

Redacted - 9/2003

**Fourth Quarter 2002 Summary of
Incidents, Complaints, and Enforcement Actions**

Prepared by

**Helen Watkins, James Ogden, Kim Bradshaw
Incident Investigation
Cathy McGuire - Escalated Enforcement**

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

Telephone: 512/834-6688

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

**Copies of this report are available on the internet at
<http://www.tdh.state.tx.us/radiation/>**

TABLE OF CONTENTS

Summary of Incidents for Fourth Quarter 2002

Summary of Complaints for Fourth Quarter 2002

Complaints Closed since Third Quarter 2002

Appendix A

 Summary of Hospital Overexposures
 Reported during Fourth Quarter 2002

Appendix B

 Summary of Radiography Overexposures
 Reported during Fourth Quarter 2002

Appendix C

 Enforcement Actions for Fourth Quarter 2002

SUMMARY OF INCIDENTS FOR FOURTH QUARTER 2002

I-7933 - Extremity Overexposure - PETNet Houston - Houston, Texas

On October 1, 2002, the Licensee notified the Agency of an extremity radiation exposure to a pharmacist during the August 26, 2002 to September 8, 2002, monitoring period. An Agency investigation determined that four causes contributed to the pharmacist's acute doses of 54,829 millirem to the right hand and 72,810 millirem to the left hand, which resulted in a year-to-date extremity exposure of 81,210 millirem to the right hand and 109,270 millirem to the left hand. It was determined that during the production of fluorine-18, the pharmacist touched and repaired fluorine-18 anion traps. The overexposure resulted in blisters on the left thumb and forefinger which required removal of overlying skin and drainage of fluid. Burns to the right hand were less severe and were not treated. The Licensee was cited for two violations of their operating and safety procedures and for allowing a radiation exposure greater than the annual limits. The Licensee performed a root cause investigation that determined there was inadequate clearance of liquid from the traps during a production cycle, operators failed to observe existing radiation safety procedures, there was inadequate direct supervision and review of work practices, and an inadequate system existed in the facility to report failures of components or processes. As corrective actions, the Licensee replaced a pressure transducer in the delivery line, increased the low pressure push time thereby discontinuing the high pressure delivery system, implemented and enforced the revised radiation protection policies and procedures, reinforced training and work practices, and standardized use of equipment and procedures.

File Closed.

I-7934 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7935 - Radioactive Material at Landfill - BFI Blueridge Landfill - Fresno, Texas

On September 24, 2002, the Landfill operator notified the Agency that a truck loaded with trash had set off the landfill radiation alarm. An Agency inspector responded on-site and the truck was taken into the landfill and the trash was dumped to determine its contents. A survey determined the radiation was coming from a wad of tissue paper found in a plastic trash bag. The truck route included a convalescent center that may have had an outpatient who had received a nuclear medicine procedure. After the investigation, the landfill was allowed to bury the material. No violations were cited.

File Closed.

I-7936 - Source Abandoned - Baker Atlas - Pearland, Texas

On October 22, 2002, the Licensee notified the Agency that a two curie cesium-137 source and an 0.8 microcurie source were abandoned downhole at a depth of 14,100 feet on October 8, 2002 in Terrell County, Texas. The first attempt at recovery was partially successful, as the neutron source was recovered. Repeated attempts to recover the lower section of the density instrument containing the two remaining sources were unsuccessful. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7937 - Radioactive Material Found - Commercial Metals Company / DCM Transport - Dallas, Texas / Galesburg, Illinois

On September 5, 2002, the Illinois Department of Nuclear Safety notified the Agency of truck shipments of radioactive material metal that was rejected by a smelter and returned to Texas. On September 12, 2002, the trucks arrived back at the shipper's location. An Agency inspector responded to the shipments, determining that a bundle of scrap in one truck had readings of 50 microrems per hour at five centimeters from the bundle. The second truck contained several bundles of scrap with readings of 350 microrems per hour at five centimeters from the bundles. The scrap consisted of shredded aluminum. When the bundles were opened, radium aircraft gauges were found in each bundle. A total of 32 - 35 pieces of radium contaminated scrap were removed from the bundles and placed in a secure, locked container. Radiation levels of 800 microRems per hour were detected at 5 cm from the container. The secure container is being held by the scrap dealer pending pick-up by an authorized broker of radium waste. The dealer will notify the Agency when the scrap has been picked up for disposal. The generator of the contaminated scrap could not be determined.

File Closed.

I-7938 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7939 - Laser Eye Injury - Texas A&M University - College Station, Texas

On September 12, 2002, the Registrant notified the Agency of an eye injury that occurred during the use of an unregistered laser on September 10, 2002. While a Class IV, frequency doubled Nd:YAG laser being used in experimental research was readied for use,

the operator was struck in an unprotected eye by the reflected beam. The researcher received probable permanent injury to his left eye. The unregistered laser had been in use in the Mechanical Engineering Department since July 1999. The injury occurred as the researcher was aligning the mirrors prior to conducting an experiment. During the alignment process, the researcher did not wear available laser protective goggles in order to visualize the beam. The Registrant was cited for violations. Use of the laser has been voluntarily suspended by the University's Environmental Health and Safety Department pending: resolution of the Notice of Violation and extensive engineering controls/upgrades to the facility; development of written Operating and Safety Procedures; receipt of additional laser safety goggles; and supervision of the researchers during experiments.

File Closed.

I-7940 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7941 - Radioactive Material - Lost/Found - Oceaneering International, Inc. - Ingleside, Texas

On October 18, 2002, an Agency inspector was informed that a radiography exposure device had fallen from the back of an Oceaneering International, Inc. vehicle. The device contained a 76 curie, iridium-192 sealed source. The inspector determined the event occurred on August 23, 2002, when a radiography team was leaving a client's facility and an unsecured radiography device fell from the back of the truck. The radiographers drove a few blocks from the facility before realizing the device had fallen from the vehicle. When the radiographers discovered the device was missing, they retraced their route and discovered the device in the road at the gate of the facility from which they had recently departed. The device was taken to the local shop office. A leak test determined the source was not leaking. Both the radiographer trainer and the radiography trainee were reprimanded by the Licensee. The trainee's employment was terminated by the Licensee. The device was inspected for damage and displayed a slight dent on the housing. This defect would not hinder safe and proper operation of the device. The Licensee was cited for failure to properly block and brace the device during transport and for failure to report the incident to the Agency within 30 days. The radiographer trainer was cited for failure to block and brace the device, which resulted in loss of control of the device.

File Closed.

I-7942 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On September 6, 2002, the Licensee notified the Agency of a 5.027 rem exposure to an oncology therapist during the May 2002 monitoring period. The therapist was on vacation and did not wear the badge during the monitoring period. Upon returning to work, the therapist found the badge on a treatment console and turned the badge in for processing. The Licensee's investigation concluded the exposure was only to the badge. The Agency concurred with their findings. A deletion was granted and an assessment of 2.0 millirems, based on exposure history, was accepted.

File Closed.

I-7943 - Dose Irregularity - Medi Physics, Inc. dba Amersham Health / Lone Star Cardiology Consultants PA dba Cardiology Consultants of Texas - Dallas, Texas

On October 23, 2002, the nuclear pharmacy notified the Agency of a dose irregularity which occurred on September 25, 2002. During the set-up process an order was placed with routine orders for another radiopharmaceutical. The drug was dispensed and labeled as the wrong radiopharmaceutical. The drug was delivered and injected as labeled but did not perform as required for the correct radiopharmaceutical. The pharmacy determined the error as an oversight by the dispensing pharmacist and the result of multiple human errors. The patient and the 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 pharmacy was cited for mislabeling a radiopharmaceutical. The licensed using facility was cited for failure to notify this Agency of the incident within 30-days per license condition. To prevent a recurrence of this incident the pharmacy has established procedures to correct the oversight by requiring a pharmacist to check the set-up after it is performed by a certified pharmacy technician but prior to filling of any orders, and by requiring each pharmacy technician to initial the hard copy label, retained by the pharmacy, for all doses filled by that technician. This incident was forwarded to the Texas State Board of Pharmacy for possible violations under its rules.

File Closed

I-7944 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7945 - Radioactive Material Stolen - Alpha Testing, Inc. - Dallas, Texas

On October 28, 2002, the Licensee notified the Agency of the theft of a nuclear gauge containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source that occurred on October 28, 2002. The gauge was stolen from the tailgate of a company vehicle while the technician was unlocking the facility and unloading other equipment after an extended job out of state. When the technician returned to his truck the gauge was missing. A search of the local area did not locate the gauge. The Licensee reported the incident to the Dallas Police Department. The facility was cited for failure to secure the gauge. To prevent future reoccurrences the Licensee issued a warning memo to their technicians describing the incident and warning of future consequence for leaving gauges unsecured. The gauge has not been recovered.

File Inactive.

I-7946 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On September 3, 2002, the Licensee notified the Agency of a 5.027 rem exposure to a physician during the November 2001 monitoring period. The physician performed special procedures involving interventional fluoroscopy. A single badge was worn outside a protective apron. Therefore the reported exposure was multiplied by 0.3 to adjust the dose as authorized by Agency regulations. A deletion was granted and an assessment of 1.508 rem, based on recalculation, was accepted.

File Closed.

I-7947 - Dose Irregularity - Kelsey-Sebold Clinic / Mallinckrodt, Inc. - Houston, Texas

On October 17, 2002, the Clinic notified the Agency of two dose irregularities which occurred on October 7 and 8, 2002. The clinic indicated that the radiopharmaceutical doses did not perform as expected, causing one patient to be rescheduled. The second patient showed uptake in an area not normally visualized with the product but was of sufficient diagnostic quality to allow imaging. Notification to the pharmacy by the clinic resulted in additional quality control testing on the kits from which the radiopharmaceuticals were prepared. The tests indicated that the product was within acceptable limits. The pharmacy notified its corporate headquarters of the irregularities. The patients and the referring physicians were notified of the irregularity in their individual diagnostic procedures. Their whole body doses were less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7948 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7949 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7950 - Stolen X- Ray Control Panel - Century Inspection - Dallas, Texas

On October 29, 2002, the Registrant notified the Agency that a control panel for an x-ray unit was stolen. The Registrant's facility was broken into and initially, the Registrant did not realize anything was missing. One week later, upon performing a quarterly inventory on September 30, 2002, the control panel could not be located. The control panel is believed to have been stolen. The panel had no x-ray tube connected to it and is harmless because no radiation can be emitted.

File Inactive.

I-7951 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7952 - Dose Irregularity - Cardiology Consultants of Dallas - Dallas, Texas

On October 19, 2002, the Licensee notified the Agency of a dose irregularity that occurred on September 25, 2002. A patient was administered the wrong radiopharmaceutical. The pharmacy mislabeled the dose and the technologist did not accurately assay the dose in the calibrator. To prevent a recurrence, the Licensee counseled the technologist on assaying doses and added a protocol requiring the technologist's initials after assay. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The patient and the referring physician were notified of the error. The incident was referred to the Texas State Board of Pharmacy for any actions deemed necessary.

File Closed.

I-7953 - Badge Overexposure - Perry Equipment Corporation - Mineral Wells, Texas

On September 18, 2003, the Licensee notified the Agency of a reported 11,714 millirem exposure to the badge of an industrial radiographer. The radiographer discovered his badge at the end of his shift on August 29, 2002, at the bottom of a vessel that had been subjected to x-ray inspection in a shielded room. His badge was submitted for evaluation to the monitoring company on September 1, 2002. An Agency investigation was performed in conjunction with the facility's annual inspection on January 14, 2003. The inspection determined that the dose was only to the badge. A request for deletion was submitted and accepted by the Agency. An assessed dose for the monitoring period was assigned based on the exposure of a co-worker performing the same tasks during the monitoring period.

File Closed.

I-7954 - Badge Overexposure - Global X-Ray & Testing - Aransas Pass, Texas

On November 11, 2002, the Licensee notified the Agency of a 5.336 rem exposure to a radiographer trainee on September 8, 2002. While moving the radiography equipment, the trainee felt a tug on his clothing. After performing radiography on a rolled tubular, the trainee noticed his badge on the ground. The badge was sent for processing and the exposure was 2.017 rem. The exposure to the badge resulted in a total annual exposure of 5.336 rem. A deletion was granted and an assessment of 0.291 rem, based on past exposures, was accepted. To prevent a recurrence, the Licensee counseled the trainee on the proper use of personnel monitoring equipment and held a safety meeting with all employees.

File Closed.

I-7955 - Dose Irregularity - University of Texas Southwest Medical Center - Dallas, Texas

On October 3, 2002, the Licensee notified the Agency of a dose irregularity that occurred when two patients were misidentified and given each others treatment by the radiotherapy staff on October 2, 2002. Both patient's size, build, hairstyle and accented speech were similar and caused the technologist to confuse one patient with the other. Even when called by the other patient's name the patient responded. Since both patients were being treated for the same condition and their skin markings were similar, the setup parameters were met for both patients. When the second patient arrived for treatment in the afternoon, the technologist realized the mistake and notified both the prescribing and referring physicians. The physician evaluated the difference in total dose delivered for the single fractional treatment as insignificant. The hospital implemented a new procedures requiring verbal and counter checks for all patients undergoing external beam radiotherapy. All radiation oncology staff were required to attend training on the new procedures. The procedure is designed to prevent the wrong patient from receiving another's treatment plan. No violations were cited.

File Closed.

I- 7956 - Leaking Source - SPECTRO - Marble Falls, Texas

On November 6, 2002, the Licensee notified the Agency that a 100 millicurie iron-55 source was found leaking on October 23, 2002. The source was found to have 0.17 microcuries of removable contamination during a routine wipe of the source face prior to the servicing of a proportional counter. The contamination was confined to the face of the source and proportional counter window on the interior of the instrument. All other interior components and exterior surfaces were wipe tested and found to have no detectable contamination. The source was placed in storage pending disposal and the proportional counter window was decontaminated. No violation was issued.

File Closed.

I-7957 - Dose Irregularity - Central Cardiovascular Institute of San Antonio - San Antonio, Texas

On November 11, 2002, the Licensee notified the Agency that the wrong dose had been administered to a patient November 11, 2002. A technologist ordered and administered a dose different than the one intended. The patient and the referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To avoid future occurrences, the Licensee counseled the technologists to check the physicians' orders in the patients' charts. Also special procedures utilizing different radiopharmaceuticals will be indicated by placement of a different tag on a patient chart.

File Closed.

I-7958 - Radioactive Material at Landfill - BFI - Austin, TX

On Friday November 22, 2002, a landfill notified the Agency that a dumpster activated a gate radiation alarm and was rejected by the landfill. A landfill representative provided contact information for the company with the rejected trash. The Agency contacted the company and determined the dumpster had been set aside in a secured and isolated location at a construction site. The dumpster contained construction trash from the building of new residences in a local subdivision. An Agency survey of the dumpster using a multichannel analyzer determined iodine-131 was in the dumpster. The Agency was unable to determine who discarded a radioactive isotope typically used in medical therapy treatment in the dumpster. The dumpster was stored at the construction site until sufficiently decayed prior to disposal.

File Closed.

I-7959 - Leaking Source - SPECTRO - Marble Falls, Texas

On November 20, 2002, the Licensee notified the Agency that a 50 millicuries iron-55 source was found leaking on November 13, 2002. The source was found to have 0.0126 microcuries of removable contamination during a routine wipe of an instrument to be serviced. The contamination was confined to the face of the source and proportional counter window on the interior of the instrument. All other interior components and exterior surfaces were wipe tested and found to have no detectable contamination. The source was placed in storage pending disposal and the proportional counter window was decontaminated. No violation was issued.

File Closed.

I-7960 - Badge Overexposure - Hi- Tech Testing - Longview, Texas

On November 26, 2002, the Licensee notified the Agency of a 7.964 rem exposure to a radiographer during the September 2002 monitoring period. The Licensee believes the exposure was only to the badge. The radiographer could not recall a situation that would have resulted in the excessive exposure. The radiographer stated that his pocket dosimeter had not gone off scale and his alarming rate meter had not alerted him to the possibility of a high radiation field. The Licensee removed the radiographer from work involving radioactive material for the remainder of the 2002 monitoring period. An Agency investigation was unable to determine the exposure was only to the badge, therefore, the Licensee was cited for the exposure. The exposure remains as a part of the radiographer's exposure history. The radiographer is no longer employed by the Licensee.

File Closed.

I-7961 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7962 - Excessive Package Levels - Dallas - Ft. Worth Airport - Dallas, Texas/Schlumberger - Houston, Texas

On December 16, 2002, the United States Customs office notified the Agency of a shipment from Singapore to a Texas Licensee that was set aside at the airport due to inconsistencies in the radiation labels and the measured radiation levels. An Agency investigation and the Texas Licensee verified the inconsistencies. The radiation level was correctly declared and did not change during transport. However, an overpack was incorrectly labeled with Yellow II labels. The overpack contained packages with Yellow III labels and a transport index of

8.5, therefore, the overpack itself should have been labeled with Yellow III instead of the Yellow II labels. The incident was non-jurisdictional for Texas regulations. Assistance was provided based on request. No violations were cited.

File Closed.

I-7963 - Radioactive Material Found - Source Production & Equipment Company (SPEC) - St. Rose, Louisiana

On December 16, 2002, the Agency received notification that the United States Customs office had set aside a package at the airport that had arrived at British Air Cargo. The package was determined to have a reading of 240 millirem per hour at an unspecified distance from the container which was labeled as "Empty". An Agency inspector performed surveys of the package to determine the contents of the package. The package wrapped in cardboard and a burlap bag, was determined to be an empty, depleted uranium, Type B package, source container/exchanger that was being returned to the source manufacturer by a user in Pakistan. Radiation levels on contact were measured at levels ranging from background to 0.5 millirem per hour. The package was determined to be correctly labeled in accordance with 49 Code of Federal Regulations 173.426 and was released through United States Customs for continued shipment.

File Closed.

SUMMARY OF COMPLAINTS FOR FOURTH QUARTER 2002

C-1713 - Uncredentialed Technologists - Ralph Nieto dbd Mobile Imaging - Harlingen, Texas

On October 7, 2002, the Agency received a complaint transferred from the Medical Radiologic Technologist Program (MRT) alleging the Registrant allowed Limited Medical Radiologic Technologists (LMRT) to perform mobile x-ray procedures which are classified as dangerous and hazardous procedures by the MRT Program and are outside the scope of the LMRT credential. An Agency investigation, confirmed at least two LMRTs performed mobile radiographic procedures unassisted. The Registrant was cited for allowing LMRTs to perform dangerous and hazardous procedures. Additional allegations were received on December 5, 2002, alleging LMRTs were continuing to operate mobile x-ray equipment at 10 named facilities and at least two un-named facilities. Follow up investigations determined the Registrant had discharged the LMRTs and was operating with credentialed MRTs.

File Closed.

C-1714 - Unauthorized Possession - Promenade Center - Richardson, Texas

On October 4, 2002, the Agency received a complaint alleging an unauthorized person was in possession of a nuclear gauge and attempted to sell it to individuals performing construction work at shopping plaza. An Agency investigation did not obtain any further information on the gauge. The Agency determined the allegation was largely hearsay and could not be substantiated. Local law officials were not notified.

File Closed

C-1715 - Regulation Violations - Weslaco Advanced Medical Imaging - Weslaco /McAllen, Texas

On October 15, 2002, the Agency received an anonymous complaint alleging that two registered x-ray facilities and a mammography facility were operating in violation of Agency regulations. Specifically, the x-ray facilities were allegedly using Limited Medical Radiologic Technologists (LMRTs) to perform dangerous and hazardous procedures and the mammography facility was allegedly not providing reports of mammography examinations within 30 days on a regular basis. Other allegations beyond the scope of this Agency's authority were also alleged. A joint x-ray and mammography inspection was performed that determined at least one LMRT had performed dangerous and hazardous procedures. The mammography inspector checked available records and could not confirm the allegation of reports not provided within 30 days. A copy of the report was forwarded to the Texas Department of Health (TDH) Bureau of Food and Drug Safety for any actions deemed necessary.

File Closed.

C-1716 - Uncredentialed Technologists - Rio Mobile X-Ray - Harlingen, Texas

On October 15, 2002, the Agency received an anonymous complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation substantiated the allegation. The investigation also determined the Registrant failed to notify the Agency, in writing, within 30 days of a change of radiation machine inventory; and the Registrant's operating and safety procedures were inadequate. The Registrant was cited for the violations.

File Closed.

C-1717 - Uncredentialed Technologist - Brown Dental Health Management, Inc. - Fort Worth, Texas

On October 25, 2002, the Agency received a complaint alleging an uncredentialed technologist used the name of a former credentialed technologist to perform dental radiographs at the facility. The previous employee had departed the facility three years prior to the complaint. Each radiographic film examined at the facility contained the initials of the technologist on the chart along with the documentation of the radiographs performed. A review of random samples of files for a period of and one half years did not find any files using the name or initials of the former employee. The allegation could not be substantiated.

File Closed.

C-1718 - Unlicensed Radioactive Material - Roof Consultant Services /Dave Knigge - Harlingen, Texas

On October 25, 2002, the Agency received a complaint from the United States Nuclear Regulatory Commission (NRC), alleging a former NRC Licensee had failed to pay required licensing fees and departed the NRC jurisdiction for Texas. An Agency investigation determined the NRC Licensee was storing a nuclear roof gauge in Texas, and that the storage location was not approved by the Agency. The gauge was impounded under Emergency Order on December 16, 2002. The gauge is in Agency storage pending disposal. The gauge owner was cited for the violation. NRC was notified of Texas' actions.

File Closed.

C-1719 - Regulation Violation - National Institute of Technology - Houston, Texas

On October 30, 2002, the Agency received an anonymous complaint alleging that the Registrant allowed dental students to perform radiographs of other students for non-diagnostic purposes. An Agency investigation determined facility staff and instructors required dental students to perform 18 radiographs per month. However, during the complaint period the dental mannequins were broken and could not be utilized for training purposes. Therefore, the students were instructed to perform radiographs on fellow dental students. The Registrant was cited for allowing the performance of non-diagnostic dental radiographs both by and on students for non-diagnostic purposes. In addition, during a routine Agency inspection, it was determined that the Registrant had not appointed a replacement for the Radiation Safety Officer who had departed in March 2001. A repeat violation was cited for this violation. The complaint was forwarded to the Texas Dental Board for any actions deemed necessary.

File Closed.

C-1720 - Regulation Violations - Family Healthcare Association - Grapevine, Texas

On October 21, 2002, the Agency received an anonymous complaint alleging a radiographic film processor had temperature problems that resulted in dark films and diagnostically unacceptable images. An Agency investigation determined the dark films resulted from improper radiographic exposure technique settings on the x-ray unit rather than temperature problems with the film processor. To prevent a recurrence, the Registrant provided training sessions to the technologist on radiographic techniques. No violations of Agency regulations were found during the investigation.

File Closed.

C-1721 - Uncredentialed Technologists - Antonio Esparza, M.D., P.A. / Antonio Esparza, M.D. dba Babies and Children's Clinic - Pharr, Texas

On November 4, 2002, the Agency received an anonymous complaint alleging three facilities allowed uncredentialed technologists to perform radiographs. An inspection at the three facilities determined that two of the three facilities had uncredentialed technologists performing radiographs. In addition, it was determined that the three facilities were operating without required Operating and Safety Procedures. Other machine and record related violations were noted at one of the facilities. The facilities were cited for a total of six violations.

File Closed.

C-1722 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1723 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1724 - Regulation Violations - Waco Cardiology - Waco, Texas

On November 14, 2002, the Agency received an anonymous complaint alleging a Licensee allowed an untrained technologist to perform nuclear medicine procedures. An Agency investigation substantiated the allegation. The Licensee was cited under a License Condition for failure to ensure that a trained and certified nuclear medicine technologist performed all nuclear medicine injections. A nuclear medicine technologist was observed performing radiopharmaceutical injections in a room identified as a storage room, an unauthorized location. The Licensee was cited for failure to confine the use and possession of radioactive material to the locations and purposes authorized in the Radioactive Materials License.

File Closed.

C-1725 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1726 - Uncredentialed Technologist - Doctors Clinic - Duncanville, Texas

On December 9, 2002, the Agency received an anonymous complaint alleging a Registrant allowed an individual without the proper credentials to perform radiographs. An Agency investigation was unable to substantiate the allegation. A technologist with appropriate credentials had performed radiographs through November 1, 2002, but was no longer employed at the facility. The licensed medical practitioner is performing the radiographs until another technologist is hired.

File Closed.

C-1727 - Radioactive Scrap Metal - Sabine Industries, Sabine Pass, Texas

On December 11, 2002, the Agency received a complaint alleging that personnel were exposed to radioactive material contaminating a load of scrap pipe that was refused by a metal recycler due to radiation levels. The pipe was allegedly returned to Sabine Industries by Commercial Metals, Beaumont, Texas. An Agency investigator conducted an investigation accompanied by the complainant. A survey of the area indicated by the complainant as where the pipe was allegedly returned found only pipe that was not contaminated. Commercial Metals indicated a load of scrap pipe was rejected and returned to Sabine Industries after a gate monitor alarmed. The gate monitor alarms when very low radiation levels are detected. The pipe located in the yard at Sabine Industries had background levels of radiation. The allegation could not be substantiated.

File Closed.

C-1728 - Aesthetic Centre of Dallas - Dallas, Texas

On December 16, 2003, the Agency received a complaint transferred from the Texas Department of Health's, Bureau of Food and Drug, Drugs & Medical Devices Division. The complaint alleged a laser was in use without proper medical supervision and might not be registered. An Agency investigation determined the laser was registered. The investigation found and cited the following violations of Agency regulations. The Registrant failed to perform and document examination of eye protection at 12-month intervals, to ensure the reliability of protective filters and integrity of protective filter frames. The laser logotype and signage failed to list the pulse duration of the laser. The logotype and signage for the laser failed to include the word "invisible" immediately prior to the word "radiation" on labels and signs for a device operating at wavelengths outside the range 400 to 700 nanometers. The allegation of lack of medical supervision was referred to the Texas State Board of Medical Examiners for any actions deemed necessary.

File Closed.

C-1729 - Dose to Public - G. Wayne Farrimond, DDS, Inc. - Schertz, Texas

On December 17, 2002, the Agency received a complaint alleging that a panoramic x-ray unit belonging to the Registrant was located in the facility in a manner that would allow the primary beam from the machine to expose members of the public in the facility waiting room. An Agency investigation determined the machine located in the hallway was not owned by the Registrant but by another dentist that practices at the location only on Mondays. The inspectors determined that the orientation of the machine does not expose members of the public and that exposures on the machine are announced by facility staff to keep the hallway empty when the machine is energized. No violations were noted.

File Closed.

COMPLAINTS CLOSED SINCE THIRD QUARTER 2002

C-1675 - Unauthorized X-Ray Screening - Midland Imaging Center dba Golder X-Ray - CAT Scan & MRI Center - Midland / Odessa, Texas

On May 20, 2002, the Agency received an anonymous complaint alleging a registered facility performed screening CT scans without the authorization of a licensed practitioner. Agency investigations did not document any examinations identified as screening examinations. Procedures at the facility indicated a licensed practitioner examines all patients before an examination is performed. The allegation could not be substantiated.

File Closed.

APPENDIX A

**SUMMARY OF HOSPITAL OVEREXPOSURES REPORTED DURING
FOURTH QUARTER 2002**

APPENDIX B

**SUMMARY OF RADIOGRAPHY OVEREXPOSURES REPORTED DURING
FOURTH QUARTER 2002**

APPENDIX C

ENFORCEMENT ACTIONS FOR THE FOURTH QUARTER 2002

Enforcement Conference: Karnes County Hospital District, Kenedy, Texas – Mammography

On October 3, 2002, an enforcement conference was held with representatives of Karnes County Hospital District, holder of Certificate of Mammography No. M00732.

The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on June 21, 2002. The violations stated in the Notice of Violation issued on July 15, 2002, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency requested the following actions be performed by Karnes County Hospital District.

1. Karnes County Hospital District will continue to use their outside consultant. The consultant must visit at least once per calendar quarter. Should Karnes County Hospital District choose to change consultants, the new consultant must be pre-approved by the Agency. The same criteria used to select the current consultant must be used to determine any replacement consultant.

2. Patient notification will be performed for those patients who received mammograms from the period March 2001 through June 2002. A draft patient notification letter indicating the deficiency should be submitted to the Agency for approval prior to distribution to the patients. The draft letter will be provided to the Agency within 30 days from the date of the enforcement conference summary. If the patient had more than one mammogram for the period indicated above the patient should only receive one letter. If a patient had a repeat mammogram since June 2002 then the patient does not need to be notified.

2. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

3. The inspection frequency for Karnes County Hospital District will be increased and unannounced inspections will be conducted.

The representatives from Karnes County Hospital District agreed to perform the above requested actions and the conference was concluded.

Enforcement Conference: Everest Exploration, Inc. Corpus Christi, Texas – Uranium

On October 16, 2002, an enforcement conference was held with a representative of Everest Exploration, Inc., holder of License No. L03626. The conference was held as a result of an Agreed Order issued on February 25, 2002.

The conference began with the Everest representative passing out a survey map of a Phase II Irrigation Area – Gamma Survey Post Homogenization and a survey map of Tex-I Project which outlines well fields, roads, gates, and plant locations. Phase II and III homogenization has been completed. The representative stated that Phase I area could be homogenized in approximately one weeks time. However, larger equipment will need to be utilized to acquire the appropriate dilution factor since the excavation depth will need to be between 36” to 42”. This soil homogenization will take approximately 3 weeks to complete. Upon completion the survey information compiled by Everest will be sent to Licensing and in turn Licensing will forward to Incident Investigations to perform a close out survey.

The representative reported that Everest has completed the land swap, and now Everest Corporation owns the Hobson site. The representative indicated that the pipe at Mt. Lucas site could be moved over to the Hobson site, and that this would be a good rainy day job.

A Complaint to Revoke Everest’s license has been issued by Accounting for non-payment of fees. The Agency will discuss this as the first topic at the next enforcement conference scheduled for December 5, 2002.

Enforcement Conference: Correct Care Clinic, Garland, Texas – X-Ray

NO SHOW

Enforcement Conference: Edwin A. Chin, D.D.S., Houston, Texas – X-Ray

On November 15, 2002, an enforcement conference was held with Edwin A. Chin, D.D.S., who is unregistered, however, an application for registration has been submitted and is pending. The conference was held as a result of the number, type and severity of violations noted during an inspection conducted on March 19, 2002.

The violations stated in the Notice of Violation issued on May 23, 2002, and the responses to the violations were reviewed.

After reviewing the violations and the responses, the Agency made the following recommendations with Edwin A. Chin, D.D.S.:

1. Edwin A. Chin, D.D.S. will provide a written statement to the Agency indicating he has reviewed, understands, and will abide by the Responsibilities of RSO as listed in §289.232(h)(10) and §289.323 (h)(11). The statement shall be

provided to the Agency within 30 days from the date of the enforcement conference summary.

2. Administrative penalties will be assessed to Dr. Edwin A. Chin, D.D.S. for operating without a valid registration.
3. The inspection frequency, for Dr. Chin will be increased and unannounced inspections will be conducted. Dr. Chin will also be removed from the self inspection list until such time that Dr. Chin has successfully completed two inspections in which no violations higher than a severity level IV or V are cited. Once this requirement has been met, Dr. Chin will resume routine inspection intervals and will be allowed to perform self-inspections.
4. Dr. Chin will provide the Agency with an inventory of all machines at both locations. (This was provided at the enforcement conference).
5. Dr. Chin shall complete and submit a new application for registration. (This was completed at the time of the enforcement conference).
6. Dr. Chin will submit technique charts to the Agency for the Little York location. This will be submitted within 30 days from the date of the enforcement conference summary.
7. Dr. Chin will provide a copy of the service report from Gant Dental service, which contains the information regarding half value layer to the Agency within 45 days from the date of the enforcement conference summary. If for any reason Dr. Chin cannot obtain the report from Gant Dental Service, Dr. Chin shall have another service company perform the test and shall submit the data from the new service company.
8. Dr. Chin shall provide a copy of the Operating and Safety Procedures for each site to the Agency within 30 days of the date of the enforcement conference summary.
9. The Agency will verify at the next inspection the "Caution Radiation" sign, "Radiation Machine" stickers, and temperature sign in the dark room indicating "automatic temperature control", are appropriately posted.
10. Dr. Chin will provide the Agency with a written statement indicating he has reviewed §289.232(k)(1)(X)(i) through §289.232(k)(1)(X)(iii) and will comply with the regulation. This statement will be submitted to the Agency within 30 days from the date of the enforcement conference summary.

Dr. Edwin A. Chin, D.D.S. agreed to the above recommendations and the conference was concluded.

Enforcement Conference: Southern Services, Inc., Lake Jackson, Texas - Industrial Radiography

On November 5, 2002, an enforcement conference was held with representatives of Southern Services, Inc., holder of License No. L05270. The conference was held as a result of the number, type and severity of violations noted during an inspection conducted on May 30-31, 2002. The violations stated in the Notice of Violation issued on July 8, 2002, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency discussed the following items with Southern Services, Inc.:

1. The inspection frequency for Southern Services, Inc. will be increased and unannounced inspections will be conducted.
2. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

Southern Services, Inc. agreed to the above recommendations, and the conference was concluded.

Enforcement Conference: Bellville General Hospital, Bellville, Texas - Mammography

On November 26, 2002, a management conference was held with a representative of Bellville General Hospital, holder of mammography certification no. M00517. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on August 21, 2002. The violations stated in the Notice of Violation issued on September 23, 2002, and the responses to the violations were reviewed. After reviewing the violations and the responses, the Agency reviewed the following recommendations with the hospital representative:

1. Patient Notification should be performed for those patients that received mammograms from the period of April 8 – 15, 2002; February 23 – March 14, 2002; and April 5 – May 5, 2002. The patient notification should include an explanation of the mammography system failure; and the potential consequences to the mammography patient. The patient notification letter should be submitted to the Agency for approval prior to initiating the notification process. The letter should be provided to the Agency within 30 days from the date of the management conference summary.
2. Bellville General Hospital will review each mammography examination report to ensure that each report contains a final assessment category as stated in

TAC §289.230(c) (25) (A-F). The Agency will review these at the next inspection.

3. Bellville General Hospital should log one of the standard eleven reasons from the ARC manual into their log when processor parameters are changed.
4. Bellville General Hospital should document on a sign in sheet when processor quality control tests are performed.
5. The Lead Interpreting Physician will provide the Agency with a written statement indicating they have read, understand, and will abide by TAC §289.230(k)(1)(A) explaining the responsibilities of the Lead Interpreting Physician. The statement shall be provided to the Agency within 30 days from the date of the enforcement conference summary.
6. The Radiation Safety Officer will provide the Agency with a written statement indicating they have read, understand, and will abide by TAC §289.226(w)(2) which specifies the duties of the Radiation Safety Officer. The statement shall be provided to the Agency within 30 days from the date of the enforcement conference summary.
7. The inspection frequency for Bellville General Hospital has been increased and unannounced inspections will be conducted.
8. No administrative penalties are being assessed at this time, however, should any Severity Level I, II or repeat violations be cited upon follow up inspection, then administrative penalties may be assessed.

The hospital representative agreed to the above recommendations and the conference was concluded.

Enforcement Conference: Dan Daniel and Company, Ltd., Carrollton, Texas - X-Ray

On December 12, 2002, an enforcement conference was held with Dan Daniel and Company, holder of certificate of registration no. R25761. The conference was held as a result of the number, type and severity of violations noted during an inspection conducted on February 27, 2002. The violations stated in the Notice of Violation issued on March 8, 2002, and the responses were reviewed.

After reviewing the violations and the responses, the Agency reviewed the following recommendations with Mr. Daniel:

1. Mr. Daniel will apply for a new certificate of registration for healing arts screening. Mr. Daniel will not perform any healing arts screenings until a new certificate has been received indicating he is registered to perform healing arts screenings.

2. Mr. Daniel will apply for a hardship exemption through the MRT Board. The exemption will expire annually, so this will need to be kept up to date on an annual basis.
3. Mr. Daniel will become familiar with the rules listed on his certificate of registration and §289.202 and submit a written statement to the Agency that he has reviewed, understands, and will abide by the regulations. The regulations should be book marked, and available for review at the next inspection.
4. Mr. Daniel will submit a statement to the Agency indicating where all records noted on violation #6 in the NOV dated March 8, 2002 are posted or can be found.
5. The inspection frequency has been increased and unannounced inspections will be conducted.
6. No administrative penalties will be assessed at this time, however, upon follow up inspection should any severity level I, II or repeat violations be cited, administrative penalties may be assessed.
7. Operating and Safety Procedures will be provided to the Agency within 30 days from the date of the enforcement conference summary.
8. Mr. Daniel will prove a written response to each violation listed on the Notice of Violation issued on March 8, 2002.

Mr. Dan Daniel agreed to the above recommendations and the conference was concluded.