

**REDACTED - 8/2003**

**Third Quarter 2000 Summary of  
Incidents, Complaints, Enforcement Actions**

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i NOTE: Items within these summaries have been redacted (blackened out) due to confidential medical information under the Medical Practice Act and The Texas Public Information Act.

“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.”

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**TABLE OF CONTENTS**

Summary of Incidents for Third Quarter 2000 . . . . . 1

Summary of Complaints for Third Quarter 2000 . . . . . 17

Incidents Closed since Second Quarter 2000 . . . . . 29

Complaints Closed since Second Quarter 2000 . . . . . 31

Appendix A . . . . . 33

Summary of Hospital Overexposures  
Reported during Third Quarter 2000

Appendix B . . . . . 35

Summary of Radiography Overexposures  
Reported during Third Quarter 2000

Appendix C . . . . . 37

Enforcement Actions for Third Quarter 2000

## **SUMMARY OF INCIDENTS FOR THIRD QUARTER 2000**

### I-7617 - Leaking Sealed Source - SPECTRO - Austin, Texas

On July 10, 2000, the Licensee notified the Agency of a leaking 50 millicurie, iron-55 sealed source. The source was discovered leaking on June 20, 2000, during routine leak test procedures. The leak test indicated 0.07 microcuries of removable contamination on the source. The source was removed from service and placed in storage pending disposal. The Licensee will notify the Agency upon final disposition of the leaking source.

File Closed.

### I-7618 - Radioactive Material Contamination - Cotter Corporation - Lakewood, Colorado

On June 21, 2000, a company notified the Agency that a uranium contaminated centrifuge was shipped to Houston, Texas. The centrifuge had been used in a yellowcake product building and was internally contaminated at the time of release. The incident occurred despite staff efforts to clean and survey the equipment before releasing it. An affiliate of the company was dispatched to Houston where proper actions were taken.

File Closed.

### I-7619 - Source Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On August 22, 2000, the Licensee notified the Agency that a radioactive source was abandoned downhole after numerous attempts at retrieval. The 1.5 curie source was abandoned in Howard County, at a depth of 3,155 feet. A 40 foot steel baffle was inserted immediately above the tool and 50 feet of red concrete was injected to a depth of 3,102 feet. An additional 40 feet of steel baffle was inserted on top of the concrete plug to protect the source from future intrusion. A warning plaque has been ordered for installation on the wellhead. The Texas Railroad Commission was also notified. 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-7620 - Radioactive Material Lost - International Isotopes Incorporated / Grand View Hospital - Denton, Texas Sellersville, Pennsylvania

On June 12, 2000, the Licensee notified the Agency that one iodine-125 seed with an activity of 0.38 millicuries was missing from a June 29, 2000, shipment. A hospital reported that 81 seeds were ordered for a procedure to be performed on July 5, 2000. When the hospital's physicist counted the seeds, he found only 80 seeds. The physicist performed several recounts and performed extensive surveys, but did not locate the missing seed. The physicist believes the vendor mistakenly shipped only 80 seeds. The vendor believes the shipment contained the 81 seeds as ordered. The vendor's dispensing process involves three independent counts and extensive surveys of areas where seeds were handled. The location of the seed was unresolved. An iodine-125 seed poses minimal radiation hazard due to its low energy gamma radiation and short half life.

File Closed.

I-7621 - Badge Overexposure - Cryovac Sealed Air Corporation - Iowa Park, Texas

On June 30, 2000, the Licensee notified the Agency of a 592,178 millirem deep exposure, 611,126 millirem lens of the eye exposure, and 635,506 millirem shallow exposures to an employee during the March 10, to May 9, 2000, monitoring period. The employee recalled that he had lost his badge for a short period on April 26, 2000. The badge was located soon after the loss and the employee did not report the incident as he felt his badge had not been exposed. However, records indicate that the irradiator operated for 37 minutes at 0.5 MeV and 50 ma during the period the badge was lost. [REDACTED]

[REDACTED] The Licensee requested deletion of the exposure and a 10 millirem assessment for the reporting period. The Agency granted the deletion and accepted the 10 millirem assessment.

File Closed.

I-7622 - Radioactive Material Found - Eric Swayder - Brownsville, Texas

On July 15, 2000, the Texas Natural Resource Conservation Commission notified the Agency that radioactive material was stored in the garage of a private residence. A landlord had evicted an individual and realized the garage was filled with hazardous materials and chemicals. Several drums of chemicals were hauled away, however, no radioactive material was located. A radiation survey detected only background radiation levels.

File Closed.

I-7623 - Badge Overexposure - The University of Texas Health Science Center at San Antonio - San Antonio, Texas

On July 21, 2000, the Registrant notified the Agency of a 8,178 millirem high energy exposure to an employee during the April, 2000 monitoring period. The exposure was also reported as static, indicating no movement of the badge during exposure. The employee performed duties as an x-ray technologist at the University Hospital and wore a single dosimeter at the collar, outside of a lead apron. The employee performed duties with two senior technologists and never performed procedures alone. The employee's two co-workers received exposures of minimal and 144 millirem. The registrant requested a deletion and an assessment equal to the highest dose received by the employee's two co-workers. The Agency granted the deletion and accepted a 144 millirem assessment.

File Closed.

I-7624 - Dose Irregularity - River Oaks Imaging - Houston, Texas

On July 20, 2000, the Licensee notified the Agency of a dose irregularity that occurred on July 11, 2000. [REDACTED] was administered for a [REDACTED] instead of the [REDACTED] procedure. Upon receiving the test results, the referring physician realized the test was not the one prescribed. The referring physician notified the hospital and the patient. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. The Licensee implemented a procedure where a nuclear procedure is not initiated unless a physician has approved the procedure.

File Closed.

I-7625 - Equipment Malfunction - Cooperheat-MQS, Inc. - Houston, Texas

On July 19, 2000, the Licensee notified the Agency of a source that failed to return to the fully shielded position upon completion of an industrial radiography exposure. The Licensee's radiation safety officer was notified, but before he could arrive on site, a radiographer trainer, following the Licensee's operating and emergency procedures, had disassembled the crank cable housing and manually pulled the source into the shielded position using the drive cable. The crank assembly was then reassembled and the equipment removed from service. It was determined that the guide tube had internal damage that could not have been discovered by the routine inspection of equipment prior to operation. The guide tube was removed from service and destroyed. The Licensee was cited for performing source retrieval operations without specific authorization by license condition.

File Closed.

I-7626 - Badge Overexposure - Big State X-Ray - Odessa, Texas

On July 18, 2000, the Licensee notified the Agency of a 7,173 millirem exposure to a radiographer during the May 20, 2000 to June 19, 2000 monitoring period. During the month, there were no unusual occurrences or incidents, the pocket dosimeter did not go off-scale nor did it have high readings. The badge processor was unable to determine if the exposure was static or dynamic. The Licensee believes the exposure was only to the badge. An Agency investigation concurred with the Licensee's findings. A deletion was allowed and a 265 millirem assessment, based on past average exposures, was accepted.

File Closed.

I-7627 - Badge Overexposure - Longview Inspection, Inc. - Houston, Texas

On July 13, 2000, the Licensee notified the Agency of a 6,600 millirem exposure to a radiographer during the June 2000, monitoring period. The Licensee concluded that the exposure was only to the badge. An Agency investigation also determined the exposure was likely only to the badge. The Licensee requested deletion of the 6,600 millirem exposure and an assessment of 88 millirem, based on the radiographer's pocket dosimeter reading. This pocket dosimeter reading closely matched that of the radiographer's co-workers and his exposure history. The deletion was granted and an 88 millirem assessment, based on pocket dosimetry records, was accepted.

File Closed.

I-7628 - Stolen Gauge - Tolunay Wong Engineers, Inc. - Houston, Texas

On August 1, 2000, the Licensee notified the Agency that a moisture density gauge was stolen from a company truck parked overnight at an employee's residence. The gauge had been taken home to perform an early morning job assignment the following day. The employee departed his residence at approximately 5:00 a.m. and was paged by the Licensee at approximately 8:00 a.m. He left his vehicle unattended for approximately 15 minutes while searching for a telephone. During the telephone call, he was informed that his job assignment and job site location had been changed. He reported to the new job site. At approximately 11:00 a.m. he noticed the gauge was missing and reported this to his supervisor. He completed work at this site, and returned to the Licensee's office where he was told to return to his residence and search for the gauge. The gauge was not located. The Licensee was cited for storage of radioactive material at an unauthorized storage location and failure to secure the radioactive material from unauthorized removal. The gauge has not been recovered.

File Inactive.

I-7629 - Laser Injury - RWR Company L.L.C. dba Soma Bell - McAllen, Texas

On July 25, 2000, the Registrant notified the Agency of an injury that occurred during a laser hair removal procedure. The notification stated that [REDACTED] were caused by aggressive treatment by a technician who had set the [REDACTED] to a higher level than authorized by the physician. As a corrective action the physician trained the technicians on [REDACTED] and establishing appropriate [REDACTED] for each patient. Information concerning this incident was forwarded to the Texas State Board of Medical Examiners for possible action under their rules.

File Closed.

I-7630 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7631 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7632 - Source Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On August 3, 2000, the Licensee notified the Agency that a 1.5 curie cesium-137 source had been abandoned downhole in Howard County at 3,155 feet on July 30, 2000. Attempts to retrieve the source were unsuccessful. 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-7633 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7634 - Radioactive Material Lost & Found - Welding Testing X-Ray - Baton Rouge, Louisiana

On August 13, 2000, ChemTrec, a first responders emergency contact, notified the Agency that a radiographic device was found on August 13, 2000. The device contained a 112 curie iridium-192 source. A pedestrian called the local sheriff's office after seeing a package marked radioactive, in the middle of the road, at an intersection near Canyon Lake. The local sheriff's department and fire department responded to the scene, blocked the intersection, and contacted the national emergency response organization. An Agency investigator responded, performed surveys, found the source was fully shielded, and determined the device was undamaged. The device was removed to the roadside and the intersection was reopened. A Louisiana radiography crew working under reciprocity lost the device en route to a job site near New Braunfels, Texas. The two radiographers were contacted and the device was released to them. The radiographers indicated the device had been placed on the truck's bumper and forgotten while the two obtained their morning coffee. The Licensee and the radiographers were cited for loss of control of the device, failure to secure the device for transport, and failure to have shipping papers and emergency information in the radiography truck. Additionally, the Licensee was cited for failure to submit radiographer certifications for the two radiographers involved in the incident.

File Closed.

I-7635 - Stolen Gauge - Terra-Mar, Incorporated - Fort Worth, Texas

On August 14, 2000, the Licensee notified the Agency that a moisture density gauge containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241 source, had been stolen. The driver/operator had stopped his vehicle at a convenience store and when he returned from the store he noticed that the gauge was missing. The gauge had not been properly secured in the vehicle. The Licensee gave a verbal and written reprimand to the operator. A reward was offered in a

local daily paper. As a corrective action, the Licensee circulated a memo to all technicians regarding proper security of nuclear gauges and compliance with the Licensee's Radiation Protection Program. Finally, the Licensee has required their field supervisor to perform unannounced job site inspections to verify compliance with this policy. The Licensee was cited for failure to secure the gauge against unauthorized removal. The gauge has not been recovered.

File Inactive.

I-7636 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7637 - Laser Injury - Rio Grande Surgery Center - McAllen, Texas

On August 8, 2000, incidental to a complaint investigation, the Agency was informed of an alleged death caused by an [REDACTED] that occurred during a [REDACTED]. An Agency investigation determined that the [REDACTED]

[REDACTED]. The patient died from [REDACTED]. The laser involved in the incident had preventive maintenance performed in January 1996, and was checked after the incident. No problems were found with the equipment. The Registrant was cited for failure to notify the Agency of the laser injury.

File Closed.

I-7638 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7639 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7640 - Badge Overexposure - H & G Inspection - Houston, Texas

On August 14, 2000, the Licensee notified the Agency of a 6,240 millirem exposure to a radiographer during the July 10, 2000, to August 9, 2000, monitoring period. The Licensee believes the exposure was only to the badge. A written report was not received from the Licensee. The Licensee was cited for failure to submit a written report within 30 days.

File Closed.

I-7641 - Badge Overexposure - The University of Texas Health Science Center at San Antonio - San Antonio, Texas

On August 21, 2000, the Registrant notified the Agency of a 7,589 millirem, low energy, dynamic exposure to an employee during the May 2000, monitoring period. The badge was lost two days before exchange date. The badge was found two weeks later and sent in for processing. The Registrant's investigation indicated a badge only exposure, and a deletion was requested. An Agency investigation concurred. The deletion was granted, and a 25 millirem assessment, based on the highest dose received by personnel performing similar duties, was accepted. The Registrant reminded the technologists to report lost or misplaced dosimeters immediately and two training sessions were held on August 17, 2000, for the x-ray department.

File Closed.

I-7642 - Dose Irregularity - West Texas Nuclear Pharmacy - Midland, Texas

On August 19, 2000, the Licensee notified the Agency of dose irregularities that occurred on August 11, 2000. The Licensee dispensed several [REDACTED] that deteriorated rapidly and became chemically disassociated. Six patients at three medical facilities were administered the doses. The whole body doses were less than 5 rem and no organs received greater than 50 rad. The patients and referring physicians were notified. The pharmacy indicated that quality control testing performed just after preparation showed greater than 95% tagging efficiency. However, patients [REDACTED] as expected. A retest of tagging by the pharmacy showed 62-67% efficiency. Other medical facilities were notified not to use the doses. The manufacturer of the dose kits was notified and indicated no complaints were received from other customers regarding the lot number. The pharmacy believes the kits may have been reconstituted or boiled incorrectly during dose preparation at the pharmacy. To prevent a recurrence, the pharmacy will delay the performance of quality control until one to two hours after the doses have been prepared.

File Closed.

I-7643 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7644 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7645 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7646 - Equipment Malfunction - Reynolds Metal Company - Gregory, Texas

On September 11, 2000, the Licensee notified the Agency of a gauge malfunction that occurred on September 2, 2000. The gauge contained a 188 millicurie cesium-137 source. The source housing shutter on the fixed density gauge was jammed half open. Vibrations associated with operations most likely caused the problem. The gauge had been mounted on a pipe for ten to fifteen years. A technician checked the shutter and determined it was inoperable. A certified technician from the distributor replaced the shutter. There was no radiation exposure to company workers as a result of the incident. The device was mounted in a manner that prevented exposure to the public.

File Closed.

I-7647 - Source Abandoned Downhole - Baker Atlas - Houston, Texas

On August 25, 2000, the Licensee notified the Agency of three sources that were abandoned downhole, in Zapata County. The sources became stuck at 6,800 feet on August 22, 2000. Five attempts to fish the sources from the well were unsuccessful. On August 25, 2000, the decision was made to abandon the sources. The sources were immobilized at 6,844 feet by 219 feet of red tagged cement and an additional 620 feet of Class H cement. In addition, a whipstock was placed at 6,005 feet to protect the sources from intrusion. A plaque has been ordered for placement on the wellhead. 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-7648 - Radioactive Material Lost - Anheuser-Busch, Inc. - Houston, Texas

On August 14, 2000, the General Licensee notified the Agency of the loss of two, 7.6 curie tritium exit signs. The signs had hung above the exit doors to the men's and women's locker rooms. A demolition of the locker rooms resulted in the loss of the signs. The signs were last seen on July 24, 2000. The Licensee searched the construction site and surrounding area, interviewed employees, checked at a recycling facility, and checked at a local landfill. The signs were not found. Actions taken by the Licensee to recover the signs included posting notices to employees warning that the signs must not be disposed of as municipal waste, and assured a confidential reporting mechanism for information and a penalty free transfer. To prevent a recurrence, a prominent tag warning individuals to contact proper authorities prior to removal was added to remaining signs, all employees will receive safety training related to the signs, project engineers will be held responsible for signs, and the signs will be replaced with electrically powered signs. The General Licensee was cited for failure to transfer or dispose of the radioactive material in a manner authorized by the Agency.

File Closed.

I-7649 - Source Disconnect - Rockwood Industrial Services dba Longview Inspections, Inc. - Houston, Texas

On August 24, 2000, the Licensee notified the Agency of a source disconnect that occurred during radiography operations on August 10, 2000. After an exposure, the source failed to retract to the shielded position due to the cable connector ball breaking off the cable end and becoming stuck in the source tube. Proper retrieval procedures were followed for return of the source to the shielded position. An assessment of the damaged equipment indicated the hardness of the connector was 26 versus the normal hardness of approximately 83. A combination of age, hardness, and wear and tear contributed to the failure of the connector. The Licensee has initiated a procedure to ensure inspection of the connectors on a daily basis, in addition to quarterly maintenance procedures. These activities will be reviewed during the radiation safety officer's corporate audits.

File Closed.

I-7650 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7651 - Stolen Gauge - Quality Testing and Engineering, Inc. - Dallas, Texas

On September 13, 2000, during an Agency inspection of the Licensee's facility, it was determined that a nuclear density gauge had been stolen on January 14, 2000. The gauge was stolen from a company vehicle when the driver made a stop at a grocery store while returning to the Licensee's

facility. The Licensee was cited for failure to make proper notification and for failure to make a written follow-up report required by the Agency.

File Inactive.

I-7652 - Misadministration - Cancer Therapy Research Center - San Antonio, Texas

On September 13, 2000, the Registrant notified the Agency of a misadministration that occurred between August 22 and August 29, 2000. [REDACTED] were administered to an area inferior to the prescribed target area for a total misadministered dose of [REDACTED]. The physician prescribed a [REDACTED] to consist of a [REDACTED]. The radiation oncologist indicated that [REDACTED] were expected as a result of the misadministration. The patient, the patient's family, and the referring physician were notified of the error. The [REDACTED]. The radiation therapist uses the [REDACTED] as a reference point to set the location of the treatment fields on the patient. A CT technologist placed the [REDACTED] on the patient using [REDACTED]. The dosimetrist determined the coordinates by reviewing a [REDACTED]. The CT technologist and the dosimetrist enter data and review information using separate computers at separate workstations. The coordinate numbers were incorrectly transposed during a transfer of information between the two from a computer screen to a handwritten form. The error was found when the weekly portal film was reviewed and compared to the CT film and the [REDACTED] did not match. To prevent a recurrence, the dosimetrist will print the information and provide it to the CT technologist.

File Closed.

I-7653 - Misadministration - M.D. Anderson Cancer Center - Houston, Texas

On August 7, 2000, the Licensee notified the Agency of a therapeutic misadministration that occurred on July 21, 2000. An interlock failed to warn the therapist that an [REDACTED] was not present. The failure occurred because a maintenance representative wired a bypass for a machine interlock. Absence of the [REDACTED] resulted in [REDACTED] for treatment. The patient [REDACTED]. The patient and surgeon were both informed of the incident and were informed that it was a low risk event to the patient. The interlock has been restored on the accelerator. Corrective actions have been instituted to prevent a reoccurrence of this incident.

File Closed.

I-7654 - Lost/Stolen Gauge - Raba-Kistner Consultants, Inc. - Austin, Texas

On September 14, 2000, the Licensee notified the Agency of the loss/theft of a moisture density gauge containing a 5.4 millicurie cesium-137 source and a, 39 millicurie americium-241 source. The Licensee's driver/operator placed the gauge in the back of a company pickup, outside of the authorized transportation box, and unsecured to the vehicle. The vehicle and the unsecured gauge were left unattended. Returning to the vehicle, the technician drove away. While driving he noticed the tailgate was down. After stopping the vehicle, he determined that the gauge was missing. The technician notified the Licensee. A search of the route taken and the job site did not locate the gauge. The Licensee reinstructed the technicians on proper handling and storage requirements of nuclear gauges. The Licensee was cited for failure to keep the gauge under constant surveillance and for failure to secure the gauge for transport.

File Inactive.

I-7655 - Stolen Gauge - Arias & Kezar Engineering - San Antonio, Texas

On September 25, 2000, the Licensee notified the Agency of the theft of a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was stolen from the back of a company truck along with the operator's tool box. The security chains for the gauge had been cut. A police report was filed. Television and print media were notified of the theft and reported the potential dangers of the stolen device to the public. A reward was offered for return of the device.

File Inactive.

I-7656 - Radioactive Material Found - Structural Metal Inc. - Seguin, Texas

On August 25, 2000, the steel mill notified the Agency that a radioactive source was found in a load of scrap metal on July 6, 2000. The source was analyzed at an offsite laboratory and identified as 180 microcuries of radium-226. The source appeared to have been a part of a static eliminator. The steel mill arranged for disposal through a licensed company.

File Closed.

I-7657 - Radioactive Materials Found - Grapevine Fire Department - Grapevine, Texas

On September 15, 2000, the fire department notified the Agency that an individual found a radioactive material package in his garage and turned it over to the fire department. During an Agency investigation the package labeled "Radioactive Material Gamma Radiation @ the surface of the parcel less than 10 milliroentgens for 24 hrs/No alpha, beta, or neutron Radiation" was surveyed with no radiation readings above background. The package was lead lined and contained three lead cylinders inside each other. A glass vial, containing a liquid, was inside the cylinders. It was labeled as "cobalt-60, 2 milliliters, 0.98 microcuries, Dec 23, 1963, solution CoCl<sub>2</sub>." A survey of the glass vial indicated no radiation levels above background. The fire department was instructed to dispose of the package after removing or defacing all radioactive material labels.

File Closed.

I-7658 - Radioactive Material Found - Structural Metals Inc. - Seguin, Texas

On September 29, 2000, the steel mill notified the Agency that radioactive material was detected in a load of scrap metal on September 3, 2000. The material was analyzed at an offsite laboratory and was identified as radium-226 with an activity of 0.00002 microcuries. The steel mill arranged for the disposal of the material through a licensed company.

File Closed.

I-7659 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7660 - Source Abandoned Downhole - Schlumberger - Sugarland, Texas

On September 26, 2000, the Licensee notified the Agency that a 1.7 curie cesium-137 source was abandoned downhole at 6,288 feet on August 26, 2000, in Sutton County. Attempts to retrieve the source were unsuccessful. 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.

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## COMPLAINT SUMMARY FOR THIRD QUARTER 2000

### C-1492 - Unregistered Laser - Medical Clinic/Sunil R. Cheruku, M.D. - Austin, Texas

On July 7, 2000, the Agency received an anonymous complaint alleging an unregistered laser was in use. A search of Agency records did not indicate a laser registration at the address given in the allegation. An Agency investigation determined that two unregistered lasers had been in use at the clinic since June 1, 2000. The clinic was cited for failure to register the laser equipment within 30 days of commencement of laser operations.

File Closed.

### C-1493 - Unregistered Provider of Services - General Electric Clinical Services / Columbia Hospital System of Texas - Pewaukee, Wisconsin

On July 7, 2000, the Agency received an anonymous complaint alleging that the company was providing unauthorized laser installation, alignment, calibration, and services under contract. The complainant alleged that services were not being completed by the company because the company did not possess service keys for some brands of equipment and was therefore, providing services by just changing a sticker on the equipment. An Agency investigation determined that the service provider had been registered since March 1997, to perform laser installation, alignment, calibration, and services. The Registrant had maintenance keys for lasers. The allegations were unsubstantiated.

File Closed

### C-1494 - Regulation Violations - Michael Ramsey/West Texas Spine - Odessa, Texas

On July 13, 2000, the Agency received an anonymous complaint alleging that an x-ray unit in use at a facility was unregistered and an uncredentialed technologist performed dangerous and hazardous procedures. An Agency investigation determined the unit was unregistered, however, the unit had been operated for less than 30 days. The unit was operated by an individual registered as a non-certified technician (NCT). The Agency was unable to substantiate the allegation that the NCT performed procedures that were not allowed with the NCT credential.

File Closed.

C-1495 - Regulation Violation - H & G Inspection, Inc. - Houston, Texas

On August 14, 2000, a radiography trainee notified the Agency that his pocket dosimeter had gone off scale but that he was told to remain at the job site. He stated that he remained at the because he was afraid he would be fired if he did not. An Agency investigation determined that the trainee was told to remain at the job site, but was instructed to discontinue radiation work. The trainee's personnel monitoring device was sent for immediate processing. The report indicated a 25 millirem exposure.

File Closed.

C-1496 - Regulation Violation - Safety Incorporated - Nederland, Texas

On June 26, 2000, the Agency received an anonymous complaint alleging a company failed to apply for a General License Acknowledgement. An Agency investigation determined the company was in possession of a spectrum analyzer lead detector containing a 10 millicurie cadmium-109 source and had been using the device for several years. The company had not applied for the General License Acknowledgement. The company was cited for the violation.

File Closed.

C-1497 - Regulation Violation - Physicians Center for Diagnostics - Houston, Texas

On July 14, 2000, the Agency received a complaint alleging an [REDACTED] was performed. The complainant claimed a [REDACTED] performed on [REDACTED], did not reveal a [REDACTED] that was later found by [REDACTED] at another facility. An Agency investigation determined an [REDACTED] procedure performed on June 23, 2000, did not indicate a specific abnormality. A [REDACTED] performed on [REDACTED], revealed a [REDACTED]

File Closed.

C-1498 - Regulation Violations - Conam Inspection - Pasadena, Texas

On July 28, 2000, the Agency received an anonymous complaint alleging that: the receipt and transfer of radiography sources are not properly documented; radiography devices are not secured during transport; radiography devices are left unattended; radiation surveys of use areas are not performed; and restricted area boundaries are either not set up or access is not controlled. An Agency field site inspection of a radiography crew found a restricted area was set up and controlled, caution radiation signs were posted and barrier tape was completely around the site, post-exposure and lockout radiation surveys were performed, surveillance of the device was maintained, blocking and bracing equipment and an overpack for transport was available. Six violations of Agency regulations were identified during the inspection. An Agency inspection at the Licensee's records location determined receipt and transfer records for licensed sources were maintained as required. However, records documenting the receipt and transfer of all registered sources were not maintained. The inspection at the records location found four additional violations of Agency regulations for licensed activities and eight violations for registered activities. The Licensee was cited for the violations and referred for escalated enforcement actions.

File Closed.

C-1499 - Unregistered Equipment - Rosenberg Veterinary Clinic - Rosenberg, Texas

On August 1, 2000, the Agency received an anonymous complaint alleging that a veterinary facility using x-ray equipment was unregistered, was not providing shielding for employees who were holding animals, and allowed uncredentialed operators to perform radiographs. An Agency investigation determined that the facility had been operating an x-ray unit since 1977 without a Certificate of Registration. The facility did have protective aprons and gloves available for use by employees who held animals. Credentials are not required for the performance of veterinary radiographs. The inspection also determined that the facility did not provide personnel monitoring equipment for all employees that were occupationally exposed. The facility was cited for being unregistered and for failure to monitor all employee's occupational radiation exposure.

File Closed.

C-1500 - Regulation Violations - Conam Inspection - Pasadena, Texas

On August 3, 2000, the Agency received a complaint alleging that the Licensee either changed badge readings or switched badges, a female radiographer had declared a [REDACTED] in writing but her work schedule was not adjusted to accommodate the [REDACTED], and she believed she received an exposure of about one rem during her three and one-half month employment. An Agency investigation did not locate a written declaration of [REDACTED] nor any evidence to substantiate a [REDACTED]. Monthly personnel monitoring badge records reviewed indicated exposures for the radiographer as follows: 65 millirems for April, 2000; 85 millirems for May, 2000; and the June 2000, badge reading had not been received from the badge processing company. Daily pocket dosimeter records reviewed indicated an exposure of 10 millirems on one job and zero to one millirem on other jobs. A review of co-worker's pocket dosimeter records indicated most exposures were between zero to ten millirems. The maximum pocket dosimeter reading recorded for other radiographers was 20 millirems. Follow-up requests to the Licensee obtained monthly personnel monitoring badge records indicating the radiographer's exposure for June 2000, was 30 millirems. For July, 2000, the badge processor indicated there was no detectable dose to the badge. Based on badge records reviewed, the radiographer received a total dose of 180 millirems during employment, which is below the 500 millirem dose limit to a [REDACTED]. The investigation did not find evidence to substantiate the allegation of falsification of personnel monitoring records.

File Closed.

C-1501 - Possible Badge Overexposure - ADAC Laboratories - Milpitas, California

On August 8, 2000, the Agency received a complaint alleging that a former employee may have been overexposed to cesium and gadolinium sources used in calibration and repair of nuclear medicine cameras. The former employee stated that he had handled the sources with his bare hands during installation or removal from the cameras. The company was not licensed within the State of Texas and had not requested reciprocal recognition of their California License. An Agency investigation determined that there were no physical signs of radiation injury. The former employee had not used extremity monitoring devices and relied solely on a whole body monitoring. The dosimetry service was contacted and the exposure records did not indicate an overexposure to the individual. The company was cited for failure to obtain reciprocity. The Agency notified California Radiation Control of this incident.

File Closed.

C-1502 - Exposure to the Public - North Star Steel - Rose City, Texas

On August 24, 2000, the Agency received a complaint alleging radioactive material stored at the steel mill was exposing nearby workers to a radiation hazard. An Agency investigation determined pipe contaminated with naturally occurring radioactive material was stored in a roll off box at the mill. A survey of the box determined that a person leaning continuously against the box could receive a radiation dose of about 25 times below the allowable limit. Storage of the contaminated pipe did not pose a health risk to workers at the mill.

File Closed.

C-1503 - Unlicensed Source Material - Iso-Tex Diagnostics, Inc.- Friendswood, Texas

On June 16, 2000, the Agency received an anonymous complaint alleging that the Licensee was in possession of unlicensed quantities of strontium-90 (Sr-90) and was producing yttrium-90 (Y-90). An Agency investigation determined that the Licensee possessed millicurie quantities of Sr-90 and Y-90 and quantities of other radioactive materials greater than authorized by license. The Licensee also failed to provide required financial assurance. The Licensee was cited for the violations and was recommended for escalated enforcement actions.

File Closed.

C-1504 - Regulation Violations - Austin Radiological Association - Austin, Texas

On August 11, 2000, the Agency received a complaint transferred from the U.S. Food & Drug Administration alleging a [REDACTED] was interpreted on May 28, 1998, by an unqualified neuroradiologist who missed [REDACTED]. The complainant indicated she had contacted the Texas State Board of Medical Examiners concerning the physician's diagnosis. A review of Agency records determined the physician who interpreted the [REDACTED] was an approved physician who had the proper credentials, continuing education, and experience.

File Closed.

C-1505 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1506 - Failure to Provide Mammograms - Crystal Woman's Foundation formerly (Texas Mobile Health) - Seabrook, Texas

On August 18, 2000, the Agency received a complaint alleging a patient's mammogram films were

not provided upon request nor were the films retained. The films were from an examination performed on October 29, 1996. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1507 - Regulation Violation - Superior Testing Services - Port Lavaca, Texas

On August 30, 2000, the Agency received a complaint alleging that unauthorized radiography teams were working at temporary job sites. An Agency investigation determined that a radiographer had performed duties with a radiographer trainee on July 21, 2000, prior to being named a radiographer trainer on August 2, 2000. The Licensee was cited for the violation.

File Closed.

C-1508 - Regulation Violations - Crystal Woman's Foundation formerly (Texas Mobil Health) - Seabrook, Texas

On June 20, 2000, the Agency received a complaint alleging mammography clinical images were underexposed, mismarked, and mislabeled. The Agency reviewed the images and evaluated the quality and determined the mediolateral images were underexposed. The craniocaudal images were mismarked in that the markers were placed on the medial aspect of the breast instead of the lateral aspect as required. The label identified the facility as Texas Mobil Health, a name under which the facility had previously operated. The allegations were substantiated and the Registrant was cited for the violations.

File Closed.

C-1509 - Regulation Violations - Hope Star Orthopedics - Sugarland, Texas

On August 14, 2000, the Agency received an anonymous complaint alleging that the walls in the Registrant's x-ray room had insufficient shielding. Prior to an Agency investigation a licensed medical physicist performed a radiation survey. The results of the survey indicated that the walls provided shielding that meets or exceeds the specifications of the radiation design criteria. An Agency investigation determined that during the period June 10, 1999, to July 9, 2000, occupationally exposed employees' personnel monitoring received minimal exposures. Based on the physicist's survey and the employees' documented exposure history, the allegations were unsubstantiated.

File Closed.

C-1510 - Regulation Violations - Mammography and Ultrasound Specialists - Bellaire, Texas

On August 22, 2000, the Agency received a complaint from an interpreting physician alleging that mammography films were of such poor quality that he refused to interpret them. An Agency investigation determined the facility that performed the mammogram examination failed to perform analysis of fixer retention at the correct time interval. The facility was cited for the violation.

File Closed.

C-1511 - Unregistered Provider of Services - Bay Area Dental Supply - Tynan, Texas

On August 24, 2000, the Agency an anonymous complaint alleging that an unregistered provider of services had been providing x-ray services in South Texas and in the Rio Grande Valley. An Agency investigation determined that the provider of services was unregistered. Agency follow-up at facilities where the unregistered provider of services had installed equipment revealed that installations had taken place during a period from February 1998, through August 2000. The provider of services was cited for failure to obtain a Certificate of Registration prior to providing x-ray services.

File Closed.

C-1512 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1513 - Unregistered Equipment - Next Med L.L.P. dba Sabine Lithotripsy - Tucson, Arizona

On August 25, 2000, the Agency received an anonymous complaint alleging that an unregistered provider of service was operating in Texas. The Agency contacted the Arizona headquarters of the provider of service and determined that two providers of service were operating two unregistered mobile units in Texas. The provider of service was cited for failure to register equipment within 30 days of commencement of operations and the Texas Registrants were cited for failure to notify the Agency, in writing, within 30 days of the change of the company contracted as Provider of Services and for contracting with a company, to provide radiation machine services, that was not registered by the Agency to provide such service. The provider of service was referred for escalated enforcement actions.

File Closed.

C-1514 - Regulation Violations - Veterans Administration Medical Center- Cleveland, Ohio / Texas Technology University - Lubbock, Texas

On August 31, 2000, the Agency received a complaint transferred from the United States Nuclear Regulatory Commission (NRC) alleging an unauthorized transfer of radioactive material. The complaint alleged university professors transferred biological tissue samples containing cesium-137 and strontium-90 to medical center professors around September 30, 1999. Allegedly, the transfer took place without obtaining a copy of the medical center's NRC license or authorization from the medical center. An Agency investigation determined the radioactive material was transferred to a professor at the medical center who was authorized to receive the material. The samples were shipped directly from the university to the medical center without going through either radiation safety officer. The university determined that the professors, in bypassing the radiation safety offices, did not follow internal procedures. To prevent a recurrence, the Licensee required the professors to attend a class in basic radiation safety. The university was cited for failure to follow operating and safety procedures.

File Closed.

C-1515 - Patient Contamination - University of Texas Health Science Center San Antonio / University Health System - San Antonio, Texas

On August 31, 2000, the Agency received a complaint from a patient alleging contamination that occurred while she was undergoing a [REDACTED]. During the process of [REDACTED] became disconnected spraying the patient's [REDACTED]. The patient was [REDACTED] radiation safety office was notified of the spill. Radiation safety personnel arrived and began area and equipment decontamination. Later, the patient [REDACTED]. The patient was [REDACTED]. The Licensee estimated that maximum exposure to members of the public was 0.2 millirem and maximum exposure to anyone involved in the event was 21 millirem. Hospital staff from both nuclear medicine and cardiology were in-serviced on standards of patient care, emergency procedures, and decontamination operations.

File Closed.

C-1516 - Uncredentialed Technologist - Family Medicine Associates - Cleburne / Joshua, Texas

On August 23, 2000, the Agency received a complaint alleging an uncredentialed technologist was allowed to perform radiographs. An Agency investigation substantiated the allegation. The facility was cited for the violation.

File Closed.

C-1517 - Unregistered Equipment - Monte Campbell & Associates, Inc. dba Plaza Dental - Nederland, Texas

On September 1, 2000, the Agency received an anonymous complaint alleging that the Registrant's x-ray machine was out in the open and possibly exposing people in a hallway and that operators were not wearing lead aprons. An Agency investigation determined that the equipment was properly installed and did not present a radiation hazard to either employees or the public. The facility had lead aprons available for patient use. The facility is exempt from dosimetry badging requirements for employees and from verification of dose to the public under Agency rules.

File Closed.

C-1518 - Regulation Violations - X-Ray Inspection, Inc. - Pearland, Texas

On September 6, 2000, the Agency received an anonymous complaint alleging radiography devices were not signed out properly, were taken home, and personnel monitoring histories were not requested. An Agency investigation did not substantiate the allegations. However, the investigation found the Licensee failed to maintain records, as required, of oral or written practical examinations administered by the Licensee to radiographers. The Licensee was cited for the violation.

File Closed.

C-1519 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1520 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

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## **INCIDENTS CLOSED SINCE SECOND QUARTER 2000**

### I-7561 - Radioactive Material Stolen - Petra Technologies Incorporated - Houston, Texas

On January 10, 2000, the Licensee notified the Agency of the theft of a nuclear moisture density gauge. The gauge was recovered at a local landfill on August 9, 2000. A leak test on the gauge indicated no leakage.

File Closed.

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**COMPLAINTS CLOSED SINCE SECOND QUARTER 2000**

NO COMPLAINTS WERE CLOSED SINCE SECOND QUARTER 2000

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## APPENDIX A

### SUMMARY OF HOSPITAL OVEREXPOSURES REPORTED DURING THE SECOND QUARTER 2000

NO HOSPITAL OVEREXPOSURES REPORTED DURING SECOND QUARTER 2000

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**APPENDIX B**

SUMMARY OF RADIOGRAPHY OVEREXPOSURES  
REPORTED DURING SECOND QUARTER 2000

NO RADIOGRAPHER OVEREXPOSURES REPORTED DURING SECOND QUARTER 2000

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## APPENDIX C

### ENFORCEMENT ACTIONS FOR THIRD QUARTER 2000

#### Enforcement Conference: South Texas Medical Clinic - Wharton, Texas - X-Ray

On July 5, 2000, an Enforcement Conference was held with South Texas Medical Clinics, P.A. Registrant representatives attending the conference were Ms. Amy Schoppe, R.T., (M)(R), Director of Radiology and Mr. David Clark, Administrator. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), Rick Munoz, and Tommy Cardwell and Madames Jackie Carter and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on May 11, 2000.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Ms. Jackie Carter.

After reviewing 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. The technique chart currently in use must be revised by July 30, 2000, in order to lower the entrance exposure for the Lumbo-Sacral Spine procedure. After the revision, measurements of the entrance exposures for the Lumbo-Sacral Spine (AP), Cervical Spine (AP), and Abdomen (KB) procedures must be submitted to the Agency by August 5, 2000.
2. The Registrant shall determine if the collimating shutters for the General Electric fluoroscopic unit located in Room 1 are able to close totally so that no x-ray field is present on the viewing device. If an x-ray field is present, measurements must be taken to determine if the minimum size of the field at the maximum source-to-image distance does not exceed 5 centimeters by 5 centimeters. The results of the determination and/or measurements must be forwarded to the Agency by August 5, 2000.
3. A copy of all personnel monitoring records indicating the readings from the area monitor badges, along with the specific location of the area monitor badges, must be submitted to the Agency by August 5, 2000. If further investigation determines that the violation regarding public dose surveys was cited in error, the violation will be rescinded by the Agency.

4. The Agency will increase the Licensee's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections. If the results of these inspections show a significant improvement in the radiation safety program, the inspections will return to the routine frequency.

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

Enforcement Conference: Johnson Chiropractic Clinic, Inc. - Rosenberg, Texas - X-Ray

On July 13, 2000, an Enforcement Conference was held with Johnson Chiropractic Clinic, Inc. The Registrant's representative attending the conference was Marc A. Johnson, D.C. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), Rick Munoz, and Tommy Cardwell and Madames Jackie Carter and Cathy McGuire.

The conference was held as a result of the type, number, severity level, and repetitiveness of violations noted during an Agency inspection conducted at the Registrant's facility on May 17, 2000.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Ms. Jackie Carter.

After reviewing 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. The 100 mA station of the Universal x-ray unit, Model No. 3402, Serial No. DF2001-301, located in the x-ray room, must be disabled. A written statement, that the station has been disabled, must be submitted to the Agency within 30 days of receipt of this memorandum.
2. Correspondence must be submitted to Decker X-ray Co., requesting them to perform an equipment performance evaluation, on or before June 2, 2002. A copy of this correspondence must be submitted to the Agency within 30 days of receipt of this memorandum.
3. A copy of the completed protective device log must be submitted to the Agency within 30 days of receipt of this memorandum.
4. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections. These inspections will be conducted between the hours of 9:00 a.m. and noon, and 1:30 p.m. and 5:00 p.m. on Monday, Wednesday, or Friday. If the results of these inspections show a significant improvement in the radiation safety program, the inspections will return to the routine frequency.

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

Enforcement Conference: Universal MRI and Diagnostics, Inc. dba: Champions MRI and Diagnostic Center - Houston, Texas - Medical

On August 3, 2000, an Enforcement Conference was held with Champions MRI & Diagnostic Center. The Registrant's representative attending the conference was Mr. Tom Keefe, Corporate Radiation Safety Officer. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), David Wood, and Tim Schley and Madames Cathy McGuire and Kitty Emerson.

The conference was held as a result of the type and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on April 4, 2000.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Ms. Kitty Emerson.

After reviewing the violation 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. The Registrant shall submit to the Agency a written response for each violation within 10 days of receipt of this memorandum. The response to violation number 1 shall include a written statement that the document previously submitted, regarding the radiation safety officer's monthly inspection log and Dr. Cain's signature, was fabricated.
2. No nuclear medicine studies shall be conducted at this facility without prior approval by the Agency.
3. The Registrant's facility will be inspected in approximately six months, to determine if any sources of radioactive material are present.
4. Administrative penalties will be assessed.

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