

REDACTED - 8/2003

**Second Quarter 1999 Summary of
Incidents, Complaints, Enforcement Actions**

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**| 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.**

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SUMMARY OF INCIDENTS FOR SECOND QUARTER 1999

I-7435 - Radioactive Material Found at Landfill - BFI - San Antonio / Southeast Baptist Hospital - San Antonio, Texas

On March 31, 1999, a landfill notified the Agency that radiation alarms had been activated when a dumpster from a Licensee was brought to the facility. A regional Agency inspector notified the Licensee of the contaminated load and explained that the Licensee would need to investigate the load and report their findings to the Agency by letter. The Licensee inspected the load and determined that the trash contained contamination from a 5 millicurie I-131 capsule that had been regurgitated, cleaned up, and placed in the hospitals regular trash. This trash had in turn been placed in the dumpster and sent with regular trash to the landfill. The material was recovered by the Licensee and returned to their facility for decay-in-storage. After decay and monitoring with the appropriate survey instruments, the trash was returned to the landfill for disposal. The Licensee was cited for unauthorized transfer of radioactive material for disposal.

File Closed.

I-7436 - Radioactive Material Found - Dr. Joel Cohen / Houston Northwest Medical Center - Houston, Texas

On February 23, 1999, a Licensee notified the Agency that on April 1, 1996, they had taken possession of a radioactive source on behalf of a physician who was a former member of their Radiation Safety Committee. The physician did not have a license to possess the source. An Agency investigation determined that the source was radium-226 with an approximate 100 millicurie activity. An analysis later determined it to be 20 millicuries. The source was transferred to a licensed waste broker for disposal.

File Closed.

I-7437 - Dose Irregularity - St. Luke Episcopal Hospital - Houston, Texas

On March 25, 1999, the Licensee notified the Agency of a dose irregularity that had occurred on March 23, 1999. A handwritten order was misinterpreted and entered into the hospital scheduling computer as a request for a [REDACTED]. The actual order was not for a nuclear medicine procedure. The misinterpreted order was transmitted to the Nuclear Medicine Department where a [REDACTED] was prepared. The technologist who was to administer the radiopharmaceutical could not read the patient's chart and asked a nurse to verify the request for the [REDACTED]. The nurse confirmed that the test was correct and the technologist administered the radiopharmaceutical. The technologist was reprimanded for asking a nurse to verify a patient's chart instead of following the hospital's procedure. It should have been referred back to a Nuclear Medicine supervisor or physician, or the ordering physician. 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.

File closed.

I-7438 - Source Disconnect - Technical Welding Laboratories - Pasadena, Texas

On March 28, 1999, the Licensee notified the Agency of a 52 curie Co-60 radiography source disconnect at a temporary job site. Personnel at the job site included a radiographer trainer, radiographer, and a radiography trainee. The trainer was not present at the time of the disconnect. He had gone to get "shooter sheets" when the radiographer attempted a radiograph. The source became disconnected from the drive cable, fell from the source tube and was fully unshielded. The radiographers covered the source with lead shot and lead sheets and contacted the Radiation Safety Officer (RSO). After contacting the RSO the radiographers, without permission, retrieved the source, using a pair of channel lock pliers, and placed it in the exposure device. Based on a pocket dosimeter reading, one radiographer received a total exposure of 90 millirem for the day. Prior to the recovery, one of the radiographers had removed his shirt, where his personnel monitoring badge was located. The Licensee was cited for: failure to maintain two qualified radiographic personnel for each exposure device in use for radiography; failure of a radiographer to wear personnel dosimetry during radiographic operations; failure to use the provided twelve half-value layer collimator during radiographic operations and for the performance of an unauthorized source retrieval.

File Closed.

I-7439 - Package Radiation Levels - Anytime Cartage/Korean Airlines - Grapevine/Dallas-Fort Worth International Airport (DFW)/Houston International Airport (HIA), Texas

On March 29, 1999, the U.S. Customs Department in Houston, Texas notified the Agency of damage to a package, containing radioactive materials, received at the HIA. An Agency investigation determined that a source had become dislodged from the shielded position during transport. The package, a 5-gallon drum, had arrived at DFW on a Korean Airlines flight in good condition on February 29, 1999. The shipment was loaded on a contract carrier truck for transport to HIA at approximately 2:00 a.m. on February 30, 1999. The shipment arrived at Anytime Cartage in Houston before 6:00 a.m. for transfer to Korean Airlines at approximately 7:30 a.m. for transport to Houston. When the truck was opened in Houston to unload the shipment, the 5-gallon drum had fallen off its transport pallet. The lid was off the drum and the source, still in its shield, was on the floor. The drum was picked up and the shield and source was picked up by the pigtail and placed in the drum. The drum was then placed in an isolated area until a owner company representative repackaged the source and shield for continued shipment. The package apparently shifted during transport, fell off its transport pallet, and became dislodged. No individual was exposed to significant amounts of radiation during the incident.

File Closed.

I-7440 - Package Radiation Levels - Korean Airlines - Dallas / Fort Worth International Airport - Irving, Texas

On March 29, 1999, the U.S. Customs Department inspector at Dallas-Fort Worth International Airport, Irving, Texas, notified the Agency that a radioactive materials shipment from Singapore enroute to a Houston firm had fallen over and dumped its contents inside the air cargo terminal. The shipment consisted of eight packages. Three each contained a 0.6 millicurie Co-60 source and five each contained a 1.5 curie cesium-137 source. An Agency investigator surveyed each package. Surveys indicated that no package surface reading was above 2 millirems per hour, all packages appeared undamaged, were correctly labeled as either Yellow II or Yellow III, and the manifest and shipping papers were in order. The shipment was released for continued transport.

File Closed.

I-7441 - Radioactive Material at Scrapyard - Chaparral Steel - Midlothian, Texas

On March 30, 1999, the steel mill notified the Agency that a load of scrap metal had activated the company's radiation detector alarm. An Agency investigator located a gauge within the load with a surface radiation reading of 4 millirems per hour. The gauge was removed from the scrap and placed in an isolated and secured area. The gauge was returned to the shipper in Wichita Falls, Texas for appropriate handling.

File Closed.

I-7442 - Equipment Damaged - Price Construction, Incorporated - Big Spring, Texas

On March 30, 1999, the Licensee notified the Agency that a moisture/density gauge containing eight millirems of cesium-137 had been damaged at a construction site. A water truck operator did not heed the warning signals of the gauge operator and struck the gauge causing damage to the keyboard and the shielded casing. A survey conducted by the Radiation Safety Officer did not detect any radiation leakage. The gauge was returned to the manufacturer. A leak test confirmed no radiation leakage.

File Closed.

I-7443 - Dose Irregularity - Cuero Community Hospital / Syncor International Corporation - Cuero, Texas / Corpus Christi, Texas

On April 7, 1999, the Licensee notified the Agency of a dose irregularity that occurred on March 30, 1999. A patient was administered a [REDACTED] instead of the prescribed dose of [REDACTED]. The dose was properly labeled and prepared but had disassociated prior to injection. Several doses from the same lot were reported by other facilities as not performing appropriately. 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.

File Closed.

I-7444 - Equipment Damage - Geoscience Engineering and Testing, Inc. - Dallas, Texas

On March 16, 1999, the Licensee notified the Agency that a moisture/density gauge was damaged while unattended. During the operator's absence, a bulldozer backed out of a trench and ran over the gauge. Construction operations were discontinued and the area around the gauge was roped off until the gauge was recovered. Both sources within the gauge were undamaged. The gauge was transferred to a sales company for repair or disposition. The Licensee was cited for failure to maintain surveillance of the gauge.

File Closed.

I-7445 - Radioactive Materials Transportation - China Airlines - Dallas/Fort Worth International Airport (DFW) - Irving, Texas

On April 23, 1999, the U.S. Customs Service notified the Agency that an employee's alarming dosimeter was activated at a DFW Cargo Terminal. An Agency inspector performed surveys of packages contained in several large wooden crates. Four pallets surveyed contained multiple packages of cobalt-60, cesium-137, and californium-252. All packages had proper shipping papers and were properly labeled as to the materials enclosed, the container type, addresses. The shipment was adequately marked and documented. Radiation levels at one meter from the pallets were measured at 2 millirems per hour. The shipment was released for transport by common carrier.

File Closed.

I-7446 - Dose Irregularity - Syncor International Corporation / Southwest Methodist Hospital - San Antonio, Texas

On April 19, 1999, the Licensee notified the Agency of a dose irregularity involving [REDACTED]. A patient was injected with a dose labeled [REDACTED] but the [REDACTED]. A pharmacy investigation determined the dose was [REDACTED]. The misidentification resulted from the incorrect product being placed in a shield labeled for the prescribed radiopharmaceutical. The pharmacy has conducted in-service sessions for all pharmacists, emphasizing a requirement to double check all products before placing them into shields for dispensing. 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-7447 - Dose Irregularity - Park Plaza Hospital - Houston, Texas

On April 14, 1999, the Licensee notified the Agency of a dose irregularity that occurred on April 6, 1999. A nuclear medicine technologist injected the wrong patient with [REDACTED] after asking the patient's identity and receiving an affirmative answer. However, the patient's armband was not checked as required by hospital policies and procedures. 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. To prevent a recurrence the correct procedures were reviewed with all technologists during in-service training.

File Closed.

I-7448 - Dose Irregularity - Saint Luke's Episcopal Hospital / Syncor Pharmacy Services - Houston, Texas

On April 12, 1999, the Licensees notified the Agency concerning an irregularity involving a [REDACTED] that occurred on April 12, 1999. The dose was delivered to the Nuclear Medicine Department instead of the Cardiology Lab. When notified by the Cardiology Department that the expected dose had not been received, the pharmacy delivered a second dose to the Cardiology Lab. In the meantime, the first dose was located, delivered internally to the correct floor, and injected. The second dose was held for decay by the hospital.

File Closed.

I-7449 - Dose Irregularity - Saint Luke's Episcopal Hospital / Mallinckrodt - Houston, Texas

On April 15, 1999, the Licensees notified the Agency of a dose irregularity that occurred on April 15, 1999. An eight millicurie dose of technetium-99m sulfur colloid was delivered instead of technetium-99m choletec. The shipment was labeled choletec so the hospital notified the pharmacy that the prescription had been incorrectly filled. The dose was retrieved and the correct radiopharmaceutical was delivered. The pharmacy suspects the error occurred due to the similarity of labeling procedures for "hepatic" vs "hepatobiliary". All pharmacy personnel were made aware of the dose irregularity and have modified the final check off procedures to prevent a recurrence.

File Closed.

I-7450 - Dose Irregularity - Mallinckrodt / Baylor Medical Center at Irving (d.b.a. Irving Healthcare System) - Irving, Texas

On April 19, 1999, the pharmacy notified the Agency of a dose irregularity that occurred on March 28, 1999. A patient was injected with [REDACTED] instead of the intended dose of [REDACTED]. The dispensing pharmacist filled the prescription with the wrong radiopharmaceutical and mislabeled the dose. Shortly after the injection the hospital was notified of the error by the nuclear pharmacy. 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. The hospital was cited for failure to notify the Agency within 30 days of the incident.

File Closed.

I-7451 - Unregistered Radioactive Material and Laser - J. J. Pearce High School - Richardson, Texas

On November 19, 1998, an Agency employee noted a web page advertising physics classes at a high school using radioactive materials and lasers. An Agency investigation determined that the quantities of radioactive materials being used in the classes were exempted from regulations. However, the laser in use required registration with the Agency. The school was cited for the operation of unregistered lasers and given instructions on how to register the lasers.

File Closed.

I-7452 - Radioactive Material Found - Kendleton, Texas

On Monday, April 19, 1999, the Agency was notified that two radioactive sources were found in dirt removed from a ditch by the Texas Department of Transportation (TxDOT) along Highway 59 near Kendleton, Texas. One source was a ½ inch long, needle-like piece of wire that has tentatively been identified as radium-226. It is believed the second source is also radium-226. The probable origin was an old medical device. The ditch had not been dug out for more than 20 years. When the dirt was transported to a landfill, radiation monitors detected the sources. The radium needles were found in a relatively isolated area and it is unlikely that the general public received any significant radiation exposure. The Texas Department of Health (TDH) took possession of the sources pending disposal. TxDOT continued to clean the ditches in this area and TDH radiation control personnel continued to monitor. No other sources were found.

File Closed.

I-7453 - Source Abandoned Downhole - Schlumberger - Upton County, Texas

On April 29, 1999, the Licensee notified the Agency of the abandonment of a 1.7 curie cesium-137 density source and a 16 curie americium-241beryllium neutron source at a depth of 8,315 feet. A logging tool, containing the sources, became stuck on April 25, 1999. Repeated attempts to retrieve the sources were unsuccessful. 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-7454 - Dose Irregularity - Baptist Health System - San Antonio, Texas

On May 3, 1999, the Licensee notified the Agency of a dose irregularity that occurred on April 19, 1999. The wrong patient had been injected with [REDACTED]. The patient injected was in the same nursing unit and had the same last name as the intended patient. The technologist failed to check the patient's wrist band prior to the injection. 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. To prevent a recurrence the hospital instructed staff technologists to confirm patient identification, the correct radiopharmaceutical, and appropriate dosage for the study just before the dose is administered.

File Closed.

I-7455 - Radioactive Material Detected at Landfill - Doctor's Regional Medical Center / BFI Landfill (Sinton) - Corpus Christi, Texas

On April 20, 1999, the landfill notified the Agency that a septic tank pumper truck had activated the alarm on a radiation monitor at the landfill on April 20, 1999. An Agency inspector contacted the medical center that was listed on the truck's work route and determined the pumper truck had been used to clean a grease trap. The medical center indicated the contamination could have resulted from nuclear medicine procedures performed on patients. An Agency investigation revealed that when the truck returned to the landfill on April 21, 1999, radiation levels had decreased to levels acceptable for sludge dumping and the waste was accepted by the landfill. The decrease in radiation levels indicated the sludge contained radionuclides with short half-lives.

File Closed.

I-7456 - Radioactive Material at a Scrapyard - Pro-Metal Processing Company / MRAM - Houston, Texas

On April 4, 1999, a scrap metal company notified the Agency that a 56 microcurie radium-226 source had been found in a load of scrap metal. An Agency investigation determined the source was from a ionization cell originally owned by the Veterans Administration Hospital in Houston. The hospital was notified and took possession of the source.

File Closed.

I-7457 - Dose Irregularity - Syncor / Columbia Medical Center- McKinney, Texas

On May 1, 1999, the pharmacy notified the Agency of a dispensing irregularity that occurred on April 29, 1999. The pharmacy dispensed [REDACTED] labeled as [REDACTED]. A patient was [REDACTED] with the dose and imaging results were not as expected. The hospital notified the pharmacy of the error. The pharmacy determined that a pharmacy technologist inadvertently drew the wrong dose for the hospital. The technologist was counseled on procedures to prevent dispensing a wrong dose. 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-7458 - Dose Irregularity - Syncor Pharmacy Services / Arlington Memorial Hospital - Arlington, Texas

On May 1, 1999, the pharmacy notified the Agency of a dispensing irregularity that occurred on April 29, 1999. A [REDACTED] dose was dispensed instead of [REDACTED]. After notification, the pharmacy realized that the dispensed volume was [REDACTED] instead of [REDACTED]. The smaller volume indicated the wrong preparation was used to draw the dose. 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-7459 - Badge Overexposure - Spohn Hospital Shoreline / Radiology & Imaging of South Texas, LLP. - Corpus Christi, Texas

On May 4, 1999, the Licensee notified the Agency of a 5.785 rem exposure to a radiologist during the 1998 monitoring period. An Agency investigation determined the radiologist exclusively performed fluoroscopic interventional procedures. A dose adjustment was accepted based on regulatory provisions that resulted in a dose reduction from 5.785 rem to 1.736 rem. The hospital was authorized to report this adjustment to their dosimetry service.

File Closed.

I-7460 - Leaking Source - Southwest Research Institute - San Antonio, Texas

On May 3, 1999, the Licensee notified the Agency that during disassembly of a cesium-137 teletherapy head, a source of approximately 1,000 curies was determined to be leaking. Further testing determined the source weld was not complete. On April 28, 1999, the leaking source was placed in a R container, overpacked and certified as a Type B package and returned to the manufacturer for repair. The package was confirmed to have been received by the manufacturer on May 4, 1999.

File Closed.

I-7461 - Dose Irregularity - Harris Methodist Hospital - Cleburne, Texas

On May 5, 1999, the Licensee notified the Agency of a dose irregularity involving [REDACTED] of [REDACTED]. The [REDACTED] was injected instead of the intended [REDACTED] for a [REDACTED]. 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. The [REDACTED] was successfully completed at a later date. An additional step has been implemented to identify and match patient and dose, where the technologist will read the injection dose from the dose shield to the patient.

File Closed.

I-7462 - Radioactive Material Spill - Cogema Mining, Inc. - Bruni, Texas

On May 11, 1998, the Licensee notified the Agency of a 2000 gallon spill of 11.7 parts per million uranium impregnated restoration water due to the failure of a 1" nipple and union on the well field pipe. The spill spread over approximately 1,800 square feet within a restricted area.

File Closed.

I-7463 - Moisture Density Gauge Lost - Maxim Technologies, Inc. - Dallas, Texas

On May 21, 1999, the Licensee notified the Agency that a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 beryllium source had been lost. The Licensee reported that a technician placed the gauge in its transport container in the back of a pickup truck but did not secure the gauge with a chain and lock. When the technician arrived at a job site the tail gate on the pickup was open and the gauge was missing. The technician retraced his route from his previous stop but could not find the gauge. The Licensee notified the local police and fire departments and the Agency. The Agency notified the gauge manufacturer and local gauge repair facilities of the loss. The Licensee also placed an ad in the local newspaper offering a reward for the return of the gauge. The gauge has not been located. The technicians employment was terminated and all other gauge users were reminded to properly secure gauges during transport. The Licensee was cited for regulation violations and an escalated enforcement conference has been recommended.

File Inactive.

I-7464 - Stolen Moisture Density Gauge - Texas Department of Transportation - Houston, Texas

On May 21, 1999, the Licensee notified the Agency that a moisture density gauge, containing an eight millicurie cesium-137 source and a 40 millicurie americium-241 beryllium source, was stolen from a field office during the night of April 21 - 22, 1999. The gauge, office machinery and other tools were reported stolen to the local police department. The gauge had been secured in a locked cabinet, inside a locked building with burglar bars over the windows, within a fenced yard with a locked gate. Locks had been cut to gain access. The gauge was inside its locked case and had its rod-handle locked. A thorough search of vacant lots and dumpsters in the area by Licensee personnel did not locate the gauge or its case. The gauge has not been recovered.

File Inactive.

I-7465 - Lost Moisture Density Gauge - Maxim Technologies - Dallas, Texas

On May 6, 1999, the Licensee notified the Agency that a moisture density gauge was missing from inventory. A Licensee inventory check on May 5, 1999, determined the gauge was missing from storage. The gauge was present during an April 22, 1999, inventory check. All employees were asked about the gauge but the gauge was not located. The Licensee notified the local police and fire departments as well as the Agency. The Agency notified the gauge manufacturer and local gauge repair facilities of the loss. The Licensee placed an ad in the local newspaper offering a reward for the return of the gauge. The gauge has not been located. The Licensee was cited for regulation violations and an escalated enforcement conference was recommended.

File Inactive.

I-7466 - Source Abandoned Downhole - Reeves Wireline - Gregg County, Texas

On May 8, 1999, the Licensee notified the Agency of the probable abandonment of radioactive sources in an oil well. This was confirmed by letter May 24, 1999, after repeated attempts to recover the 2.7 millicurie cesium-137 source and 20.6 millicurie americium-241/beryllium source were unsuccessful. The sources were abandoned at an estimated depth of 7800 feet. A cement plug was set from 6254 feet to 6354 feet with red dyed cement. A permanent plaque is being fabricated for attachment to the wellhead. A Texas Railroad Commission representative was on-site during recovery attempts. 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-7467 - Exposure to the Public - ASARCO, Incorporated - Amarillo, Texas

On May 19, 1999, the Licensee notified the Agency that the unauthorized removal of a 90 millicurie cesium-137 density gauge had resulted in exposure to four members of the public who had been doing repair and refurbishment near the gauge. The removal of the gauge, with the shutter in the open position, resulted in estimated exposures to two individuals of 26 millirem and 17 millirem. The Licensee was cited for failure to comply with license conditions requiring the use of licensed radiation workers to perform installation and maintenance on the gauge.

File Closed.

I-7468 - Dose Irregularity - Methodist Diagnostic Imaging - Lubbock, Texas

On May 7, 1999, the Licensee notified the Agency of a dose irregularity involving the injection of the wrong dose of a radiopharmaceutical to a patient scheduled for a [REDACTED] on April 22, 1999. The patient was injected with a [REDACTED] that had been ordered for another patient, instead of the prescribed dose of [REDACTED]. The technologist who administered the dose did not follow authorized hospital procedures listed in the Licensee's application. The Licensee was cited for failure to follow prescribed hospital procedures and applicable License Conditions. The Licensee conducted in-service training for all technologists emphasizing requirements for verification of all information on the pharmaceutical label before injection of radiopharmaceuticals. 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.

File Closed.

I-7469 - Dose Irregularity - Lake Area Central Pharmacy - Orange, Texas

On May 25, 1999, the Licensee notified the Agency of a dose irregularity involving the injection of the wrong dose of a radiopharmaceutical to a patient scheduled for a [REDACTED] on April 29, 1999. The patient was injected with [REDACTED] instead of the prescribed [REDACTED]. The patient and physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. Another dose of [REDACTED] was ordered for the patient and injected a few hours later. The initial dose had been drawn from the wrong vial by the dispensing pharmacist. Procedural changes at the nuclear pharmacy now require checking the vial used to draw a dose both before and after a dose is drawn. 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-7470 - Dose Irregularity - Columbia Regional Oncology Center - El Paso, Texas

On May 24, 1999, the Licensee notified the Agency that a patient received an incorrect dose from an [REDACTED] containing [REDACTED] when the patient removed [REDACTED] of the [REDACTED] prior to the scheduled removal. The [REDACTED] and [REDACTED]. During a check of the patient at [REDACTED]. When hospital personnel went to the patients' room for the [REDACTED]. The intended dose for the patient was [REDACTED]. It was estimated that the patient received [REDACTED]. The resulting dose was [REDACTED].

File Closed.

I-7471 - Misadministration - M.D. Anderson Cancer Treatment Center - Houston, Texas

On March 10, 1999, the Licensee notified the Agency of a misadministration that occurred when a patient [REDACTED]. Reports indicated that the patient was loaded with a [REDACTED] for a planned [REDACTED]. On the evening after the implant, a nurse noticed the [REDACTED]. The implant was taken by hospital staff and placed in storage. The estimated treatment time for the patient was only [REDACTED]. The [REDACTED]. The treatment dose differed from the prescribed dose by more than [REDACTED]. All notifications were properly made by the hospital.

File Closed.

I-7472 - Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On June 2, 1999, the Licensee notified the Agency of an 11.382 rem exposure to a radiographer for the January 1999 through April 1999 monitoring period. The exposure for April 1999 was 10.082 rem. On April 27, 1999, the radiographer worked in circumstances where he was unable to maintain an adequate distance from the source during radiographic exposures. The radiographer reset his pocket dosimeter several times when it approached its upper limit. The radiographer received more exposure than was recorded by totaling the pocket dosimeter readings. The Licensee was cited for allowing the exposure and was recommended for escalated enforcement.

File Closed.

I-7473 - Missing Moisture Density Gauge - Rone Engineering - Dallas, Texas

On June 22, 1999, the Agency was notified of a missing moisture-density gauge containing an eight millicurie cesium-137 source and a 40 millicurie americium-241 beryllium source. The utilization log indicated the gauge was checked in to the company storage facility on Friday, June 18, 1999. When a technician went to check the gauge out on June 22, 1999, the gauge was missing from its authorized storage area. The sign-out log did not list the gauge as checked out by any employee. The missing gauge was reported to the local police department and to the manufacturer.

File Inactive.

I-7474 - Missing Radioactive Material - 3M - Austin, Texas

On May 27, 1999, the Licensee notified the Agency of the loss of a generally licensed device containing approximately 7.5 curies of tritium. The tritium exit sign was one of thirteen shipped to the 3M, Austin facility by the manufacturer. A contractor received the shipment on March 19, 1999, for installation during expansion of the Licensee's facility. On May 13, 1999, the contractor and the facility Radiation Safety Officer determined that one of the signs was missing. Cross checks of the shippers records confirmed the shipment of a thirteenth sign but searches of the facility were unable to locate the sign. The remaining twelve signs have been identified by location and serial number and entered into the corporate database and radioactive material inventory system.

File Inactive.

COMPLAINT SUMMARY FOR SECOND QUARTER 1999

C-1382 - Uncredentialed Technologist - Najah M. Al-Shalchi, MD, PA - San Antonio, Texas

On April 16, 1999, the Agency received a complaint alleging that the Registrant allowed an uncredentialed technologist to perform radiographs at the facility. The Agency conducted an investigation and confirmed the allegation. The Registrant was cited for the violation.

File Closed.

C-1383 - Fire near UMTRA Site - Falls City, Texas

On April 15, 1999, the Agency was notified of a fire on state property near a federal uranium mill tailings remediation site. The grass had caught fire during mowing operations on April 15, 1999. Landowners with property adjacent to the site called the local fire department during the evening when the fire burned out of control. The fire department responded and extinguished the fire. A visual assessment by Agency investigators determined grass was burned on about 150-200 acres of the state's 600 acre tract. About 5000 square feet of grass was burned on federal land. The grass was not burned beyond the state and federal fence lines. The site containing radioactive material was not involved in the fire, therefore no radiological hazard resulted.

File Closed.

C-1384 - Uncredentialed Technologist - Center For Pain Management - McAllen, Texas

On April 23, 1999, the Agency received an anonymous complaint alleging that an uncredentialed technologist was performing radiographs and fluoroscopy procedures and that the facility had not corrected a violation cited during a previous inspection. An Agency inspector determined that the employee had been a non-certified technician performing radiographs for the physician under the physician's license. The certificate had expired December 31, 1999, with the Texas Department of Health's Medical Radiological Technologist Program but was eligible for immediate renewal. The technician was given an application for renewal. The allegation concerning an uncorrected violation from a previous inspection was unsubstantiated. The facility was cited for allowing an uncredentialed technologist to perform radiographs.

File Closed.

C-1385 - Uncredentialed Technologist / Unregistered Facility - All American Smiles Center - Carrollton, Texas

On April 30, 1999, the Agency received an anonymous complaint alleging that uncredentialed technologists were performing dental radiographs at an unregistered facility. The complainant also alleged the x-ray equipment had not been calibrated and the staff was performing radiographs without using lead aprons for either the patients or the technologists. An Agency investigation determined the facility was registered under the dentists' names. The technologists were registered with the Board of Dental Examiners, with two additional technologists in the process of taking their Board examinations. The equipment was installed on January 8, 1999, and does not require an equipment performance evaluation until January 8, 2002. Aprons were available, serviceable, and were being used while the inspector was present. No violations of Agency regulations were noted.

File Closed.

C-1386 - Exposure to Public - Bonded Inspection, Inc. - Garland, Texas

On April 30, 1999, the Agency received a complaint alleging that individuals may have been exposed to radiation during industrial radiography performed in an office building on Sunday, April 25, 1999. The Licensee was radiographing the floors of the building on a weekend. Holes were to be drilled through the floors for cabling and the radiographs were to ensure there was no structural damage. The radiographers started on the top floor and worked their way down to the bottom floor. The procedure was to clear the floors above and below the floor being radiographed. In one instance an above floor was not cleared and an individual was working on the floor when the radiograph was performed. The individual was not exposed to any significant radiation and no rules or regulations were violated.

File Closed.

C-1387 - Unsupervised Use of Medical Lasers - Liponics Sculpting Center - Dallas, Texas

On May 3, 1999, the Agency received an anonymous complaint alleging that two lasers have been in use at a medical facility for 6 to 9 months, that the lasers are not under the supervision of a physician, and that the user of the lasers deceptively uses the initials M.D. after his name implying that he is a physician when in fact the initials in this case stand for Medical Director. The Drugs and Medical Devices Division of the Texas Department of Health and the Agency investigated the complaint and determined that the devices were not lasers but high intensity light sources. These units do not require registration by this Agency. The facility was associated with a physician whose clinic provides referrals to this facility for treatment. The facility Medical Director does not portray himself as a medical doctor, but did note the possible confusion in the use of the initials M.D. The operation of the equipment was stopped until some state requirements are met. No violations were noted that were under the jurisdiction of this Agency.

File Closed.

C-1388 - Regulation Violation - Cosmetic Laser Center - San Antonio, Texas

On April 27, 1999 the Agency received an anonymous complaint referred from the Drugs and Medical Devices Division of the Texas Department of Health. The complainant alleged a laser was being used to remove tattoos, age spots, birthmarks, etcetera, and was not medically supervised. A review of Agency records revealed the laser had been registered with the Agency; however, the registration had been revoked on March 30, 1999, for failure to pay fees. Two use locations were identified in Agency records. Agency investigations at both locations determined other businesses had been operating from the locations for several years. Lasers were not located at either address.

File Closed.

C-1389 - Falsification of Records - Pitt-Des Moines, Incorporated - The Woodlands, Texas

On April 28, 1999, the Agency received a complaint forwarded from the United States Nuclear Regulatory Commission alleging that a facility's Radiation Safety Officer was falsifying quarterly audits of three radiographers employed by the company, by having the radiographers sign blank audit forms that were filled in later. An Agency investigation and a routine inspection were performed. The Licensee was discovered to use a two-part audit record. The first part of the record was a verbal audit of the radiographers knowledge and work practices. The second part of the audit consisted of observations of the radiographer while performing radiographic operations. Of the three radiographers who were named in the complaint: one had been terminated under unpleasant circumstances; one was out of state, performing company radiographic operations, and could not be contacted; and the third radiographer had been transferred to non-radiographic work. The latter confirmed the use of audit forms as explained by the radiation safety office. The facility was, however, cited for failure to conduct audits of all radiographic personnel at intervals not to exceed three months for the period prior to April 1999.

File Closed.

C-1390 - Unregistered Bone Densitometer - Irma Aguirre, M.D. - Buffalo, Texas

On May 7, 1999, the Agency received a complaint alleging an unregistered portable densitometry unit had been in use for six months. The complainant indicated the unit was used in a hallway, and questioned the safety of the location. An Agency investigation determined the unit was in use and was not registered. Documents were reviewed indicating an application for registration had been mailed to the Agency a few days prior to the investigation. The facility was cited for operating without a registration for over 30 days from commencement of operation of a radiation machine. An application for registration was received from the facility and a registration was issued on July 12, 1999.

File Closed.

C-1391 - Uncredentialed Technologist - Center For Pain Management/Mission Hospital - McAllen/Mission, Texas

On May 20, 1999, the Agency received a complaint in follow up to complaint 1384. The complainant supplied additional information to substantiate the previous allegation as well as other regulation violations. The allegation prompted further investigation and inspections. Agency inspections were conducted at both facilities in conjunction with the complaint investigation. Investigations determined that the non-certified technologist (NCT) cited in Complaint 1384 had still not registered with the Agency and determined that the individual had been operating the fluoroscopy equipment at both the Center For Pain Management and at Mission Hospital. Both facilities maintained that this practice had been discontinued when the Agency notified the facility that the technician was an NCT and therefore not authorized to operate fluoroscopy equipment. Violations were cited at both facilities based on results of the inspections. The results of the inspections were referred to the Texas State Board of Medical Examiners and the Texas State Board of Pharmacy for possible actions.

File Closed.

C-1392 - Regulation Violations - METCO - Houston, TX

On May 11, 1999, the Agency received a complaint alleging that radiography operations were performed at a job site without following all of the required regulations. Specifically, the complainant alleged that radiographers did not wear personnel monitoring badges and alarming rate meters, and they failed to perform the required radiation surveys. An Agency inspector performed an unannounced inspection at the job site and observed that the radiographers performed all required radiation surveys. After observing the radiographers for a period of time, a field site inspection was completed. The radiographers were wearing personnel monitoring badges, pocket dosimeters, and alarming rate meters. The inspection determined a current copy of the regulations was not available on site and that quarterly audits prior to April 1999 were incomplete or not performed. The Licensee was cited for the violations.

File Closed.

C-1393 - Regulation Violations - Cameca Instruments - Trumbell, Connecticut

On April 26, 1999, the Agency received a complaint alleging that service personnel were allowed to perform service on radiation producing equipment without required training in radiation safety. An investigation, performed by a Connecticut State inspector on behalf of the Agency, determined the facility did not have a record of service personnel radiation training. Further, a review of records by the Agency determined the facility did not provide required notifications of assembly and or installations of radiation producing equipment in the State of Texas. The Registrant was cited for the violations.

File Closed.

C-1394 - Regulation Violations - McCarty Diagnostic and Chiropractic - Richardson, Texas

On May 10, 1999, the Agency received an anonymous complaint alleging that a Registrant's x-ray equipment was not properly maintained and that facility walls did not provide appropriate shielding from radiation exposure to the public. An Agency inspection determined the Registrant failed to conduct equipment performance evaluations at the required interval and failed to perform surveys of radiation levels in unrestricted areas to demonstrate compliance with the dose limits for members of the public. An Agency survey determined radiation levels in areas accessible to the public were at background. The Registrant was cited for the violations.

File Closed.

C-1395 - Regulation Violations - Chiropractic of San Angelo - San Angelo, Texas

On June 23, 1999, the Agency received a complaint alleging four concerns of regulatory violations at the facility. These were: 1) potential dose to the public above regulatory levels; 2) untrained and uncredentialed operators of the x-ray equipment; 3) a lack of posted radiation warning signs; and 4) the lack of or failure to use radiation protective aprons at the facility. An Agency inspection substantiated one of the four allegations. The facility failed to perform surveys of radiation levels in unrestricted areas to demonstrate compliance with dose limits for individual members of the public. The physician indicated she was the only person to energize the x-ray equipment, stating that other badged personnel at the facility only assisted the physician in positioning patients, and setting factors on the control panel, but never activated the unit. The room where the x-ray unit was located had controlled access and did not require the posting of a "caution radiation area" sign. The facility had a lead apron hanging on the wall in the x-ray room and had documentation to show performance of the required annual examinations of the apron.

File Closed.

C-1396 - Uncredentialed Technologist - Cogdell Memorial Hospital - Snyder, Texas

On June 23, 1999, the Agency received an anonymous complaint alleging that a non-certified technologist was performing “dangerous and hazardous” procedures by operating fluoroscopy equipment during barium swallow studies. An Agency investigation determined that the technologist had not operated the fluoroscopy equipment but had completed the procedure utilizing standard x-ray equipment. It was determined that the facility Radiation Safety Office was incapacitated and unable to perform the required duties. The Radiation Safety Officer was the only listed authorized user of radiopharmaceuticals listed on the facility’s License. Notices of Violations were issued under the facility’s License and Registration.

File Closed.

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INCIDENTS CLOSED SINCE FIRST QUARTER 1999

NO INCIDENTS WERE CLOSED SINCE THE FIRST QUARTER 1999

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COMPLAINTS CLOSED SINCE FIRST QUARTER 1999

NO COMPLAINTS WERE CLOSED SINCE THE FIRST QUARTER 1999

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE SECOND QUARTER 1999

NO HOSPITAL OVEREXPOSURES WERE REPORTED FOR SECOND QUARTER 1999

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APPENDIX B

SUMMARY OF RADIOGRAPHER OVEREXPOSURES
REPORTED DURING THE SECOND 1999

Pasadena, Texas

Technical Welding Laboratory 1

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APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 1999

Enforcement Conference: Ben Banks, D.D.S. - Dallas, Texas - Dental

On April 2, 1999, an enforcement conference was held with Dr. Ben Banks, D.D.S., holder of certificate of registration number R06526. The conference was held as a result of a facility inspection conducted on November 5, 1998, and the number and frequency of violations that indicated a significant and unacceptable deficiency in regard to the application and overall effectiveness of the radiation protection program. After reviewing the violations and responses, the Agency decided to increase the unannounced inspection frequency. Dr. Banks will also conduct radiation safety meetings on an annual basis that will include minutes of the meeting being recorded and made available for inspectors review, along with maintenance of a list of attendees, and topics discussed. Any items or required tests covered in Dr. Bank's Operating and Safety Procedures will be documented.

Enforcement Conference: Tidwell Medical & Industrial Clinic - Houston, Texas - Medical

On April 20, 1999, an enforcement conference was held with representatives of Tidwell Medical & Industrial Clinic, holder of registration number R19990. The conference was held as a result of a facility inspection conducted on April 6, 1998. This inspection determined the clinic was operating with an expired registration since September 30, 1997. Of particular concern to the Agency was the failure of the Registrant to respond to the Notice of Violation in a timely manner and operating with an expired registration. After reviewing the violations and responses the Agency increased the inspection frequency and issued a Cease and Desist Order until a new certificate of registration is issued to Tidwell Medical & Industrial Clinic. Tidwell Medical was asked to supply a letter to the Agency indicating that no x-rays would be taken until a new certificate of registration is issued. Administrative penalties will be assessed due to the extended expired registration. A new registration application, franchise tax form, and \$165.00 in fees will be submitted to the Agency for a new registration. On April 21, 1999 a letter from North Freeway Medical and Industrial Clinic was received by the Agency stating that no x-rays will be taken until the new certificate is issued.

Enforcement Conference: Colorado Fayette Medical Center - Weimer, Texas - Mammography

On April 21, 1999, an enforcement conference was held with a representative of Colorado Fayette Medical Center, holder of certificate of mammography number M00492. The Conference was conducted as a result of a complaint received by the Agency and an inspection conducted on February 9, 1999, which resulted in the facility receiving a Notice of Failure. Of particular concern to the Agency was that the Registrant previously was informed by the Agency that an individual was not qualified to operate mammography equipment and willfully allowed that individual to continue to operate the equipment. In addition, The Agency inspection determined that the Registrant allowed conditions to exist that resulted in a significant delay in the production of a written mammography examination report, contrary to regulations requiring a report to be completed as soon as reasonably possible. After reviewing the violations and responses it was decided that the Agency will increase the inspection frequency for Colorado-Fayette. Additionally, the R.S.O., Administration, and the Mammography Technician will meet monthly to discuss the current status of the Mammography Program, and minutes will be taken for each meeting. Also, an administrative penalty assessment was pending upon completion of additional personnel interviews to be conducted at Colorado-Fayette. Upon completion of interviews, it was decided by the Agency that Administrative Penalties would not be assessed.

Enforcement Conference: Ned Johnson, D.C. - Humble, Texas - Chiropractic

On May 4, 1999, an enforcement conference was held with Dr. Ned Johnson, D.C., holder of registration number R08737. The conference was held as a result of a facility inspection conducted on December 2, 1998. This inspection determined that a significant and unacceptable deficiency existed with regard to the application and overall effectiveness of their radiation protection program. Current and past compliance history indicated numerous repeat violations. The violations and the responses to the violations were reviewed and it was decided by the Agency that their unrestricted area will be badged and monitored for at least six months, the inspection frequency will be increased, and unannounced inspections will be conducted. Upon reinspection, if any repeat violations are found then administrative penalties will be considered. Within 20 days from May 4, 1999, Dr. Johnson will provide ESE readings for L-spine and C-spine procedures so that ESE limits can be calculated. Dr. Johnson will contact the Agency if he is unable to obtain the Rare Earth screen he is currently trying to obtain. Documentation will be submitted to the Agency to verify that a screw was replaced/tightened to bring the tube housing assembly support violation on the H.G. Fisher unit into compliance.

Enforcement Conference: Global X-Ray & Testing Corporation - Houston, Texas - Radiography

On May 18, 1999, an enforcement conference was held with representatives of Global X-Ray & Testing Corporation (Global X-Ray), holder of license number L03663. The conference was held as a result of an incident involving a radiography trainee that resulted in a whole body exposure of 10 rem and an extremity exposure to the index finger of the right hand that resulted in a radiation injury. This incident investigation determined that there was a significant and unacceptable deficiency in regards to the application and overall effectiveness of Global X-Ray's radiation safety program. After review of the violations and responses the Agency decided that both of Global X-Ray's Texas offices (Houston and Aransas Pass) will increase the radiographers audit frequency to a monthly basis, beginning June 1, 1999. Global X-Ray will provide audit documentation that will be reviewed by the inspector at the time of the next inspection. The Agency will increase the inspection frequency for Global X-Ray. The Agency requested a copy of training topics and attendance lists indicating the names of the employees attending the training, and their dates of completion. A copy of the letter of reprimand issued to Pat Duke for violation of TRC31.54(b), when Mr. Duke assigned a trainee to work with a radiographer who was not a radiographer trainer, will be forwarded to the Agency. The letter of reprimand was issued to, and acknowledged by, Mr. Duke on May 11, 1999, and a copy of the letter was received by this Agency on May 19, 1999. The letter notified Mr. Duke of the violation incurred, and indicated that should any future violations of this, or any other TRCR regulation, or violation of any radiation safety regulation or policy occur, it would result in immediate termination of Mr. Duke's employment. The Agency will compile a Preliminary Report for Assessment of Administrative Penalties for Global X-Ray.

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