

REDACTED - 8/2003

**Third Quarter 1999 Summary of
Incidents, Complaints, and 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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SUMMARY OF INCIDENTS FOR THIRD QUARTER 1999

I-7475 - Spill of Radioactive Material - URI, Inc. - Kingsville, Texas

On June 1, 1999, the Licensee notified the Agency of a spill of approximately 9000 gallons of restoration water containing 2.7 parts per million of uranium. The spill was due to a disconnect in the flow line from the well to the disposal pond. All spilled water was contained on-site.

File Closed.

I-7476 - Badge Overexposure - Northwest Regional Hospital - Corpus Christi, Texas

On June 24, 1999, the Registrant notified the Agency of a 6.940 rem whole body exposure to an individual for the February 1999 monitoring period. The personnel monitoring company reported that the badge indicated a static filter pattern with exposure from the rear. The Registrant's investigation indicated that the badged individual had lost the badge during the period of February 15 - 28, 1999, yet did not report the incident to appropriate hospital staff. The missing badge was located in a trauma x-ray room, next to an x-ray table and in an upside down position. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7477 - Lost Alloy Analyzer - Conam Inspections, Inc. - Pasadena, Texas

On June 18, 1999, the Licensee notified the Agency of a lost alloy analyzer containing a 45 millicurie iron-55 source and a 4 millicurie cadmium-109 source. The generally licensed device was lost during transportation when the darkroom door on the transport vehicle came open during start and stop driving. When the door was discovered open, an inventory of the darkroom contents revealed that the device was missing. The loss was reported to local police. The device was recovered by the Licensee on July 23, 1999.

File Closed.

I-7478 - Dose Irregularity - Columbia/Saint David's Health Care / Syncor International Corporation - Round Rock, Texas

On June 21, 1999, the Licensee notified the Agency of a [REDACTED] irregularity involving [REDACTED]. The pharmacy investigation determined that a [REDACTED] order had been set up in a row of [REDACTED] orders and [REDACTED] was delivered instead of [REDACTED]. A [REDACTED] dose was [REDACTED] instead of the intended [REDACTED] dose. To prevent a recurrence, all staff at the nuclear pharmacy were instructed to check and double check setups before drawing doses. The patient and prescribing 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-7479 - Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On June 28, 1999, the Licensee notified the Agency of a 9.566 rem exposure to a radiographer during the May 1999 monitoring period. The radiographer indicated he had not worked on May 8, 1999, and had left his badge attached to his hard hat in the front seat of his truck. The Licensee indicated that on that day, the truck had been parked 10 feet from where 28 radiographs were taken. The Licensee indicated that the collimator may have been positioned in a direction that allowed radiation to beam toward the truck. During an Agency investigation a reenactment with an equivalent source was conducted. The reenactment verified that the cab of the vehicle, where the hard hat and badge was located, was approximately 10 feet forward of the collimator. The collimator did not allow the radiation beam to enter the cab. Maximum radiation levels at the cab could not account for the exposure to the badge. The employee was removed from working with ionizing radiation sources for the remainder of the year. The Licensee was cited for allowing an individual to receive an occupational radiation exposure greater than 5 rem.

File Closed.

I-7480 - Dose Irregularity - Columbia Hospital At Medical City Dallas, d.b.a. Medical City Dallas Hospital - Dallas, Texas

On June 21, 1999 the Licensee notified the Agency of a dose irregularity involving [REDACTED]. One patient was scheduled for a [REDACTED] with [REDACTED] and a second patient was scheduled for a [REDACTED] with [REDACTED]. A different technologist was scheduled to inject each patient. One technologists laid the syringes down. Another technologist picked up the wrong syringe and injected a patient with the wrong radiopharmaceutical. The second technologist noticed the mistake before injecting the second patient. The first patient and his prescribing physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The [REDACTED] procedure was rescheduled. To prevent a recurrence, the technologist was counseled to verify future doses prior to injection.

File Closed.

I-7481 - Badge Overexposure - General Inspection Services, Incorporated - Hempstead, Texas

On June 1, 1999, the Licensee notified the Agency of a 6.965 rem exposure to a radiographer during the April 1999 monitoring period. A Licensee and Agency investigation determined the radiographer had dropped his badge while performing radiographs but did not report it at the time because he thought he noticed it before it was exposed. The radiographer worked with two other radiographers whose badge exposures corresponded with his pocket dosimeter exposure. A deletion was granted and a 790 millirem assessment, based on pocket dosimetry and co-worker's exposures, was accepted.

File Closed.

I-7482 - Radioactive Material at a Landfill - Columbia / Saint David's Healthcare - Austin, Texas

On July 5, 1999, a landfill notified the Agency that trash from a local hospital had activated its radiation alarm. A patient undergoing a diagnostic procedure with [REDACTED] had become incontinent during the evening. The soiled diapers were placed in the regular trash by nursing staff unfamiliar with requirements for potentially contaminated radioactive waste. To prevent a recurrence, the hospital established warning procedures for posting of hospital rooms of in-patients treated with diagnostic radiopharmaceuticals. All waste will be stored on-site for decay before disposal. The Licensee was cited for failure to comply with license conditions for proper disposal of radioactive waste.

File Closed.

I-7483 - Dose Irregularity - Columbia Medical Center of Denton, d.b.a. Denton Regional Medical Center - Denton, Texas

On June 28, 1999, the Licensee notified the Agency of a dose irregularity involving [REDACTED]. A nuclear medicine technologist administered the radiopharmaceutical to the wrong patient. The patient and prescribing physician were notified of the event. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the technologist was counseled concerning the correct identification of a patient prior to injection of radiopharmaceuticals.

File Closed.

I-7484 - Lost Radioactive Material - Boeing-Corinth Company - Corinth, Texas

On July 8, 1999, the Licensee notified the Agency of a missing generally licensed static elimination device containing approximately 3 millicuries of polonium-210. The Licensee believes the device was misplaced during recent remodeling and renovation at the plant. The company found the device on July 26, 1999, and returned the device to the manufacturer for disposal.

File Closed.

I-7485 - Damaged Gauge - StanTech Engineering Company - Dallas, Texas

On June 21, 1999, the Licensee notified the Agency that a moisture density gauge was damaged on April 28, 1999. The gauge was run over by a grader while the operator was watching similar tests being performed by another engineering firm. The gauge, grader, and surrounding area were surveyed and no radiation readings above background were noted. The site was released for continued work by the Licensee's radiation safety officer. The gauge was transported to the Licensee's laboratory for storage until shipment to the manufacturer for repairs. The Licensee was cited for failure to secure the sources of radiation against unauthorized removal or access resulting in damage to the device.

File Closed.

I-7486 - Radioactive Material at a Landfill - BFI Landfill - Austin, Texas

On July 22, 1999, the Agency was alerted by local media of an incident occurring at a local landfill involving radioactive materials. A City of Austin garbage truck activated the radiation alarm at the landfill. The truck driver notified a City of Austin dispatcher. The dispatcher then notified the Austin Fire Department Hazard Materials (HazMat) Unit. The HazMat unit responded and evacuated the landfill offices without allowing the landfill to notify the Agency. The media reported the story and called the Agency to inquire about the incident. An Agency investigation determined the garbage truck contained an adult incontinent diaper contaminated with a diagnostic radiopharmaceutical. The radiation levels were low and the landfill was told to bury the materials.

File Closed.

I-7487 - Dose Irregularity - Columbia Regional Oncology - El Paso, Texas

On June 18, 1999, the Licensee notified the Agency of a dose irregularity that occurred on June 4, 1999 involving a [REDACTED]. A patient received a [REDACTED] instead of an intended [REDACTED]. The error resulted from staff unfamiliarity with abbreviated terminologies used for the studies. To prevent a recurrence staff was given instruction on terminology. The patient and prescribing physician were notified of the irregularity. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7488 - Equipment Damage - Rhinehart and Associates - Austin, Texas

On July 23, 1999, the Licensee notified the Agency of an incident that occurred on July 16, 1999. During the radiographing of small castings in a permanent radiography bay, a steel plate supporting a penetrometer fell onto and crimped the source guide tube. The radiographer attempted to return the source to the shielded position at the end of the radiograph, but the source wedged at the crimp. The source could not be moved in either direction. The radiation safety officer (RSO) was notified of the incident. The RSO responded, used bags of lead shot as shielding, hammered the crimp in the guide tube until the source could be cranked out into the collimator, then added further shielding to the collimator with lead shot. The crimp was then carefully hammered until the tube appeared round. The source was then retracted into the shielded position in the radiography camera. Each participant in the incident received less than 100 millirem exposure.

File Closed.

I-7489 - Dispensing Error - Mallinckrodt, Incorporated / The University of Texas, M.D. Anderson Cancer Center - Houston, Texas

On July 22, 1999, the Licensee notified the Agency of a dispensing error that occurred when two doses of prescribed iodine-131 oral solution were determined by the hospital to have a lower activity than that ordered. The doses were returned to the nuclear pharmacy. The dose calibrator confirmed that the doses assayed at 3 millicuries each, rather than the prescribed 5 millicuries. The error is thought to have occurred when the dose calibrator used to assay the iodine-131 doses was set for technetium-99m. Correct doses were prepared by the nuclear pharmacy and sent to the hospital. To prevent a recurrence, the pharmacy instructed staff to check settings on dose calibrators prior to dispensing doses.

File Closed.

I-7490 - Dose Irregularity - Providence Memorial Hospital - El Paso, Texas

On July 7, 1999, the Licensee notified the Agency of a dose irregularity that occurred July 6, 1999, when a patient scheduled for a [REDACTED] received [REDACTED] instead of the prescribed [REDACTED]. The error was discovered during imaging when the scan showed the [REDACTED]. The technologist checked the syringe used to inject the patient and realized he had picked up the wrong dose. The patient and prescribing 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 has instituted a new tracking procedure for radiopharmaceuticals utilizing the bar codes from their nuclear pharmacy in order to track the material from beginning to end within the hospital. Further, the hospital stressed to the technologist the importance of verifying , prior to injection, that a syringe contains the correct dose.

File Closed.

I-7491 - Equipment Malfunction/Regulation Violation - ANATEC International - Nederland, Texas

On July 27, 1999, the Licensee notified the Agency of a radiography device malfunction that occurred on June 28, 1999. The source failed to return to the fully shielded position and the operator failed to follow proper survey procedures. The operator was alerted by his alarming rate meter. The radiographer notified the radiation safety officer. It was determined that the source was been located an inch from its fully shielded position. The safety latch had locked the stop ball out. Examination of the locking mechanism found no apparent problems. The locking mechanism was not dirty or gritty. To prevent a recurrence, the Licensee disciplined the operator by removing him from the job site and by requiring time off for failure to follow required survey procedures. The Licensee was cited for failure to perform a radiation survey to determine that the source had returned to its fully shielded position before repositioning or dismantling the equipment.

File Closed.

I-7492 - Misadministration - Hermann Hospital - Houston, Texas

On August 4, 1999, the Licensee notified the Agency of a misadministration that resulted in a patient with a [REDACTED] receiving a [REDACTED]. Two middle-aged female patients, both with English as a second language, were at the Nuclear Medicine Department for tests or treatment. [REDACTED] was scheduled for a [REDACTED] and [REDACTED] was scheduled for [REDACTED]. The technologist who was intending to treat [REDACTED] with the [REDACTED], approached [REDACTED] and asked if she was "[REDACTED]" and if her birth date was "[REDACTED]" referring to [REDACTED] medical chart. Not understanding the questions, [REDACTED] replied "yes" to both questions and indicated she understood the instructions previously given to her about her treatment. [REDACTED] was given the [REDACTED] and left the nuclear medicine area. Shortly thereafter, [REDACTED] returned to the nuclear medicine area and was noticed by the nuclear medicine Manager. He told the technologist to tell [REDACTED] that she could go home. The technologist then realized he had given the therapy dose to the wrong patient. A [REDACTED] was ordered and given to [REDACTED]. The nuclear medicine Manager then contacted [REDACTED] and the attending physician and remedial action was taken. [REDACTED] to the [REDACTED]. The Licensee has changed procedures for all outpatient therapeutic treatments. The format of patient information questions are now "What is your name?" and "What is your date of birth?", instead of "Is your name ...?" or "Is your date of birth ...?" Outpatients will also be asked to show a picture form of identification. In the case of pediatric patients, the parent or guardian must confirm the identification. The Licensee was cited for violations pertaining to the incident.

File Closed.

I-7493 - Dose Irregularity - Raytel Nuclear Imaging / Syncor Pharmacy Services - Orange / Houston, Texas

On July 30, 1999, the Licensee notified the Agency of a dose irregularity that involved a [REDACTED]. After patient injection the scan did not produce the expected results. A nearby pharmacy performed a check on the residue in the syringe and identified the product as [REDACTED] instead of the prescribed [REDACTED]. The likely cause for the wrong dose being dispensed was the placement of the [REDACTED] syringe with syringes to be filled with [REDACTED] by an employee who performed the setups in the drawing stations earlier that morning. The pharmacist came on duty and did not check the set up prescriptions against product prior to dispensing as required by internal procedures. To prevent a recurrence the pharmacist was cautioned to follow procedures. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The patient and referring physician were notified of the error.

File Closed.

I-7494 - Dose Irregularity - Arlington Cancer Center - Arlington, Texas

On July 15, 1999, the Licensee notified the Agency of a dose irregularity that occurred on July 9, 1999, when a technologist injected two patients with [REDACTED] instead of the prescribed [REDACTED]. The [REDACTED] doses were stored in the same area as the [REDACTED] doses. The irregularity was caused by not verifying the correct radiopharmaceutical prior to injection. Both the patients and prescribing physicians were notified of the error. Both patients received whole body doses of less than 5 rem and organ doses less than 50 rad. Both patients were rescheduled for the [REDACTED]. The Licensee was cited for failure to follow established procedures for administration of radiopharmaceuticals. The technologist was counseled on requirements to double check the patient name, the radiopharmaceutical, and the prescription prior to injection. The Licensee also changed internal operating procedures to require separating, prior to injection, syringe storage locations for different nuclear medicine procedures.

File Closed.

I-7495 - NORM Found at a Steel Mill - Structural Metals, Inc. - Sequin, Texas

On June 17, 1999, the steel mill notified the Agency of NORM found in a load of scrap metal delivered to the mill. The steel mill determined the NORM was in contaminated oilfield pipe. The pipe was properly disposed of and the cost was charged to the supplier of the scrap.

File Closed.

I-7496 - Misadministration - Guadalupe Valley Hospital - Seguin, Texas

On August 9, 1999, the Licensee notified the Agency of a misadministration that occurred on August 6, 1999, when a technologist injected a patient with [REDACTED] instead of the intended dose of [REDACTED]. The error involved a patient scheduled for a [REDACTED] and two radiopharmaceuticals, [REDACTED] to be injected [REDACTED] and [REDACTED] to be administered by [REDACTED]. The error occurred when the technologist inadvertently placed the [REDACTED] into a [REDACTED] intended for [REDACTED]. Once in the shield, the label on the dose could not be checked prior to administration. The [REDACTED] dose was administered [REDACTED] and noticed immediately when the [REDACTED] did not occur. The patient and two prescribing physicians were notified of the error. The administered dose was greater than five times the intended dose. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence of a similar incident, the hospital is purchasing leaded glass syringe shields which will allow double checking the label on a shielded dose prior to administration.

File Closed.

I-7497 - Radioactive Waste at a Landfill - The University of Texas, M. D. Anderson Cancer Center - Houston, Texas

On August 5, 1999, the Licensee notified the Agency of an incident that occurred on July 7, 1999, when a waste compactor was returned to the Licensee because of radiation levels detected by landfill radiation monitors. The Licensee's radiation safety personnel surveyed the waste and measured surface radiation levels of 0.2 millirem per hour and 7,000 counts per minute. The Licensee determined the isotope was iodine-131. The compactor was isolated and stored on the Licensee's property until surface readings were near background. The load was then returned to the landfill for disposal. The Licensee was cited for failure to decay radioactive waste, in accordance with Agency approved procedures, prior to disposal.

File Closed.

I-7498 - Radioactive Waste at a Landfill - The University of Texas, M. D. Anderson Cancer Center - Houston, Texas

On August 5, 1999, the Licensee notified the Agency of an incident that occurred on July 16, 1999, when a waste compactor was returned to the Licensee due to radiation levels detected by landfill radiation monitors. The Licensee's radiation safety personnel surveyed the waste and measured surface radiation levels of 0.5 millirem per hour and 17,000 counts per minute. The Licensee determined the isotope was iodine-131 that had been placed in regular hospital waste. The compactor was returned, isolated, and stored on the Licensee's property until the radioactive waste decayed to a level authorized for disposal. The licensee was cited for failure to decay radioactive waste in accordance with Agency approved procedures.

File Closed.

I-7499 - Badge Overexposure - Memorial Hospital Southwest - Houston, Texas

On August 12, 1999, the Registrant notified the Agency of a 9.56 rem high energy exposure to an instructor during the June 1999 monitoring period. The instructor had no access to high energy x-rays and did not wear the film badge nor work with radiation during the monitoring period. The film showed no filter patterns indicating exposure outside the holder. A deletion was granted, and a minimal assessment, based on the circumstances of the exposure, was accepted.

File Closed.

I-7500 - Badge Overexposure - Cancer Therapy & Research Center at Santa Rosa - San Antonio, Texas

On August 13, 1999, the Registrant notified the Agency of a 6.1 rem exposure to a therapist during the second quarter 1999 monitoring period. The therapist was on vacation for a week during the monitoring period. During that time, housekeeping found the badge on the floor of the accelerator treatment room and replaced it on the therapist's desk. The therapist had not been in the treatment room during any treatments. His exposure history for the preceding year was minimal. A deletion was granted and a minimal assessment, based past average exposure history, was accepted.

File Closed.

I-7501 - Badge Overexposure - All-American Maintenance - San Antonio, Texas

On August 17, 1999, the Licensee notified the Agency of a 6.335 rem exposure to a radiographer on August 11, 1999. It was the first working day of the monitoring period and the radiographer was wearing a monitoring badge issued that same day. The radiographer was working in a shooting bay and making the first radiograph of the day. He dropped the badge in the shooting bay and noticed it at the completion of the first radiograph. He notified the radiation safety officer and the badge was sent for immediate processing. An Agency inspector investigated and concurred that the exposure was only to the badge. A deletion was granted and a minimal assessment, based on past average exposure history, was accepted.

File Closed.

I-7502 - Badge Overexposure - University of Texas Health Science Center San Antonio - San Antonio, Texas

On August 22, 1999, the Licensee notified the Agency of a greater than 1000 rem extremity exposure to an individual during the second quarter 1999 monitoring period. The individual worked with sulfur-35 and phosphorus-32 for only three days during the monitoring period. The individual's hand was checked by a dermatologist and no damage was noted. The individual's exposure history was minimal for all monitoring periods for the past three years. An Agency inspector investigated and concluded the exposure was likely the result of badge contamination. A deletion was granted and a minimal assessment was accepted.

File Closed.

I-7503 - Dose Irregularity - University of Texas, M.D. Anderson Cancer Center / University of Texas Medical Branch Galveston - Houston / Galveston, Texas

On August 17, 1999, the Licensee notified the Agency of a dose irregularity that occurred on August 3, 1999. A radiopharmacy delivered a [REDACTED] to a hospital instead of the ordered [REDACTED]. A discussion between the facilities determined that a dose calibrator correction factor had not been applied prior to sending the requested radiopharmaceutical to the hospital. The correct dose was [REDACTED] and was administered without further incident. No violations were cited.

File Closed.

I-7504 - Overexposure - Scott and White Memorial Hospital - Temple, Texas

On August 30, 1999, the Registrant notified the Agency of a 5.942 rem exposure to a technologist during the January to August 1999 monitoring period. The exposure was accumulated throughout the monitoring period. The technologist was removed from work with radiation for the remainder of the year. The Registrant was cited for violations. The Registrant is re-assessing the facilities ALARA procedures and making recommendations for rotation of the x-ray staff.

File Closed.

I-7505 - Dose Irregularity - Good Shepherd Medical Center - Longview, Texas

On August 26, 1999, the Licensee notified the Agency of a dose irregularity that occurred on August 19, 1999. The scheduling clerk ordered an [REDACTED] using [REDACTED]. The referring physician later said he had requested an [REDACTED] using [REDACTED]. The whole body dose was less than 5 rem and the dose to any organ did not exceed 50 rad. The correct exam was successfully completed after a two week delay to [REDACTED]. The Licensee was cited for regulation violations and violation of operating procedures.

File Closed.

I-7506 - Dose Irregularity - Valley Nuclear Incorporated - Mission, Texas / Valley Baptist Medical Center - Harlingen, Texas

On August 13, 1999, the Pharmacy notified the Agency of a dose irregularity that occurred when a [REDACTED] disassociated. [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 hospital was cited for failure to submit a written report to the Agency within 30 days.

File Closed.

I-7507 - Dose Irregularity - St. Luke's Episcopal Hospital / Mallinckrodt Medical Incorporated - Houston, Texas

On August 24, 1999, the hospital notified the Agency that they had received a 3 millicurie gallium-67 citrate dose instead of the requested 5 millicurie dose of gallium-67 citrate. A 5 millicurie replacement dose was delivered by the pharmacy and the original dose was returned. The nuclear pharmacy discussed this issue with all employees, determined the cause and developed internal procedures to prevent a recurrence.

File Closed.

I-7508 - Misadministration - Sisters of Charity of the Incarnate Word d.b.a. St. John Hospital - Nassau Bay Texas

On August 16, 1999, the Licensee notified the Agency of a misadministration of [REDACTED] on August 12, 1999, to a [REDACTED]. The patient was not properly identified prior to the administration of the radiopharmaceutical. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The patient and prescribing physician were notified of the error. The Licensee was cited for failure to follow established procedures. The Licensee counseled the technologist to properly identify all patients by two separate means of identification prior to administering a dose of radiopharmaceuticals.

File Closed.

I-7509 - Radioactive Material at a Landfill - The University of Texas, M.D. Anderson Cancer Center - Houston, Texas

On August 23, 1999, the Licensee notified the Agency that on July 24, 1999, a waste compactor from the Licensee activated the radiation alarm at a landfill. The compactor was returned to the Licensee where radiation safety personnel measured 60 millirem per hour at a localized surface location. The Licensees radiation safety personnel found two iridium-192 wires of approximately 7.7 millicuries activity each. The Licensee is in the process of installing a new system of area radiation monitors with alarms connected to the institutional Monitoring Services Department that will allow 24-hour monitoring and prevent future recurrence of similar incidents. The Licensee also counseled brachytherapy personnel of proper procedures for handling radioactive materials. The Licensee was cited for regulations and License conditions violations.

File Closed.

I-7510 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7511 - Stolen Gauge - TEAM Consultants - Dallas, Texas

On September 20, 1999, the Licensee notified the Agency of a stolen moisture density gauge containing a 6.0 millicurie cesium-137 source and a 39.1 millicurie americium-241 source. The gauge user was parked at the Licensee's facility with the gauge chained and locked in the back of a pickup truck. While inside the office, the securing bolt was broken loose from the truck and the bolt, chain and gauge was taken from the truck. The user reported the incident to the facility radiation safety officer who notified the Agency and filed a report with the Dallas Police Department and the Dallas Fire Department. The Licensee was cited for failure to secure the source of radiation against unauthorized removal or access. The Licensee instructed gauge users to never leave a gauge unattended while not in storage.

File Inactive.

I-7512 - Stolen Gauge - Rone Engineers - Dallas, Texas

On September 24, 1999, the Licensee notified the Agency of a stolen moisture density gauge containing a 7.8 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was chained to the bed of a pickup truck when the driver stopped at home for dinner before returning the gauge to storage. The chain was cut and the gauge stolen at the drivers home between 8:00 p.m. and 10:00 p.m. The Licensee notified the Dallas Police Department and area testing laboratories and pawn shops of the stolen gauge.

File Inactive.

I-7513 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7514 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On September 24, 1999, the Registrant notified the Agency of a 7.110 rem exposure to a radiation therapist during the June 1999 monitoring period. The Registrant believes the exposure was only to the badge. The therapist had not been in the treatment room when the accelerator was energized. The Registrant believes the badge was inadvertently left in the room during some patient treatments and later retrieved. An Agency inspector investigated and concurred with the Registrant's findings. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

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COMPLAINT SUMMARY FOR THIRD QUARTER 1999

C-1397 - Un-registered Facility - Thomas Penner, M.D. and Robert Norris, M.D., d.b.a. Southwest Austin Family Physicians - Austin, Texas

On June 25, 1999, the Agency received an allegation that unregistered x-ray equipment was being used by the facility and the operators were uncredentialed and did not use personnel monitoring. An Agency investigation confirmed the use of an unregistered x-ray machine and that the operators were not certified nor did they use personnel monitoring. The facility was cited for failure to register a radiation machine within 30 days of commencing operation.

File Closed.

C-1398 - Regulation Violations - Universal Open MRI and Diagnostic - Tomball, Texas

On June 24, 1999, the Agency received a complaint alleging that a Registrant was performing radiographs without a medical director and was using deficient x-ray machines. An Agency investigation found no deficiencies with the x-ray machines. A credentialed technologist was on site. There was no evidence of a physician's involvement with the facility. An Agency investigation determined the facility's radiation safety officer had resigned and had not been replaced and an x-ray machine was used without the supervision of a practitioner of the healing arts as required. The Registrant was cited for the violations.

File Closed.

C-1399 - Regulation Violations - Keller Animal Clinic - Keller, Texas

On July 7, 1999, the Agency received an anonymous allegation that the Registrant was using inappropriate equipment to perform x-rays, not providing personnel monitoring for animal holders, and not using lead aprons or gloves for shielding of personnel holding animals during x-ray procedures. An Agency investigation did not substantiate the allegations.

File Closed.

C-1400 - Laser Injury - Epi Center - Dallas, Texas

On June 7, 1999, the Texas State Board of Nurse Examiners forwarded a complaint to the Agency alleging a [REDACTED] and the use of an unregistered laser by a facility. According to the information received from the Nursing Board, a patient was treated by a nurse with a [REDACTED] at the facility on July 27, 1998 and again on August 28, 1998. The patient was dissatisfied with the treatments and alleged that [REDACTED]. Subsequently, the [REDACTED], the [REDACTED], and [REDACTED]. An investigation by the Nursing Board did not determine any wrongdoings. The Mediation Committee of the Dallas County Medical Society reviewed the case and determined that it appeared the medical care rendered was appropriate. The Agency investigated to determine the facility's compliance with Texas Regulations for the Control of Laser Radiation Hazards. The investigation did not find any health and safety related violations. The investigation determined the facility had performed laser procedures initially using the services of a properly registered mobile laser company. However, on October 10, 1997, the facility received and became an owner of a laser. The laser was put into use, but was not registered with the Agency as is required. The facility was cited for the violation. The facility became registered on November 12, 1999.

File Closed.

C-1401 - Regulation Violation - Brown Dental - Fort Worth, Texas

On July 9, 1999, the Agency received a complaint alleging the arm on an x-ray machine was broken and technologists must hold the machine in place while performing radiographs. An Agency investigation determined the tube housing was not adjusted to prevent drifting from its set position during exposures. The tube support housing was held, in violation of regulations. The operator failed to stand at least six feet from the useful beam or behind a protective barrier. The Registrant was cited for the violations.

File Closed.

C-1402 - Uncredentialed Technologist - Mediclinic, Inc. - Houston, Texas

On July 12, 1999, the Agency received a complaint alleging that the Registrant allowed uncredentialed technologists to perform radiographs at its subsites. An Agency investigation determined an uncredentialed technologist at each of the three subsites was allowed to operate an x-ray unit. The Registrant was cited for the violation.

File Closed.

C-1403 - Regulation Violation - Millennium Diagnostic - Duncanville / Dallas, Texas

On July 2, 1999, the Agency received an anonymous complaint alleging that the Registrant was using equipment at two subsites that was out of compliance with Agency regulations. Specific allegations included: excessive radiation output of a fluoroscopic unit; x-ray exposure from the fluoroscopic tower when in the parked position; excessive field size on fluoroscopic spot films and the machines image intensifier; no lead shielding on the facility entrance door; inoperable fluoroscopic timer; inoperable kVp meter; inoperable collimator and a warped film bucky. The Agency conducted inspections at both facilities. At one site no violations in reference to the allegations were noted. However, it was determined that the facility had failed to perform measurements of radiation levels in unrestricted areas to demonstrate compliance with regulatory dose limits and was cited for the violation. At the other site, ownership had changed two weeks prior to the inspection. All old equipment had been disposed of and new equipment had been installed. Since the allegations involved the old equipment the investigation was terminated at this site.

File Closed.

C-1404 - Discrimination Complaint - Tulsa Gamma Ray - Tulsa, Oklahoma

On July 20, 1999, the Agency was contacted by the radiation safety officer of Tulsa Gamma Ray with an allegation of discrimination by the Agency against out-of-state radiography firms based on requirements in Agency rules. Specific complaints were: 1) out-of-state firms required to have two fully certified radiographers vs. in-state companies being allowed to use a fully certified trainer and a radiography trainee; 2) perceived differences in training requirements; and 3) the requirement for a permanent in-state address and records location for licensed firms operating within Texas. First, Texas rules will allow the use of out-of-state trainer and trainee radiography teams if they meet requirements of the trainer being a certified industrial radiographer who has one year experience as a certified radiographer and is not currently under any order that would prohibit that individual from acting as a radiographer trainer. In addition, the trainee or assistant would be required to have completed a 40-hour radiation safety course that is accepted by the Agency, another agreement state, or the U.S. Nuclear Regulatory Commission (NRC). Second, Texas rules allow an individual who has worked in a state regulated by the NRC to provide the Agency documentation of two months of on-the-job training that will meet the Texas training requirements. Third, a permanent address within Texas is required to establish an inspection site for documents and records pertaining to radioactive materials used in industrial radiography operations.

File Closed.

C-1405 - Regulation Violations - Biomechanical and Neurological Rehabilitation, Inc., d.b.a. American Orthopedic and Neurological - Dallas and Fort Worth, Texas

On July 21, 1999, the Agency received a complaint alleging the Registrant was in violation of several regulatory requirements. It was alleged that: the Registrant was incorrectly registered as a chiropractic facility when, in fact, it should be registered as a medical facility; appropriate personnel monitoring devices for all personnel operating the facilities x-ray equipment was not provided; C-arm fluoroscopy equipment was incorrectly registered with an inappropriate use code; all authorized users of the facilities equipment were not listed on the facilities application; and the x-ray equipment had been improperly transferred between facilities without notification to the Agency. An Agency investigation of three facilities substantiated that the Registrant: was incorrectly registered as a chiropractic facility; failed to monitor the occupational exposure of all users of the facilities x-ray equipment; had one new piece of equipment incorrectly registered in the wrong use code; and had other regulatory violations involving equipment, operating and safety procedures, and darkrooms. The Registrant was cited for the violations.

File Closed.

C-1406 - Regulation Violations - Jennings Scrap Metal - Longview, Texas

On August 4, 1999, the U.S. Environmental Protection Agency and the Texas Natural Resource Conservation Commission forwarded a complaint to the Agency alleging that a scrapyards was storing radioactive oil well pipe. An Agency investigation determined the scrapyards had several containers of oil well pipe contaminated with naturally occurring radioactive materials. The company was told to segregate and isolate the pipe and label the containers holding the radioactive pipe.

File Closed.

C-1407 - Regulation Violations - Law Engineering - Houston, Texas

On August 1, 1999, the Agency received a complaint alleging that the Licensee had no radiation safety officer, that technicians do not properly log gauges in or out of the facility and that technicians take moisture-density gauges home overnight rather than returning them to the secure storage location. An Agency investigation determined that a new radiation safety officer had been appointed after the termination of the former radiation safety officer. An inspection of the utilization log indicated that all gauges were logged in and out in compliance with applicable rules. The radiation safety officer indicated that all gauges were returned to storage at the end of each work day. None of the allegations could be substantiated.

File Closed.

C-1408 - Regulation Violations - Cy-Fair Medical Clinic - Houston, Texas

On August 9, 1999, the Agency received a complaint alleging that: an uncredentialed technologist was allowed to perform radiographs; radiographic images were poor with repeats necessary to obtain a usable image; no personnel monitoring was worn; scatter radiation was not shielded; no gonadal shielding was used; and a pregnant technologist performed radiographs without proper protective garments. An Agency investigation indicated that only the physician performs radiographs. Personnel monitoring was utilized by the facility and monitoring records were current. The Registrant indicated that the appropriate protective shielding was used. No violations of Agency regulations were noted.

File Closed.

C-1409 - Regulation Violations - Providence Memorial Hospital - El Paso, Texas

On August 9, 1999, the Agency received a complaint alleging that the public was insufficiently protected from radiation in a hallway adjacent to an x-ray room. An Agency investigation determined protective shielding was in place to a height of five feet. An Agency radiation survey performed during operation of the x-ray unit detected only background levels of radiation in the hallway. Although the radiation levels were in compliance, the facility had not performed the measurements or calculations to demonstrate compliance as required. The Registrant was cited for the violation.

File Closed.

C-1410 - Regulation Violations - Cypress Fairbanks Medical Center - Houston, Texas

On August 17, 1999, the Agency received an anonymous complaint alleging that the Licensee was operating in violation of their license and of established radiation safety procedures. Specifically, the complainant alleged that the facility was: leaving open syringes used for the injection of nuclear medicine in patients rooms after use, in un-shielded containers; not using syringe shields causing unnecessary radiation exposure to occupationally exposed workers within the facility; allowing personnel to eat their lunches in the scanning room while the patients were being scanned; leaving hot labs and imaging rooms open so anyone, including members of the public, could enter; not registering new flood sources with the Agency; and not giving patients "privacy". An Agency investigation did not substantiate any of the allegations.

File Closed.

C-1411 - Unregistered Facility/uncredentialed Technologist - Family Medical Clinic d.b.a Southwest Dallas Family Medical Clinic - Dallas, Texas

On August 8, 1999, the Agency received an anonymous complaint alleging that the Registrant allowed an uncredentialed technologist to perform x-ray procedures and that the facility might be unregistered. An Agency investigation determined that the facility had once held a valid registration, but the facility had been sold and the registration had not been terminated or transferred to the new owners. The facility was cited for failure to notify the Agency of a change in its registration and the new owners were cited for failure to register the facility within 30 days of the commencement of operations.

File Closed.

C-1412 - Unregistered X-Ray Unit - Family Medical Clinic of Irving - Irving, Texas

On August 25, 1999, The Agency received an anonymous complaint alleging that a facility was operating an unregistered x-ray unit. An Agency investigation indicated that this registration had been terminated. It was determined that the facility had new owners and was fully operational. The new service provider and the facility owner were cited for failure to register the facility within 30 days of the commencement of operations.

File Closed.

C-1413 - Regulation Violation - Bayou City X-Ray & Clinic - Houston, Texas

On December 14, 1999, the Agency was notified of irregularities of an x-ray provider submitting claims to an insurance company. The address provided was not a registered x-ray facility. An Agency investigation determined the facility at the address was not currently operating an x-ray unit.

File Closed.

C-1414 - Regulation Violations - M&S Imaging Partners, Inc. - San Antonio, Texas

On August 24, 1999, the Agency received a complaint alleging that the Registrant had not retained films of a mammogram performed during 1994, as required. A patient had requested the films for comparison and was told the films had been purged. An Agency investigation determined this was an isolated incident in that the film was not retained. A spot check of other patients who had mammograms performed during that time found all the films available. The Registrant was cited for the violation and the complaint has been forwarded to the Food and Drug Administration for possible enforcement under their rules.

File Closed.

C-1415 - Regulation Violations - Radiology Associates of Tarrant County - Arlington, Texas

On July 26, 1999, the Agency received a complaint alleging that the Registrant failed to provide the results of a mammogram within 30 days. Results of the mammogram were finally received eight weeks from the date of the examination. The Agency investigated and cited the Registrant for an inadequate system to communicate examination results to patients and healthcare providers, failure of the lead physician to provide oversight and direction for all aspects of the quality assurance program, and for failing to maintain a record of each complaint received by the facility.

File Closed.

C-1416 - Regulation Violation - American X-Ray Services - Houston / Kemah, Texas

On August 26, 1999, the Agency received a complaint alleging that an unregistered company was performing service on x-ray equipment. An Agency investigation did not substantiate the allegation.

File Closed.

C-1417 - Regulation Violation - Christus Spohn Hospital - Beeville, Texas

On August 27, 1999, the Agency received a complaint alleging that the Registrant refused to provide original mammograms to a second registrant for a patient. An Agency investigation determined the facilities had not communicated effectively. After Agency contacts with the registrants, the requesting Registrant documented the request and the original Registrant provided the mammograms.

File Closed.

C-1418 - Unregistered Equipment - Class Act Tattoo - Corpus Christi, Texas

On September 9, 1999, the Bureau of Food and Drug Safety forwarded a complaint alleging that a company was performing tattoo removal with an unregistered laser. An Agency investigation determined there was no laser in use at the location. The tattoo removals were performed using chemicals.

File Closed.

C-1419 - Unregistered Equipment / Uncredentialed Technologist - James Key, M.D. - Brownsville, Texas

On September 9, 1999, the Agency received an anonymous complaint alleging that unregistered equipment was being operated by uncredentialed operators. An Agency investigation determined the equipment was not being used.

File Closed.

C-1420 - Uncredentialed Technologist - Hector Samaniego, Sr., M.D. - San Antonio, Texas

On September 15, 1999, the Agency received an anonymous complaint alleging that uncredentialed technologists were operating unregistered x-ray equipment. An Agency investigation determined that there were no violations of Agency regulations.

File Closed.

C-1421 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1422 - Regulation Violations - Various Registrants - Throughout Texas

On July 27, 1999, the Agency received a complaint alleging that various Registrants were conducting x-ray screening in violation of Agency regulations. Copies of newspaper advertising were included. An Agency investigation determined that Registrants were performing radiographs in an unauthorized manner. The Registrants changed their procedures to comply with Agency regulations after the Agency contacted them and explained what was necessary for compliance. The Registrants were cited for the violations.

File Closed.

C-1423 - Regulation Violation - Med-Partners Mullikin - San Antonio, Texas

On September 21, 1999, the Agency received an anonymous complaint alleging that the Registrant allowed medical assistants, not physicians, to order x-rays and performed unnecessary x-rays. An Agency investigation determined that physicians work one on one with medical assistants. The physicians provide on-site supervision, and routine verbal orders that are relayed by medical assistants to the technologists. Occasionally the physician makes a written order, especially if a deviation from the routine radiograph is to be performed. The allegations could not be substantiated.

File Closed.

C-1424 - Regulation Violations - Key-Whitman Surgery Center - Dallas, Texas

On September 22, 1999, the Agency received an anonymous complaint alleging that the Registrant performed and/or supervised laser procedures that were not within the scope of his practice. He allegedly performed hair removal from legs and bikini areas. An Agency investigation did not substantiate the allegation.

File Closed.

C-1425 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1426 - Regulation Violation - Millennium Diagnostic Imaging - Dallas, Texas

On September 24, 1999, the Agency received a complaint alleging that the Registrant was not making mammography films available to previous patients. The facility where the mammography films were made and stored is currently operated by a Registrant who does not provide mammography services. The new owners claim the films belong to the previous owner. An Agency investigation determined the former owner failed to provide the mammography films to the previous patients as is required. The former owner was cited for the violation.

File Closed.

C-1427 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

INCIDENTS CLOSED SINCE SECOND QUARTER 1999

I-7309 - Equipment Malfunction - Formosa Plastics Corporation, Texas - Point Comfort, Texas

A cesium-137 source that had become disconnected from a retrieval cable on May 20, 1998, was recovered and repaired on August 17, 1999, during a planned plant shutdown. The source had performed normally as a level indicator during the time it was disconnected. As a precaution, the repair firm replaced the connecting pins in all other gauges at the facility.

File Closed.

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COMPLAINTS CLOSED SINCE SECOND QUARTER 1999

NO INCIDENTS WERE CLOSED SINCE THE SECOND QUARTER 1999

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE THIRD QUARTER 1999

Temple, Texas

Scott and White Memorial Hospital 1

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING THE THIRD QUARTER 1999

Pasadena, Texas

Technical Welding Laboratory, Inc. 1

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APPENDIX C

ENFORCEMENT ACTIONS FOR THIRD QUARTER 1999

Enforcement Conference: Harris Methodist Hospital - Ft. Worth, Texas - Mammography

On July 29, 1999, an enforcement conference was held with representatives of Harris Methodist Hospital - Fort Worth holder of Certificate of Mammography Number M00690. The conference was held as a result of a facility inspection conducted on March 10, 1999. This inspection determined the registrant failed to cease performing mammography after they were notified by the American College of Radiology Accrediting Body on September 26, 1997, that the instrumentation unit, Model no. MGF-110, Serial No. 6397, was no longer accredited. After reviewing the violation and responses, the Agency required the Registrant to submit protocol for determining the technical quality of the mammograms for the period of September 26, 1997 through February 19, 1999 prior to the reevaluation of the mammograms. The individuals of any mammograms determined to be of unsatisfactory quality would be notified.

Enforcement Conference: Gulf Coast Inspection, - Ingleside, TX - Radiography

On August 10, 1999, an enforcement conference was held with representatives of Gulf Coast Inspection, Inc. holder of license number L04934. The conference was held as a result of an Agency inspection on May 6, 1999, that cited one severity level II violation, three severity level III violations, fifteen severity level IV violations and two severity level V violations. This was determined to be a significant, unacceptable deficiency with regard to the application and overall effectiveness of Gulf Coast Inspection's radiation safety program. After reviewing the violations and responses, the following was required: the Agency will increase the inspection frequency for Gulf Coast Inspection; Gulf Coast Inspection's license will be amended to specify a radiation safety officer for the Houston site; full site inspections will be conducted without the knowledge of the radiographers; all check lists will be reviewed, updated, and made available for the next Agency inspection; additional documentation will be provided to the Agency on personnel monitoring records and individual device processor records; and should future repeat violations occur administrative penalties may be assessed. The representatives for Gulf Coast Inspection, Inc. agreed that these requirements were acceptable and the conference was concluded.

Enforcement Conference, Texas NDT Company - Pasadena, TX - Radiography:

On September 23, 1999, an enforcement conference was held with representatives of Texas NDT Company, holder of license number L05089. The conference was held as a result of a Agency inspection conducted on April 13, 1999. This inspection revealed an unacceptable deficiency with regard to the application and overall effectiveness of the Texas NDT radiation safety program and radiographic operations. After reviewing the violations and responses, the following requirements were placed on the Licensee: the facility's inspection frequency will be increased and unannounced inspections will be conducted; monthly structured safety meetings will be conducted for the next 12 months; documentation will be kept on the items discussed, a list of attendees, the date and time of the meetings and who conducted the meetings; all employees will attend each monthly safety meeting.

A list of the five main companies serviced by Texas NDT will be provided to the Agency within 30 days of the date of this summary. The Agency will conduct inspections at these sites.

Administrative penalties have been suspended at this time contingent upon future inspections. However, if any repeat violations occur administrative penalties will again be considered.

Mr. Musick was informed that revocation of his trainer status could occur should future compliance and inspection or enforcement actions occur.

Mr. Musick was asked to provide to the Agency survey meter and pocket dosimeter readings and his cumulative exposure for the year, within 30 days from the date of this summary.

After the caucus, the representatives for Texas NDT returned and were informed of the items discussed. The representatives from Texas NDT agreed with the Agency's findings and the conference was concluded.