

**REDACTED - 8/2003**

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

**Prepared by**

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

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

**Telephone: 512/834-6688**

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.”

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



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## SUMMARY OF INCIDENTS FOR FORTH QUARTER 1999

### I-7515 - Dose Irregularity - Diabetes Center of the Southwest / West Texas Nuclear - Midland, Texas

On September 20, 1999, the Licensee notified the Agency of a dose irregularity involving [REDACTED]. The Licensee received and administered a mislabeled dose containing [REDACTED].

The error was determined to have occurred at the nuclear pharmacy which had inadvertently placed the prescription order in the wrong location where it was filled with a [REDACTED] dose and then mis-labeled. The patient and prescribing physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The prescribed procedure was rescheduled for a later date. The nuclear pharmacy took the following corrective actions: a staff briefing on the importance of checking each prescription for the correct drug and dosage and not assuming that all prescriptions in a location are for the same drug; and a new policy that all prescriptions for [REDACTED] will be circled on the prescription to highlight this specific product. The nuclear pharmacy was cited for mis-labeling the radiopharmaceutical and was referred to the Texas State Board of Pharmacy for possible action under their rules.

File Closed.

### I-7516 - Equipment Malfunction - Dow Chemical Company - Freeport, Texas

On September 9, 1999, the Licensee notified the Agency that the shutter on a gauge containing a 100 millicurie cesium-137 source was stuck in the open position on May 21, 1999. The gauge was located on a remote vessel and did not present an exposure hazard to employees. The gauge performed a function critical to manufacturing operations. The Licensee decided to allow the gauge to remain in operation until a planned plant shutdown in October 1999. On October 10, 1999, the shutter was repaired.

File Closed.

### I-7517 - Regulation Violations - Chevron Chemical Company - Orange, Texas

During a routine Agency inspection of the Licensee on August 16, 1999, an Agency inspector determined that a source was discovered leaking on July 23, 1997. The Licensee failed to immediately notify the Agency and failed to submit a written report within 5 days. The affected source and equipment were decontaminated and the source was replaced. The Licensee was cited for this and other violations noted during the inspection.

File Closed.

I-7518 - Radioactive Material in Scrap - Nucor Steel - Jewett, Texas

On September 29, 1999, the steel company notified the Agency that a railcar containing scrap metal had activated their radiation alarm. The company's contractor removed the scrap metal from the railcar and determined that accumulated soil and debris in the bottom of the railcar activated the alarm, not the scrap metal. A radiological survey and sampling of the soil and debris identified levels of naturally occurring radioactive material that were exempt from regulation. The car was released for routine use. To prevent a recurrence of alarm activation, the railcar owner took possession of the car to remove the accumulated debris prior to transporting more scrap metal.

File Closed.

I-7519 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7520 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7521 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7522 - Source Leaking - Spectro - Austin, Texas

On September 8, 1999, the Licensee notified the Agency that a 100 millicurie iron-55 source was determined to have 0.06 microcuries of removal contamination on August 12, 1999. The contamination was confined to the surface of the source. The source was removed and placed in storage pending disposal. The source was replaced and the instrument was returned to service.

File Closed.

I-7523 \* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7524 - Radioactive Material Lost - Temple High School - Temple, Texas

On October 6, 1999, the General Licensee notified the Agency that two exit signs containing tritium could not be located. A major construction project took place on the building during the summer of 1998. The signs were removed and misplaced during the construction. The General Licensee was cited for loss of control of radioactive material.

File Closed.

I-7525 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7526 - Source Disconnect - Metco - Houston, Texas

On October 11, 1999, the Licensee notified the Agency that a 51 curie, iridium-192, radiography source became disconnected from a drive cable on September 22, 1999. While performing radiography in an exposure bay, a radiographer realized the drive cable was not functioning and the source was in the unshielded position. The Licensee had authorization to recover the source and a supervisor and the radiation safety officer were contacted to perform the retrieval. All actions were performed from outside the exposure bay. After removing the cover from the crank housing and cutting the conduit, the break in the drive cable was determined to be one foot from the crank housing. The drive cable was manually pulled to return the source to the shielded position inside the radiography exposure device. Radiation exposures to individuals were less than 2 millirems. The Licensee believes the cable needed cleaning or was worn. To prevent a recurrence, a safety meeting was held and the importance of cleaning and checking cables prior to use was discussed.

File Closed.

I-7527 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7528 - Dose Irregularity - University of Texas M. D. Anderson - Houston, Texas

On October 7, 1999, the Licensee notified the Agency of a dose irregularity that occurred on September 10, 1999. A medical facility received [REDACTED] from a nuclear pharmacy instead of the prescribed [REDACTED]. The error was noticed when the dose was assayed. The dose was ordered by telephone. The pharmacy indicated the medical center stated the patient weighed 121 pounds instead of the actual [REDACTED] pounds. Since the dose is calculated based on patient weight, a lesser dose was shipped. The prescribing physician [REDACTED] prior to administration to the patient. To prevent a recurrence, future orders of special radiopharmaceuticals will be ordered in writing instead of by telephone.

File Closed.

I-7529 - Badge Overexposure - Cercon Division of Howmet - Hillsboro, Texas

On October 12, 1999, the Licensee notified the Agency of a 29.29 rem exposure to a radiographer during the August 25 to September 24, 1999 monitoring period. The radiation safety officer believed this to be a badge overexposure based on the statement of the wearer and the circumstances surrounding the exposure. An Agency investigation of the exposure concurred with the Radiation safety officer's assessment. A deletion was granted and a 10 millirem assessment, based on past exposure history, was accepted.

File Closed.

I-7530 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7531 - Radioactive Material Lost - Halliburton Energy Services, Inc. - Houston, Texas

On October 20, 1999, the Licensee notified the Agency that a 10 microcurie, americium-241 source was lost. It was removed from its designated test fixture and transferred to a different work center without the approval of the Radiation safety officer or completion of appropriate transfer paperwork. After use, the source was not returned to its storage location and later could not be located. An extensive search and survey of the work area, the facility, and the local landfill was conducted. At the conclusion of the search and surveys, interviews were conducted with all personnel that could have knowledge of source. The material was determined to be lost. The Licensee took immediate action to identify radiation safety program deficiencies and establish an interim program of supervisory control to prevent a recurrence of the loss. A radiation source utilization logbook for each work group was established. The facility Radiation safety officer assumed control of all source locker keys until the laboratory staff demonstrated the ability to maintain control and accountability of radioactive sources without direct supervision. The Licensee was cited for loss of control of radioactive material and for failure to maintain records of transfer of radioactive material.

File Inactive.

I-7532 - NORM at Scrapyard - Nucor Steel - Jewett, Texas

On October 11, 1999, the steel company notified the Agency that soil and debris in the bottom of a railcar had elevated radiation levels and activated radiation alarms. The railcar was used to transport scrap metal. A survey of the scrap metal removed from the car determined the scrap metal was not radioactive. The Agency coordinated an investigation with a consultant contracted by the railcar company. Samples of the accumulated soil and debris in the bottom of the railcar were collected and analyzed. The analysis determined the debris contained low levels of naturally occurring radioactive material (NORM) that were exempt from regulation. The railcar company was advised that the accumulated soil and debris should be removed from the railcar to prevent the activation of radiation alarms. On November 4, 1999, the Agency was notified by the steel mill that another railcar containing debris had activated their radiation alarms. An Agency investigation again concluded the railcar contained exempt NORM. The railcar company indicated that several railcars were out of service because of the accumulated granite ballast debris. To prevent a recurrence, the railcar company sent the railcars to a contractor for removal of the debris.

File Closed.

I-7533 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7534 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7535 - Dose Irregularity - M.D. Anderson Cancer Center / University of Texas Medical Branch Galveston - Houston / Galveston, Texas

On October 15, 1999, the Licensee notified the Agency of a dose irregularity that involved a dose of holmium-166. The prescribed dose was for 4.25 curies but the delivered dose assayed at only 3.1 curies. The dose was not injected due to insufficient activity.

File Closed.

I-7536 - Dose Irregularity - University of Texas Southwestern Medical Center - Dallas, Texas

On October 27, 1999, the Licensee notified the Agency of a dose irregularity that occurred on October 8, 1999. A [REDACTED] was administered to the wrong patient. Upon inquiry at a nurse's station, a nurse directed the technologist to an intensive care cubicle. The technologist entered the wrong cubicle, called out the patient's name but received no response. The technologist administered the dose, but did not check the patient's identification bracelet. A nurse called out that the technologist was injecting the wrong patient. To prevent a recurrence, the technologist was counseled to verify two forms of patient identification prior to administering radiopharmaceuticals. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7537 - Misadministration - Munson Cancer Center - Denison, Texas

On October 19, 1999, the Registrant notified the Agency of a misadministration that occurred during [REDACTED]. The prescribed treatment dose was [REDACTED]; [REDACTED]. During treatment verification it was determined that dose distribution would be improved if variable wedges in the machine head were used. The first treatment parameters were manually entered into the computerized system, but not saved in the data file. Six subsequent treatments were given under previously saved parameters. This caused an overlap of treatment fields. The patient and referring physician were notified of the error. The treatments were discontinued. The Registrant implemented a treatment preparation routing form that will track the various stages of a patient's treatment planning and ensure a double check of treatment parameters by a second staff member.

File Closed.

I-7538 - Uranium Spill - URI, Incorporated - Kingsville, Texas

On January 24, 2000, the Licensee notified the Agency of a spill of "bleed water" that occurred on October 26, 1999, when a feed line became disconnected from a main trunk line. A well field operator discovered a flange connection between a feed line and a main trunk line had separated resulting in a 2000 gallon spill. The area was on higher ground causing the water to flow down and collect in a low area inside the fenced property. The spill covered an area of approximately 4800 square feet and was contained onsite.

File Closed.

I-7539 - Stolen Gauge - Price Construction, Incorporated - Laredo, Texas

On November 12, 1999, the Licensee notified the Agency that a moisture density gauge was stolen on November 11, 1999. The gauge had been secured in the back of a company pickup truck at a construction site near Laredo, Texas. The driver/operator drove to the work site and stopped his truck approximately 500 feet from the paving operation. He left the truck unattended and proceeded to the job site to get station locations for density tests. When he returned to his truck he immediately noticed that the gauge was missing and that the security chain had been cut. A police report was filed with the Laredo Police Department. The gauge was recovered along FM 1472 by an unidentified truck driver who turned it over to a local laboratory. The laboratory contacted the Licensee and returned the gauge on November 19, 1999. The gauge appeared undamaged but was leak tested to ensure integrity of the sources. No leakage was detected and the gauge was returned to service.

File Closed.

I-7540 - Radioactive Material Found at Landfill - BFI Blue Ridge Landfill - Fresno, Texas

On September 28, 1999, the landfill notified the Agency of elevated radiation levels on a trash truck. An Agency investigation located material that appeared to be cat litter with radiation levels up to 10 millirem per hour on contact. The Agency concluded the absorbent material was probably used to clean up body waste from a nuclear medicine patient. The origin of the waste could not be determined. The material remained at the landfill for burial.

File Closed.

I-7541 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7542 - X-Ray Equipment Stolen - Rainbow Medical Imaging Center - San Antonio, Texas

On October 8, 1999, the Registrant notified the Agency that a bone densitometer was stolen in March of 1999. An imaging center was broken into and equipment was taken. The Registrant was unable to locate the equipment.

File Inactive.

I-7543 - Radioactive Materials Lost - Schenker International / TN Technologies - Round Rock, Texas

On November 18, 1999, the shipping company notified the Agency that a shipment containing an alloy analyzer was lost during transport between Miami, Florida, and Round Rock, Texas. No notification to TN Technologies was made by the owner or original shipper when the material was shipped May 18, 1998, as required by TN Technologies. The analyzer contained sources with approximately 45 millicuries of iron-55, 5 millicuries of cadmium-109, and 0.5 millicuries of americium-241. The shipper had no indication that the shipment was properly marked to indicate that the box contained radioactive materials. The shipment could not be located.

File Inactive.

I-7544 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7545 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7546 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7547 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7548 - Badge Overexposure - University of Texas Medical Branch - Galveston, Texas

On November 30, 1999, the Registrant notified the Agency of a 23.737 rem whole body exposure to a technologist during the February 1999 monitoring period. The Registrant determined the technologist inadvertently dropped the personnel monitoring badge in a room where fluoroscopic procedures were performed. In January 1999, the Registrant switched to newly designed badges. The participants were not used to wearing and exchanging the new badges. To prevent dislodging of the badges, the employees secure the badges more carefully. A deletion was granted and a 10 millirem assessment, based on past average exposures, was accepted.

File Closed.

I-7549 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7550 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7551 -\* Health and Safety Code-Chapter 241.051(d) .

File Closed.

I-7552 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7553 - Overexposure - METCO - Houston, Texas

On December 6, 1999, the Licensee notified the Agency of a 6.5 rem exposure to a radiographer on December 3, 1999. The radiographer was performing industrial radiography using a 35 curie iridium-197 source. After each exposure, the radiographer checked his pocket dosimeter. After the ninth or tenth exposure the radiographer noted his dosimeter was off scale. He notified his co-worker, who was in the darkroom developing film. The Licensee's radiation safety officer was notified and another radiographer was brought to the site to complete the job. The radiographer's badge was sent for emergency processing. The radiographer was removed from radiation duties for the remainder of the year. An Agency investigation of the incident indicated a possible cause of the incident was a crimp in the guide tube. The radiographer believed the source was fully retracted, but it was stopped at the crimp, thus remaining approximately two inches from the fully retracted position. The Agency inspector noted that the radiographer failed to conduct a required radiation survey after each radiographic exposure to ensure that the source was retracted to its fully shielded position. A contributing factor was the radiographer wearing his alarming rate meter in his pants pocket in a noisy environment, thus was unable to hear the alarm when activated. Both the Licensee and the radiographer were cited for violations.

File Closed.

I-7554 - Lost Radioactive Material - Presco Products - Sherman, Texas

On December 17, 1999, the General Licensee notified the Agency that a gauge containing a 150 millicurie americium-241 source was lost. The gauge had been out of service and in storage since 1986. The gauge was relocated to another storage location in 1989. During a reorganization of the department, the gauge was determined to be missing. Radiation surveys and visual searches failed to locate the source. A safe deposit cabinet was installed for storing all sources not in service.

File Inactive.

I-7555 - Stolen Radioactive Material - Reed Engineering Group - Dallas, Texas

On December 16, 1999, the Licensee notified the Agency of a stolen moisture density gauge that was taken from a truck between December 15 and 16, 1999. The gauge was taken home by the employee in violation of company policy. The gauge and miscellaneous tools were stolen from the truck. The gauge was stolen by cutting the chain that secured it to the truck bed. The Licensee was cited for failure to secure the gauge in accordance with established policy. A written policy requiring all gauges to be returned to secure storage on a daily basis was issued for all operators to prevent recurrence of this theft.

File Inactive.

I-7556 - Misadministration - University of Texas Medical Branch - Galveston, Texas

On December 20, 1999, the Licensee notified the Agency of a misadministration that occurred on December 16, 1999. An individual undergoing treatments under an [REDACTED] received an [REDACTED]. The [REDACTED], the administered dose was [REDACTED]. The error was discovered on December 20, 1999 when [REDACTED].

[REDACTED]. The patient and referring physician were notified. No harmful effects are expected. To prevent a recurrence, the prescribed dose will be [REDACTED].

File Closed.

I-7557 - Unlicensed Source - Andrew H. Card - Fort Worth, Texas

On December 23, 1999, the Agency was notified of an auction being conducted on the World Wide Web that claimed to be selling a "Watchmakers RADIUM Hand and Dial Refinishing Kit". The kit resembled several that were discovered in Texas in the past. The Agency contacted the online auction company and attempted to contact the seller to arrange inspection of the sales item. The owner contacted the Agency on December 24, 1999, and wanted assurance that this was a legitimate request from an authorized agency. The auction company identified the seller for the Agency on January 3, 2000. An Agency investigation detected radiation levels slightly higher than background. The material did not appear to be luminous. The inspectors concluded that the material was not radium and did not contain significant levels of radiation. The inspectors released the material for completion of the sales transaction.

File Closed.

## COMPLAINT SUMMARY FOR FORTH QUARTER 1999

### C-1428 - Regulation Violation - Mesa Verde Animal Clinic - Midland, Texas

On October 5, 1999, the Agency received a complaint alleging a Registrant did not require employees and technologists to wear personnel monitoring devices and the lead aprons used for protection were damaged. An Agency investigation determined monitoring devices were worn as well as protective gloves and aprons. The gloves and aprons were in good condition with no cracks in the lead.

File Closed.

### C-1429 - Regulation Violation - Cercon Division of Howmet - Hillsboro, Texas

On October 7, 1999, the Agency received an anonymous complaint alleging that the facility: was operating without a radiation safety officer; was utilizing out of state radiographers who were not credentialed in Texas; and had radiographers at the facility without proper credentials. An Agency investigation did not substantiate the allegations. A new radiation safety officer was supervising the facilities operations. Records and conversations with radiographers indicated that only Texas credentialed radiographers or trainees, under the direct supervision of a trainer, had operated the equipment at the facility.

File Closed.

### C-1430 - Regulation Violations - Allergy & Asthma Association - Webster, Texas

On October 12, 1999, the Agency received a complaint alleging the following: the Registrant used old, non-compliant x-ray equipment; a chest x-ray was taken that probably missed the area of interest; and a male x-ray technologist was unqualified. An Agency investigation determined the x-ray unit was manufactured in 1994 and met compliance standards. The only males who worked at the facility were attending physicians who do not perform radiographs. The female technologist who performed radiographs at the facility was credentialed and could not recall any retakes of radiographs in recent months.

File Closed.

C-1431 - X-Ray Overexposure - International Total Services - El Paso, Texas

On October 13, 1999, the Agency was notified of a complaint that had originated with the U.S. Occupational Safety and Health Administration. The complaint alleged that operators of baggage x-ray units were experiencing excessive hair loss and were not informed by their employer of their occupational radiation dose. An Agency investigation determined the machines were in compliance with regulations and employees were provided reports of occupational radiation exposure annually. No correlation between the reported "excessive hair loss" and the baggage x-ray machines was established. During the investigation it was determined that a new machine had been added to the inventory at the international gate of the airport. An registration application was left with the facility.

File Closed.

C-1432 - Suspected Radiation Exposure - Channing Marks Apartments - Austin, Texas

On October 13, 1999, the Agency received a complaint alleging a resident of a second floor apartment used a radiation device to expose a tenant in the apartment below. An Agency investigation determined there was no radiation device in the apartment. A survey of both apartments detected no radiation levels above background.

File Closed.

C-1433 - Radiation Exposure To The Public - Cowboy Corning - Mansfield, Texas

On October 14, 1999, the Texas Natural Resources Conservation Commission forwarded to the Agency a complaint received by the U.S. Environmental Protection Agency (EPA). The complaint alleged that a load of scrap metal from a company had been turned away from a smelter due to elevated radiation levels. In addition, the company was alleged to have other environmental hazards due to illegal disposal of batteries and dumping of waste oil. Agency inspectors were unavailable and the EPA completed the investigation. The onsite investigation detected no elevated radiation levels nor evidence of the other environmental hazards. Results were forwarded to this Agency for review.

File Closed.

C-1434 - Unregistered Facility - Franklin Clinic - Kerrville, Texas

On October 19, 1999, the Agency received an anonymous complaint alleging a facility operated an x-ray unit without a registration, an uncredentialed individual performed radiographs, the radiographic quality was indicative of possible processor problems, and some radiographic views did not correspond to the physician's orders. An Agency investigation determined the x-ray unit was not registered but had been in use for less than thirty days. The facility was provided an application for registration and advised of the requirement to submit the application within thirty days of commencement of use of the unit. A violation was cited for allowing an uncredentialed technologist to perform radiographs. After the facility is registered, the Agency will perform an inspection to determine compliance with regulations.

File Closed.

C-1435 - Regulation Violation - South Texas Radiology Imaging Center - San Antonio, Texas

On October 21, 1999, a Registrant contacted the Agency alleging excessive delays in receiving images of previous mammograms from a facility for comparisons. It was alleged that these delays were caused by offsite storage of films. An Agency inspector reviewed a written policy to send original mammograms to another medical facility or physician's office. The policy did not mention a specific time frame for the action to be accomplished. Agency regulations stipulate transfer of original mammograms but do not establish a mandatory time frame for the action. The Registrant stated they routinely act on requests for mammograms stored on-site within two days. Mammograms stored off-site may take an additional day. No intentional delay in the transfer of mammograms was determined. The process seemed to be operating smoothly due to recent personnel changes and a cooperative spirit between the two mammography facilities.

File Closed.

C-1436 - Regulation Violations - Orthopedic & Sports Medicine - Denison, Texas

On November 3, 1999, the Agency received a complaint alleging a Registrant: did not have a radiation safety officer; did not have adequate technique charts for the procedures commonly performed, which led to excessive retakes; and did not require personnel monitoring devices to be worn routinely. An Agency investigation determined there was a radiation safety officer at the location, adequate technique charts were available and personnel monitoring was available.

File Closed.

C-1437 - Regulation Violation - Symphony Mobilex - Dallas, Texas

On November 5, 1999, the Agency received a complaint alleging that a Registrant unnecessarily exposed a visitor, did not ask the visitor to leave the room during x-ray exposures, and did not offer the visitor a lead apron during the procedures. An Agency investigation determined that conflicting versions of the facts existed between the complainant and the technologist performing the procedures. The technologist did not wear an apron during the procedures, but stated that he was at the full extension of the machine's exposure cord, which would place him beyond 6 feet from the primary beam. However, a visitor was in the room when the exposures were made. Before the report of this inspection was completed, a similar complaint was received against the same company at another location with similar allegations. This complaint was investigated by the same Agency investigator who determined that once a visitor was not asked to exit the room before exposures were made. A violation was issued for failure to follow Agency rule and a company operating procedure.

File Closed.

C-1438 - Radioactive Contamination - Geoscience Engineering & Testing Inc. - Houston, Texas

On September 16, 1999, the Agency received a complaint alleging construction workers were contracted by a Licensee to perform work on a warehouse that was either contaminated or contained radioactive material. The workers, believing a radiological hazard existed, left the site before the job was completed. An Agency investigation detected no radiation levels above background at the facility.

File Closed.

C-1439 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1440 - Uncredentialed Technologists - McAllen Primary Care Associates - McAllen, Texas

On November 15, 1999, the Agency received an anonymous complaint alleging uncredentialed technologists were allowed to perform bone densitometry on patients. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1441 - Regulation Violation - Technical Welding Laboratories, Inc. - Pasadena, Texas

On September 3, 1999, the Agency received an anonymous complaint alleging that an unauthorized radiography team had been dispatched to perform industrial radiography. An

Agency investigation determined the team consisted of a radiographer and a radiographer trainee, not an authorized team, but no exposures had been made that day. However, documentation indicated that similar teams composed of a radiographer and a radiographer trainee had made exposures on August 21, and 27, 1999. The Licensee was cited for violation of regulations.

File Closed.

C-1442 - Regulation Violation - Weslaco Radiology - Weslaco, Texas

On November 29, 1999, the Agency received a complaint alleging a facility was not maintaining a quality control program during the performance of mammograms. An Agency investigation and inspection identified eight health or potentially health related violations that required immediate correction. The Registrant was cited for the violations.

File Closed.

C-1443 - Regulation Violation - Ignacio Chaves, M.D. / Crestview Family Medical Clinic - San Antonio, Texas

On December 1, 1999, the Agency received a complaint alleging that the facility operated an x-ray machine and a bone densitometer without a Certificate of Registration and that persons operating this x-ray equipment were not qualified under the hardship exemption letter issued to the facility by the Texas Department of Health's Medical Radiologic Technologist Certification Program. An Agency investigation determined that the facility was registered with the Agency. However, the registration did not authorize use of a bone densitometer. The operators were authorized to operate the equipment by a hardship exemption. The Registrant was cited for failure to notify the Agency within 30 days of the type of radiation machine services provided.

File Closed.

C-1444 - Regulation Violation - ProLog Great Southern Wireline Services - Houston, Texas

On December 1, 1999, the Agency received a complaint alleging a Louisiana licensee moved to Texas and began a well logging operation using sources containing americium-241 without Agency authorization. A review of Agency records did not locate a radioactive materials license authorizing operations in Texas. An Agency investigation determined that the Louisiana licensee transferred a five curie americium source to a Texas licensee not authorized to possess the source. A cease and desist order was issued to the Texas licensee. The Texas Licensee requested an amendment to their license and received authorization to possession the sources.

File Closed.

C-1445 - Regulation Violation - Heart Clinic, Incorporated - Harlingen, Texas

On November 10, 1999, the Agency received an anonymous complaint alleging that the Licensee was reusing the same IV bag on multiple patients after having contaminated the bag with radioactive material. It was also alleged the Licensee was drawing saline solution from the contaminated IV bag to flush nuclear medicine doses through the tubing. An Agency inspector surveyed the facility. No evidence was found to substantiate the allegations. The Agency inspector reviewed rules and procedures for proper uses of injectable radiopharmaceutical with the facility staff.

File Closed.

C-1446 - Regulation Violations - R& D Long, Inc. dba Sherry Lane Imaging Center - Dallas, Texas

On December 14, 1999, the Agency received an anonymous complaint alleging the facility was: operating without being registered; was using uncredentialed technologists; and did not have an associated doctor to authorize and supervise use of the radiation machines. An Agency investigation determined the facility had operated an x-ray unit for more than thirty days without a Certificate of Register. The operators of the unit were monitored for occupational radiation exposure, but were not credentialed as required. The facility was cited for the violations.

File Closed.

**INCIDENTS CLOSED SINCE THIRD QUARTER 1999**

I-6775 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

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**COMPLAINTS CLOSED SINCE THIRD QUARTER 1999**

NO COMPLAINTS WERE CLOSED SINCE THE THIRD QUARTER 1999

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**APPENDIX A**

**SUMMARY OF HOSPITAL OVEREXPOSURES**  
**REPORTED DURING THE FOURTH QUARTER 1999**

NO HOSPITAL OVEREXPOSURES WERE REPORTED DURING FOURTH QUARTER 1999

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**APPENDIX B**

SUMMARY OF RADIOGRAPHER OVEREXPOSURES  
REPORTED DURING THE FOURTH QUARTER 1999

Houston, Texas

METCO ..... 1

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## APPENDIX C

### ENFORCEMENT ACTIONS FOR FOURTH QUARTER 1999

#### Enforcement Conference: Providence Memorial Hospital - El Paso, Texas - Medical

On October 7, 1999, an Enforcement Conference was held with Providence Memorial Hospital, holder of Certificate of Registration #R00345. Providence Memorial Hospital representatives present were Messrs. Richard Cobos, B.S., R.T.(R)(T), MRT., Richard Levison, R.T.(R), MRT., Joseph M. Campbell, Associate Administrator, Ancillary Services, Mario Castillo, and Robert Waggener, L.M.P. Agency representatives present were Madames June Ayers, Helen Watkins, and Cathy McGuire and Messrs. Rich Muñoz, Thomas Cardwell, James Odgen, and Quincy Wickson (Chairman).

The Conference was held as a result of the number, type and severity of violations noted during an inspection of the radiology department conducted by an Agency representative on August 9, 1999. This demonstrated a need for improvements in Providence Memorial Hospital's radiation safety program.

The violations and the responses to the violations were reviewed by Ms. June Ayers. Of particular concern to the Agency were violations regarding the high exposure at skin entrance (ESE) rates.

After reviewing the violations and responses, representatives of Providence Memorial Hospital were asked to leave while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. An extension of a 30-day time period from the date of this memorandum to review and/or amend the technique charts for all of the x-ray facilities associated with Providence Memorial Hospital was granted by the Agency. However, if more time is needed to complete this task, the Agency will allow future extensions until this task is completed.
2. Because of the differences in the linearity measurements by the inspector and the two licensed medical physicists, it was decided that the machine parameters for the Toshiba x-ray unit, Model No. KX0650A, Serial No. B2513065, located in Room 4, would be retested by an Agency representative other than the initial inspector. If the retesting determined that the initial measurements were in error, this violation will be removed and a corrected Notice of Violations will be issued.
3. It was requested that a copy of the shift supervisor check list that familiarizes the x-ray equipment operators with the proper use of the technique charts be submitted to the Agency within 30 days of receipt of this memo.

4. The Agency will call and schedule future inspections to inspect other x-ray units, paying close attention to the ESE rates for these units.
5. Any administrative penalties will be withheld pending the results of future inspections.

After the caucus, the representatives for Providence Memorial Hospital returned and were informed of the items discussed during the caucus. The representatives agreed to these items and the Conference was concluded.

#### Enforcement Conference: South Texas Utility Contractors - Mercedes, Texas - Gauge

On October 29, 1999, an enforcement conference was held with South Texas Utility Contractors, holder of License #L05065. The South Texas Utility Contractors representative present was Mr. Albert Closner, President. Agency representatives present were Messrs. Rick Muñoz (Chairman), Robert Green, and William Stringfellow and Madames Barbara Taylor, Jo Turkette, and Cathy McGuire.

The conference was held as a result of an inspection conducted on September 15, 1999 in which the Agency determined that there was a significant unacceptable deficiency with regard to the application and overall effectiveness of South Texas Utility Contractors' radiation safety program.

The violations and the responses to the violations were reviewed by Mr. Bob Green. Of particular concern to the Agency was the unacceptable deficiencies with regard to the application and overall effectiveness of South Texas Utility Contractor's radiation safety program.

After reviewing the violations and responses, Mr. Closner was asked to leave while a caucus was held by the Agency representatives. During the caucus the following was determined: South Texas Utility Contractors will pay a \$1,000.00 fee to the Agency within 20 days of the date of this summary, to cover outstanding fees, plus a late fee penalty. A certified letter requesting termination of the license, documentation showing leak test results and a transfer/disposal document will also be submitted to the Agency within the 20 day period. If the fee and request for termination is not received within the 20 day period, administrative penalties will be recommended.

After the caucus, the representative for South Texas Utility Contractors returned and was informed of the items discussed. The representative from South Texas Utility Contractors agreed with the Agency's findings and the conference was concluded.

Enforcement Conference - Houston Medical Imaging - Houston, Texas - Mammography

On November 4, 1999, an Enforcement Conference was held with Houston Medical Imaging, holder of Certificate of Mammography #M00685. The Houston Medical Imaging representative present was Mr. Marcos Calderon, M.D. Agency representatives present were Messrs. Rick Muñoz (Chairman), Arthur Tate, Jerry Cogburn, and Thomas Cardwell, and Madames Jackie Carter, Kaye Goss-Terry, and Cathy McGuire.

The conference was held as a result of an inspection conducted on July 8, 1999 in which the Agency determined that there was a significant unacceptable deficiency with regard to the application and overall effectiveness of Houston Medical Imaging's radiation safety program.

The violations and the responses to the violations were reviewed by Mr. Jerry Cogburn. After reviewing the violations and responses, Dr. Calderon was asked to leave while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. Additional credentialing information for Dr. Huynh and Dr. Bass will be provided to the Agency by November 12, 1999. Dr. Calderon will also submit a letter to the Agency to assign a lead interpreting physician.
2. An application and medical physicist report for the General Electric biopsy unit will be provided to the Agency.
3. The inspection frequency will be increased and unannounced inspections will be conducted.
4. Administrative penalties have been suspended at this time contingent upon future inspections. However, if any repeat violations occur, administrative penalties may be considered.
5. Dr. Calderon was asked to consider reassigning a technical person as Radiation Safety Officer for Houston Medical Imaging.

After the caucus, the representative for Houston Medical Imaging returned and was informed of the items discussed. The representative from Houston Medical Imaging agreed with the Agency's findings and the conference was concluded.

All credentialing information, assignment of a lead interpreting physician, an application for the G.E. biopsy unit and medical physicist report for the G.E. unit, and a request for changing the Radiation safety officer, were all received in the Agency office by November 11, 1999.

Enforcement Conference - Laser Magic - Fort Worth, Texas - Laser

On November 1999, an Enforcement Conference was held with Laser Magic. The Laser Magic representative present was Mr. Richard Van Zandt. Agency representatives present were Madames Jackie Carter, Cathy McGuire, and Karan Raines, and Messrs. Rick Munoz, and Quincy Wickson (Chairman).

The Conference was held as a result of the failure of Laser Magic to obtain a certificate of laser registration and a federal variance to operate an open-beam type laser. This demonstrated a need for immediate action to prevent a public health hazard.

The violation and the response to the violation were reviewed by Ms. Karan Raines. Of particular concern to the Agency was the continued operation of a laser with an open-beam type configuration without approval in the form of a federal variance and without a certificate of laser radiation.

After reviewing the violation and responses, Mr. Van Zandt was asked to leave while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. An order of impoundment will be issued until all sources of laser radiation have been properly registered with the Agency and a federal variance is obtained.
2. Administrative penalties based on the operation of a source of laser radiation without a federal variance and certificate or laser registration may be issued at a later date. The amount of the penalty would be determined after a meeting with the Division Director of Compliance and Inspection.

After the caucus, Mr. Van Zandt returned and was informed of the items discussed during the caucus. He agreed to these items and the Conference was concluded.

Enforcement Conference - Little York Medical Center - Houston, Texas - Mammography

On November 3, 1999, an Enforcement Conference was held with Little York Medical Center, holder of Mammography Certification #M00556. The Little York Medical Center representative present was Dr. William Clark. Agency representatives present were Messrs. Rick Muñoz (Chairman), Thomas Cardwell, and Jerry Cogburn, and Madames Jackie Carter and Cathy McGuire.

The conference was held as a result of a facility inspection conducted on July 9, 1999. This inspection determined an unacceptable deficiency with regard to the application and overall effectiveness of Little York Medical Center's radiation safety program.

The violations and the responses to the violations were reviewed by Ms. Jackie Carter. Of particular concern to the Agency was the failure of the Registrant to conduct appropriate quality control requirements and the lead interpreting physician's failure to provide oversight and direction for all aspects of the quality assurance program.

After reviewing the violations and responses, the representative of Little York was asked to leave while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The inspection frequency will be increased and unannounced inspections will be conducted.
2. Little York Medical Center will not be performing mammography, and an application to perform mammography at Tidwell Medical Center will be submitted. Therefore, Little York Medical Center and Tidwell Medical Center will be cross referenced upon issuance of Certification of Mammography Systems to Tidwell Medical Center.
3. Due to Little York Medical Centers' personnel and equipment being the same as that at Tidwell Medical Center, the previous compliance history for Little York Medical Center will be used for review purposes, should future compliance issues arise. Thus, Little York Medical Center's previous non-compliance history could be used to determine possible assessment of future administrative penalties.
4. Little York will be required to conduct patient notification for those patients receiving mammograms from November 19, 1998 through February 6, 1999. The notification will include an explanation of the mammography system failure and the potential consequences to the patient due to this failure. Little York will be required to keep a record of all patients contacted.

After the caucus, the representative for Little York returned and was informed of the items discussed. Dr. Clark agreed with the recommendations, and the conference was concluded.

Enforcement Conference - Scott & White Memorial Hospital - Temple, Texas - Medical

On December 7, 1999, an Enforcement Conference was held with Scott and White Memorial Hospital. Scott and White Memorial Hospital representatives present were Philip D. Bourland, Ph.D., Radiation safety officer, and Wayne T. Stockburger, FACHE, FAHRA, Director, Department of Radiology. Agency representatives present were Madams June Ayers, Lisa Buedigan, and Cathy McGuire and Messrs. Rick Munoz, and Quincy Wickson (Chairman).

The Conference was held as a result of the an exposure in excess of the regulatory limit. This demonstrated a need for immediate action to prevent a public health hazard.

The violations issued and the responses to the violations were reviewed by Ms. June Ayers.

After reviewing the violations and responses, Mr. Bourland and Mr. Stockburger were asked to leave while a caucus was held by the Agency representatives. During the caucus, the following was determined: The next regularly scheduled inspection of the facility will be held approximately six months before the due date. During the course of the inspection the inspector will confer with the radiation safety officer and review the film badge reports to determine if the readings have elevated to such a degree that might result in future high exposure readings. In addition, the inspector will gather information for the Agency to determine the cause, if any, of any discrepancies noted in the monitoring device quality control.

After the caucus, Mr. Bourland and Mr. Stockburger returned and were informed of the items discussed during the caucus. They agreed to these items and the Conference was concluded.