleging an unregistered laser facility caused a burn to a patient that resulted in permanent scarring. The patient was allegedly never seen by a physician prior to treatment and was treated by a Registered Nurse without the doctor in the building during treatment. An Agency investigation determined the laser was not registered. The patient was not treated with a laser but an Intense Pulsed Light (IPL) device attached to the same power supply. It could not be determined that the physician was or was not on-site during the treatment. The treatment was provided under written standing orders and procedures approved by the physician. At the time of the incident, no requirement from the Texas State Board of Medical Examiners existed that required the physician to be on-site during treatment. The facility was cited for failure to register the laser.

File Closed.

C-1568 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-1569 - Abandoned Radioactive Material - N-Spec Quality Services, Inc. - Odem, Texas

On June 1, 2001, the Agency received an anonymous complaint alleging the Licensee had abandoned a subsite and left radioactive material behind. An Agency investigation conducted on June 4 and 11, 2001, did not substantiate the allegation.

File Closed.

C-1570 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-1571 - Unauthorized Storage Location - Central Texas Pharmacy - Orange, Texas

On June 1, 2001, the Agency received a received a complaint referral from the Nuclear Regulatory Commission, alleging a nuclear pharmacist stored bulk technetium in his residential garage in order to provide bulk technetium to the pharmacy's customers without going into the pharmacy. An Agency investigation determined that the pharmacist stored "cold kits" at his residence which contain only tagging agents for mixing with bulk technetium stored at area hospitals, both in Texas and Louisiana, for use in emergency preparation of unit doses onsite by the pharmacist. No violations were noted by the investigators.

File Closed.

C-1572 - Regulation Violations - Southern Dental Associates - Houston, Texas

On June 22, 2001, the Agency received an anonymous complaint alleging the Registrant allowed an unqualified dental technologist to perform radiographs and a lead apron was not used to shield the patient. The complainant expressed general concerns about the overall regulatory compliance of the facility. The allegations were referred to the Texas State Board of Dental Examiners for any actions deemed necessary under their regulations. The Agency performed a routine inspection and found violations of regulations as follows: the technique factors used for clinical images were not the technique factors indicated on the technique chart located in the x-ray room; the Registrant failed to conduct equipment performance evaluations for two x-ray units in use; a copy of the operating and safety procedures were not available; required records were not maintained at the authorized use location; automatic film processing did not meet the requirements; and the Registrant failed to notify the Agency, in writing, within 30 days of the change of radiation machine inventory. The Registrant was cited for the violations.

File Closed.

INCIDENTS CLOSED SINCE FIRST QUARTER 2001

NO INCIDENTS WERE CLOSED SINCE FIRST QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

COMPLAINTS CLOSED SINCE FIRST QUARTER 2001

NO COMPLAINTS WERE CLOSED SINCE FIRST QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE SECOND QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING SECOND QUARTER 2001

NO RADIOGRAPHY OVEREXPOSURES REPORTED DURING SECOND QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 2001

Enforcement Conference: El Paso Healthcare Systems, Inc., dba Las Palmas Medical Center – Houston, Texas - Mammography

On May 3, 2001, an Enforcement Conference was held with El Paso Healthcare Systems, Inc., dba Las Palmas Medical Center, holder of Certificate of Mammography No. M00490. Las Palmas Medical Center representatives attending the conference were Messrs. John Gallagher, M.B.A, M.H.A, Associate Administrator, Richard N. Umeh, M.S., Medical Physicist, and James M. Rowland, B.S., R.T. Agency representatives attending the conference were Messrs. Quincy M. Wickson (Chairman) and Jerry Cogburn and Madames Cathy McGuire and Kim Floyd.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on January 18, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. After review of the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. Within 45 days of the date of the Enforcement Conference, the Registrant must submit at least 10 % of the mammograms performed in the Fischer room for the period of May 19, 2000 through October 23, 2000 to their accrediting body for review. If 10% of the sample fails to meet the accrediting body standards, all mammography patients examined in the Fischer room during the period of May 19, 2000 through October 23, 2000 must be notified of the quality assurance program failure. If the 10% sampling determines that a mammogram fails to meet the accrediting body standards, that patient must be notified of the failure. The Agency will be notified, in writing, on a monthly basis of the ongoing status of this action. The final results of the sampling will be sent to the Agency within 30 days of completion. All patient notification letters must be approved by the Agency prior to being issued.

2. The lead interpreting physician shall continue to review all quality assurance records on a monthly basis for a period of 12 months.

3. The inspection frequency will be increased and unannounced inspections will be conducted at this facility.

4. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: W. J. Mangold Memorial Hospital – Lockney, Texas – X-Ray

On May 22, 2001, an Enforcement Conference was held with W. J. Mangold Memorial Hospital, holder of Certificate of Registration No. R00612. The W. J. Mangold Memorial Hospital representative attending the conference was Johnny Hucks, Director of Radiology. Agency representatives attending the conference were Messrs. Quincy M. Wickson (Chairman) and Rick Munoz and Madames June Ayers and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on January 30, 2001. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. June Ayers reviewed the violations and the responses. After review of the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. Since the annual survey by the health physicist is due, it is requested that the physicist perform the entrance exposure measurements listed under 25 TAC 289.227(k) for each x-ray machine. The Registrant shall submit a copy of the physicist's report along with the measurements to the Agency immediately after receipt of the report from the physicist

2. Unannounced inspections will be performed at this facility on a more frequent basis.

3. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. The Registrant's representative agreed to these items and the conference was concluded.

THIS PAGE IS INTENTIONALLY BLANK