

Fourth Quarter 2001 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

“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/radiation/>**

TABLE OF CONTENTS

Summary of Incidents for Fourth Quarter 2001	1
Summary of Complaints for Fourth Quarter 2001	19
Incidents Closed since Third Quarter 2001	33
Complaints Closed since Third Quarter 2001	35
Appendix A	37
Summary of Hospital Overexposures Reported during Fourth Quarter 2001	
Appendix B	39
Summary of Radiography Overexposures Reported during Fourth Quarter 2001	
Appendix C	41
Enforcement Actions for Fourth Quarter 2001	

SUMMARY OF INCIDENTS FOR FORTH QUARTER 2001

I-7806 - Radiography Camera Lost & Found - Hi-Tech Testing - Longview, Texas

On September 25, 2001, a local fire department notified the Agency that a radiography device containing a 93 curie iridium-192 source was found in a roadway intersection on September 25, 2001. The fire department removed the device from the road, obtained Licensee information from the labeling, and contacted the Licensee to take possession of the device. The Licensee surveyed the device, determined the source had remained shielded, and the public had not been exposed. A visual inspection determined the camera was not damaged. The device was out of the Licensee's possession for about two hours. A radiographer had placed the device on the back bumper of the truck, then went to perform other tasks. Upon returning to the truck, he drove off prior to placing the device in the transport case and performing transport surveys. The radiographer was unaware of the loss until contacted by the Licensee. The Licensee and radiographer were cited for failure to secure the device against unauthorized removal, failure to adequately block and brace the device during transport, and for failure to perform radiation surveys before transport.

File Closed.

I-7807 - Leaking Source - Computalog - Fort Worth, Texas

On October 4, 2001, the Licensee notified the Agency of loose radioactive material found on a 10 microcurie cesium-137 test source. A routine leak test conducted on September 28, 2001, indicated 0.5476E-02 microcuries of removable contamination. A second leak test conducted on both the source and the source storage box indicated less than 0.0001 microcuries of removable contamination. The Licensee decided to dispose of the source and held it in storage pending disposal.

File Closed.

I-7808 - Density Gauge Lost & Found - ReHeis, Inc. - Midlothian, Texas

On October 3, 2001, a company notified the Agency that a density gauge was discovered at its facility in 2001. The gauge had remained in its original shipping container, unopened since 1983. Ownership of the facility changed hands several times from 1983 to the present. The present company contacted the manufacturer to find out more information and to arrange for disposal of the gauge. The manufacturer's records indicated the following: two gauges were shipped to a former owner at the address on August 26, 1983; each gauge contained a cesium-137 source assayed at 200 millicuries on June 20, 1983; the sources were leak tested by the manufacturer on August 25, 1983. The company did not find the second gauge on site or any documentation indicating its present location.

File Closed.

I-7809 - Lost Source - Ludlum Measurements - Sweetwater, Texas

On October 2, 2001, the Licensee notified the Agency that a 0.0178 microcurie, plutonium-239, sealed point source could not be located on September 5, 2001. Visual searches for the source were conducted by the radiation safety officer and other staff without success. Due to the low activity of the source significant exposure to occupationally exposed personnel and members of the public is highly unlikely. To prevent a recurrence, all personnel who use any source have been given copies of the Licensee's standard operating procedure (SOP) which explains proper use and storage of radioactive sources. The SOP was also reviewed verbally with all personnel by the facility radiation safety officer. In addition, one person in each department was assigned to check source cabinets on a weekly basis.

File Closed.

I-7810 - Density Gauge Lost and Found - Law Engineering and Environmental Service, Inc. - Fort Worth, Texas

On October 10, 2001, the Agency was notified of a nuclear density gauge found in Fort Worth, Texas. The Licensee owning the gauge was contacted and was unaware the gauge was missing from an operator in the field. Contact with the operator confirmed the gauge, chain, and lock were missing from the company vehicle. An Agency investigation determined the gauge was found within one hour of the operator leaving his home for a work location in Dallas. The gauge was picked up by Texas Department of Health Regional Staff. The Department had the gauge leak tested with results indicating the gauge was not leaking. The investigation determined that: an unauthorized storage site had been used since January 2001; the Licensee had not updated its license to reflect a change of radiation safety officer; the Licensee failed to have and provide current Texas Regulations to individuals engaged in work with nuclear gauges; employees failed to follow authorized radiation safety procedures in accordance with their current license; and the Licensee had failed to secure the gauge from unauthorized removal or access. The Licensee was cited for the appropriate violations and referred to Escalated Enforcement.

File Closed.

I-7811 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7812 - Source Abandoned Downhole - Computalog - Forth Worth, Texas

On October 16, 2001, the Licensee notified the Agency that a well logging tool containing a 100 millicurie cesium-137 source was abandoned downhole on October 16, 2001. The logging tool was stripped off during a logging operation; it fell to the bottom of an oil storage cavern and was unrecoverable. The appropriate plaque was ordered. Abandonment of the cavern is not expected anytime soon.

File Closed.

I-7813 - Stolen Moisture Density Gauge - Fugro South, Inc - Houston, Texas

On October 16, 2001, the Licensee notified the Agency that a moisture-density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was stolen from a company vehicle parked at the operator's home during the hours of darkness on October 14, 2001. The gauge was not chained or locked to the pickup as required by company procedure. The Licensee was cited for failure to secure the gauge against unauthorized removal and for failure to keep the gauge under constant surveillance while not in storage. A police report of the incident

was filed with the Harris County Sheriff's Department. The gauge has not been recovered.

File Inactive.

I-7814 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7815 - Stolen Moisture Density Gauge - HTS, Inc. - Houston, Texas

On October 3, 2001, the Licensee notified the Agency that a moisture-density gauge, containing a 10 millicurie cesium-137 source and a 50 millicurie americium-241/beryllium source, was stolen from a company pick-up parked at a convenience store enroute to a job site. The gauge was secured by chain and lock to the bed of the pickup. A locked hinge was broken off the case, allowing enough slack in the chain for the gauge to be removed from the case. A police report was filed with the Harris County Sheriff's Department. The Licensee has issued new instructions to all gauge operators to secure the gauge through all three handles of the case. The gauge has not been recovered.

File Inactive.

I-7816 - Stolen Moisture Density Gauge - QTE - Dallas, Texas

On September 9, 2001, the Licensee notified the Agency that a moisture density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was stolen on September 9, 2001. The gauge was stolen when the technician returned home for his wallet. While he was inside the house, the lock securing the gauge to the back of the pickup truck was cut and the gauge was taken. The local police were notified. The gauge has not been recovered.

File Inactive.

I-7817 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7818 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7819 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7820 - Damaged Density Gauge - Terra Mar - Dallas, Texas

On October 10, 2001, the Licensee notified the Agency that a density gauge was damaged on September 15, 2001. After taking density measurements on asphalt in a parking lot, a technician drove from the job site to purchase refreshments at a nearby store. He placed the gauge in the gauge box with locks in the source handle and then placed the gauge in the back of the truck. However, he did not secure the box to the truck or shut the tail gate before leaving the site. The boxed gauge fell from the truck and was picked up by a member of the public. The technician was alerted by another driver that the gauge had fallen from the truck. The technician notified the company radiation safety officer, who in turn, notified the Agency and the local police. The individual who found the gauge also contacted the local police. The Licensee took possession of the gauge from the individual who found it. There was no damage to the gauge nor was there any excessive radiation exposure to the individual. The Licensee was cited for failure to secure a source of radiation from unauthorized removal or access.

File Closed.

I-7821 - Badge Overexposure - Phoenix Non-Destructive Testing Company, Inc., Channelview, Texas

On October 25, 2001, the Licensee notified the Agency of a 4,290 millirem exposure to a radiographer trainee for the September 1, 2001 through September 30, 2001 monitoring period. The Licensee determined the trainee's exposure, when added to a previous exposure at another firm, exceeded the 5 rem annual limit. The trainee recalled hanging his shirt, with his badge attached, near a shoot conducted by his trainer. His pocket dosimeter indicated a total exposure of 135 millirem for the monitoring period. This exposure compared favorably with that of his trainer's badge for the monitoring period. The Licensee requested the dose be deleted and replaced with an assessed dose of 417 millirem for the monitoring period. A deletion was granted and a 417 millirem assessment, based on pocket dosimetry records, was accepted.

File Closed.

I-7822 - Excessive Package Levels - Iso-Tex Diagnostics - Friendswood, Texas

On October 15, 2001, the NRC notified the Agency that a package shipped from a Texas Licensee to a Washington Licensee had excessive radiation levels on October 12, 2001. Six phosphorous-32 plated catheters, used for angioplasty on animals, were shipped to the Washington Licensee. During shipment, connector tips broke, allowing the plated catheters to move from their shielding, resulting in elevated radiation levels at the surface of the package.

File Closed.

I-7823 - Lost Sources- Autocraft Electronic - Carrollton, Texas

On October 16, 2001, the General Licensee notified the Agency of the loss of three, 20 microcurie, polonium-210 sources in ionization cylinders, that had been used to test a manufacturing process until January 2001. In July 2001, the firm closed operations at this location and collected all equipment for disposition. After moving the equipment, the ionization cylinders could not be located. It is suspected the small cylinders were inadvertently discarded into the municipal solid waste. Potential exposure to the public from the landfill is negligible. The half-life of the isotope is 138 days and will decay to background long before the landfill will close. The General Licensee does not anticipate utilizing similar devices in future operations.

File Closed.

I-7824 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7825 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7826 - Damaged Density Gauge - Terra-Mar - Dallas, Texas

On October 29, 2001, the Licensee notified the Agency that a nuclear density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was damaged on October 29, 2001. A technician performing density tests noticed a bulldozer backing towards him. He quickly moved out of the way but was unable to move the gauge. The bulldozer backed over and damaged the gauge. A radiation survey was made of the gauge, the surrounding area, and the bulldozer. The survey determined the source had remained shielded and no contamination was detected. The source was not damaged and a leak test confirmed no leakage. The gauge was placed in storage pending its return to the manufacturer.

File Closed.

I-7827 - Stolen Moisture Density Gauge - Texas Department of Transportation - Denton, Texas

On November 12, 2001, the Licensee notified the Agency that a moisture-density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was stolen from a field construction site. The gauge was secured inside a locked closet in a locked construction trailer located inside a fenced and locked compound. The gauge was believed stolen during the hours of darkness on November 9, 2001, and was discovered the following morning when a contractor arrived on-site. The Licensee filed a report with the Denton County Sheriff's Department.

File Inactive.

I-7828 - Exposure to the Public - Schlumberger - Sugarland, Texas

On August 30, 2001, the Licensee notified the Agency of radiation exposures to members of the public on August 29, 2001. An engineer inadvertently left a cesium-137 well logging source outside of its shielding, on a rig floor, for approximately twelve hours. The engineer finished a logging operation, pulled the source from the logging tool with a handling tool, and cleaned mud from it. Although the source was inserted into a shield, the engineer did not perform a survey and did not realize the source was still attached to the handling tool. The dose rate was in excess of 20 millirems per hour. Seven individuals received a dose greater than 100 millirem with the maximum possible dose calculated at 613 millirem. In addition, nine other individuals received a dose less than 100 millirem. The Licensee was cited for failure to perform the proper surveys and for allowing members of the public to be exposed to radiation levels in excess of the regulatory limits.

File Closed.

I-7829 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7830 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7831 - Equipment Damaged - Washington Group International - Houston, Texas

On November 8, 2001, the Licensee notified the Agency of an 83-curie, iridium-192 sealed source disconnect, that occurred during operations the previous evening. An Agency investigation determined that while attempting to assemble the drive cable, the radiographer noticed the ball

connector was broken off the end of the drive cable. The radiographer borrowed drive control cables from another radiography firm onsite. Operations were routine until the radiographer attempted to disassemble the drive cables. The drive cable could not be disconnected from the exposure device. The exposure device was transported to the Licensee's facility without the required overpack. Disassembly determined the missing ball from the broken drive cable was lodged in the pigtail connector preventing a normal disconnect. Analysis by the manufacturer indicated that rust, in addition to excessive force by the operator, contributed to the failure of the initial cable. The second cable, from another manufacturer, showed similar rust patterns and, although retrofitted to fit the exposure device, did not have the same dimensions as the original cable. The Licensee was cited for failure to properly transport the exposure device and the radiographer was cited for failure to perform and document daily equipment check prior to using the equipment.

File Closed.

I-7832 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7833 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7834 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On November 19, 2001, the Registrant notified the Agency of a 5.385 rem exposure to a physician during the April, 2001, monitoring period. The badge processor noted the badge received a static exposure, indicating the badge was not worn during the exposure. The Registrant determined the badge had been lost. The badge was for the April, 2001, wear period, however, it was found and turned in for processing in October, 2001. The Agency concurred the exposure was to the badge only. A deletion was granted and a 24 millirem deep, 389 millirem shallow, and a 384 millirem eye dose assessment, based on past average exposure history, was accepted.

File Closed.

I-7835 - Badge Overexposure - Southern Services, Inc. - Clute, Texas

On November 19, 2001, the Licensee notified the Agency of a 5,668 millirem exposure to a radiographer for the September 5, 2001, through October 4, 2001, monitoring period. The radiographer maintains that his badge was not lost during that time period but had been left in the cab of a company vehicle over the weekend, near where radiography was performed. An Agency investigation determined the exposure was to the badge only. A deletion was granted and a 420 millirem assessment, based on the radiographers average exposure history, was accepted.

File Closed.

I-7836 - Equipment Malfunction - Alcoa - Elmendorf, Texas

On November 26, 2001, the Licensee notified the Agency of an equipment malfunction that occurred on October 4, 2001. A shutter on a gauge, containing a 1000 millicurie americium-241 source, was sticking and would not close completely. The gauge was taken out of service and the area secured. The shutter was manually closed using an eight foot pole. No measurable radiation exposures were associated with the incident. The manufacturer repaired the shutter by replacing a cylinder and the gauge was returned to service. The Licensee was cited for failure to submit a written report within 30 days.

File Closed.

I-7837 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7838 - Misadministration - U.S. Oncology - Wichita Falls, Texas

On December 12, 2001, the Registrant notified the Agency of a misadministration that occurred on December 12, 2001. A patient was administered a therapy dose to the wrong site. The computed tomography(CT) staff intended to move a marking for the treatment center down 10 centimeters, instead the marking was moved up 10 centimeters. A physician signed paperwork indicating the treatment plan was correct. The error was discovered when the procedure was reviewed by a chief therapist. The patient, the oncologist, and the referring physician were notified of the error. There were no side effects to the patient as a result of the incorrect treatment. To prevent a recurrence, the CT and simulation technologists were instructed to verify any shift in treatment with the dosimetrist and the chief therapist prior to implementing a change. The radiation oncologist will review the verification films before the initial patient treatment and periodically thereafter.

File Closed.

I-7839 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7840 - Therapy Event - UT Southwestern Medical Center - Dallas, Texas

On December 12, 2001, the Registrant notified the Agency of a therapy event that occurred on December 12, 2001. A patient was administered treatments to the wrong site. Previous treatments had been to one site and the therapist did not recognize the change. The patient and the referring physician were notified of the error. The prescribing physician determined the dose differences were negligible and no makeup treatments were given. To prevent a recurrence, the radiation therapists were instructed to check the patient chart, to revisit the prescriptive settings, and cross-check each other on patient set-up prior to treatment. The Registrant held staff meetings to discuss lessons learned and to re-emphasize communication.

File Closed.

I-7841 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7842 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7843 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7844 - Radioactive Material at Landfill - Vidor Sanitation Department - Vidor, Texas

On December 29, 2001, a sanitation department notified the Agency that a trash truck activated a radiation alarm at a sanitary landfill. The trash was picked up from a residential route. Contaminated trash resulting from medical treatment with short-lived radiopharmaceuticals was suspected. The sanitation department parked the truck in an isolated and secure area until the radiation levels decreased to acceptable levels. The trash was disposed of in the landfill.

File Closed.

THIS PAGE IS INTENTIONALLY BLANK

COMPLAINT SUMMARY FOR FORTH QUARTER 2001

C-1606 - Unregistered X-Ray Unit - Positive Pain - Houston, Texas

On October 2, 2001, the Agency received a complaint alleging an unregistered x-ray unit was in use at a facility. An Agency investigation substantiated the allegation. The facility was cited for the following violations: an application for registration was not submitted to the Agency within thirty days of commencement of operation of a radiation machine; the x-ray field size indicators on the beam limiting device of the x-ray unit did not accurately indicate the x-ray field size; and the light localizer of the unit which is used for defining the edges of the x-ray field did not coincide with the edges of the x-ray field.

File Closed.

C-1607 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1608 - Regulation Violations - D.S. Services - Tomball, Texas

On October 11, 2001, the Agency generated a complaint based on a review of a Registrant's Equipment Performance Evaluation. The complaint alleged a service company falsified the documentation for the evaluation of a dental unit. An Agency investigation determined the service company did not possess the proper equipment necessary to test the x-ray unit for output measures or for testing exposure reproducibility. The service company indicated the records were not falsified but filled out incorrectly, based on a lack of understanding. The service company was cited for failure to perform an adequate performance evaluation on an x-ray unit located at a physician's office.

File Closed.

C-1609 - Regulation Violations - Omni Equity Limited, Company dba Llano Laser and Aesthetic Center - Lubbock, Texas

On October 15, 2001, the Agency received an anonymous complaint alleging the Registrant performed laser hair removal procedures without a medical director, a laser safety officer, or a qualified laser operator. The complainant also alleged that four patients had laser injuries that had not been reported to the Agency. An Agency investigation determined the Registrant had

submitted documentation to amend their registration, adding a new medical director and changing the laser safety officer. It was also determined that: laser injuries had occurred at the facility and had not been reported to the Agency; the Registrant had allowed laser radiation to be applied to patients without authorization from a practitioner of the healing arts; the Registrant had allowed laser radiation be applied to individuals for the purpose of demonstration and training; the Registrant had failed to report incidents of laser injuries to both patients and operators of the laser; the Registrant had failed to apply for a registration within 30 days of commencement of operation of the laser; eyewear was not checked and safety surveys were not completed annually; the laser safety officer failed to ensure personnel were adequately trained in laser safety, and the Registrant failed to maintain applicable sections of Texas Regulations at the authorized use location. The Registrant was cited for the violations and Escalated Enforcement actions were recommended.

File Closed.

C-1610 - Regulation Violations - Richmond Imaging Affiliates dba River Oaks Imaging - Spring Valley, Texas

On October 18, 2001, the Agency received a complaint alleging the Registrant refused to release mammogram films to a patient and refused to communicate the results to the patient in a timely manner. An Agency investigation determined the results were communicated within the allowable thirty day time frame. Documentation was not found to substantiate that a request was made for the films and not acted upon. The Registrant has two protocols regarding the release of films to patients; one for the release of diagnostic x-ray films other than mammograms and another for mammography films. The Registrant believes there may have been a misunderstanding about the type of films being requested, and therefore, the wrong information could have been conveyed to the complainant. Although it was unclear which employee may have provided misinformation, the facility believes the termination of the employment of a receptionist may help prevent future misunderstandings at this particular facility. The Registrant's policies do not specifically address the permanent transfer of original films to the custody of patients. The Registrant is reviewing their policies for possible changes related to the release of original mammograms. To prevent a recurrence of similar complaints, the Registrant informed their front office and file room personnel of the regulations and their policies and procedures. The investigation determined the medical report had more than one overall final assessment of findings in violation of Agency regulations. The Registrant was cited for the violation.

File Closed.

C-1611- Regulation Violation - Robert B. KaviEFF, D.D.S. - Austin, Texas

On October 19, 2001, the Agency received an anonymous complaint alleging an x-ray unit was not collimated to the required limits and the facility had been cited for the same violation during the previous two Agency inspections. It was also alleged the technologist was not properly credentialed. An Agency investigation determined the x-ray unit had insufficient collimation.

However, the unit cited on the previous inspection was a different machine, therefore, not a repeat violation. The Registrant was cited for insufficient collimation and failure to perform equipment performance evaluations at the required four year interval. The allegation concerning the technologist was not substantiated.

File Closed.

C-1612 - Uncredentialed Technologists - Eastside Family Clinic - Beaumont, Texas

On October 23, 2001, the Agency received a complaint alleging the Registrant allowed uncredentialed technologists to perform radiographs. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1613 - Uncredentialed Technologist - Donna M. Boehme, M.D. - San Antonio, Texas

On October 29, 2001, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform radiographs and bone density studies. An Agency investigation determined the technologist in question was permitted to perform radiographs by the Texas State Board of Medical Examiners, under the physician's license, as a non-certified technician (NCT). The facility also had authorization from the Medical Radiologic Technologist Certification Program for a hardship exemption allowing the employment of a NCT through March 22, 2002.

File Closed.

C-1614 - Regulation Violations - Bharat Patel, M.D. - Webster, Texas

On October 30, 2001, the Agency received a complaint alleging the Licensee allowed patients, injected with radiopharmaceuticals, to go into unrestricted areas of a facility and expose others to radiation. An Agency investigation and inspection found no violations of Agency regulations. Some patients were allowed to visit with relatives in a reception area for five to ten minutes during the resting stage prior to stress testing or imaging. A few elderly and diabetic patients who were not allowed to eat the night before testing were allowed in the lunch area to obtain food. The presence of these individuals in the unrestricted areas did not violate Agency regulations.

File Closed.

C-1615 - Uncredentialed Technologist - Seven Oaks Women's Center - San Antonio, Texas

On October 30, 2001, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform bone densitometry studies. An Agency investigation determined that one operator performing bone densitometry was uncredentialed and had not been added to the facility's current hardship exemption. The Registrant was cited for the violation.

File Closed.

C-1616 - X-Ray Exposure - Glenn R. Felch Chiropractic - Dallas, Texas

On November 2, 2001, the Agency received an anonymous complaint against the Registrant. Additional information required to conduct the investigation was not available. No further action was taken.

File Closed.

C-1617 - Unregistered X-Ray Equipment - Cornerstone Mobile X-Ray - Wichita Falls, Texas

On November 8, 2001, the Agency received a complaint alleging the facility was providing mobile x-ray services without a Certificate of Registration. In addition, it was alleged the facility operator, a Medical Radiologic Technologist (MRT), was providing services from a fictitious radiology group, and the MRT may be providing medical reports from the x-rays taken by the unregistered x-ray service. An Agency investigation determined the provider of services was not registered with the Agency and had been providing services since May 2000. It was also determined the facility was interpreting its own x-rays and providing diagnostic medical information under provisions of medicare and medicaid. The facility became registered as a provider of services. Seven violations of Agency regulations were cited and Escalated Enforcement was recommended. Copies of the reports were provided to the MRT Program for possible violations under their regulations. Medicare and Medicaid was notified of possible fraud related to interpretation of x-rays taken by this facility.

File Closed.

C-1618 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1619 - Unauthorized Laser Exposure - Avalon Day Spa - Lubbock, Texas

On November 14, 2001, the Agency received an anonymous complaint alleging a Registrant's laser safety officer, also a licensed practitioner of the healing arts, was not prescribing or authorizing each laser procedure performed by the Registrant. An Agency investigation determined that procedures existed for the authorization of laser exposures. However, the records of this authorization were being maintained off site, in violation of Registration conditions. The facility was cited for: failure to perform annual examinations of protective eyewear; failure to perform annual surveys of the laser facility; and failure to possess applicable sections of Agency rules. Information from this inspection was forwarded to the Texas State Board of Medical Examiners for possible violations under that Agency's rules.

File Closed.

C-1620 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1621 - Unauthorized Laser Exposure - Marquis Management dba Laser Dynamics - Lubbock, Texas

On November 14, 2001, the Agency received an anonymous complaint alleging the Registrant's Medical Director did not authorize each laser procedure performed by the facility staff. An Agency investigation substantiated the allegation. The Medical Director, a licensed practitioner of the healing arts, did not authorize each procedure performed at the facility. In addition, the facility did not inspect laser eyewear annually to ensure the reliability of protective filters and did not perform required annual surveys of the facility. The Registrant was cited for these violations. Information from this inspection was forwarded to the Texas State Board of Medical Examiners for possible violations under that Agency's rules.

File Closed.

C-1622 - Regulation Violation - O'Sullivan Referral Radiology - Victoria, Texas

On November 21, 2001, the Agency received a complaint alleging a physician performed mammograms without a qualified mammography technologist to assist with positioning, compression, and quality control and assurance requirements. An Agency investigation was unable to substantiate the allegation. The investigation determined two qualified technologists were no longer employed at the facility after September 11, 2001. Another qualified technologist was hired to perform mammograms and remained at the facility from October 1-31, 2001. The physician employed technologists provided by a temporary agency beginning November 1, 2001. The quality control records indicated patients were cancelled on the dates when no qualified technologists were available. No evidence was found to show mammogram examinations were performed without qualified technologists.

File Closed.

C-1623 - Regulation Violations - Aberdeen Animal Hospital - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant does not use safety gear when x-raying animals held by employees of the clinic. It was also alleged the Registrant does not have nor use personnel monitoring devices and that inspections of lead aprons are not performed in accordance with Agency requirements. An Agency inspection determined the Registrant did have and use both personnel monitoring devices and lead aprons and gloves, and performed annual inspections of the aprons and gloves. The allegations were not substantiated.

File Closed.

C-1624 - Regulation Violation - Williams Animal Health Service - Katy, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging: the Registrant allowed employees to hold animals during radiographs without wearing protective clothing; personnel monitoring was not supplied to employees; and lead aprons were not checked annually for defects. A review of Agency records determined a routine inspection conducted at the facility noted no violations associated with the annual test of protective lead aprons, the utilization of protective clothing, nor with the use of personnel monitoring devices. The allegations were unsubstantiated.

File Closed.

C-1625 - Regulation Violations - Fry Road Animal Clinic - Katy, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant did not use aprons and gloves while holding animals for x-ray procedures. It was also alleged the veterinarian and employees do not have or use personnel dosimetry devices while performing radiographic procedures. An Agency investigation determined the facility used protective equipment while holding animals for x-rays and appropriate personnel had personnel monitoring devices. The allegations were not substantiated.

File Closed.

C-1626 - Regulation Violations - Telge Road Veterinary Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging: the Registrant allowed employees to hold animals during radiographs without wearing protective clothing; personnel monitoring for radiation exposures was not supplied to employees; and lead aprons were not checked annually for defects. A review of Agency records determined a routine inspection conducted at the facility noted no violations associated with the annual test of protective lead aprons, the utilization of protective clothing, nor with the use of personnel monitoring devices. The allegations were not substantiated.

File Closed.

C-1627 - Regulation Violations - Hearthstone Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant did not use aprons and gloves while holding animals for x-ray procedures. It was further alleged that employees are not trained in the use of available safety gear and the clinic does not provide personnel dosimetry. An Agency investigation determined the facility did have aprons and gloves and personnel dosimetry. All personnel who operate x-ray equipment are fully trained and facility operating and safety procedures detail procedures to be taken if holding of animals is required. All safety devices were fully serviceable and in use. However, no documentation could be found documenting the annual inspection of these safety devices. The facility was cited for failure to perform annual checks of protective devices. The other allegations were not substantiated.

File Closed.

C-1628 - Regulation Violations - Longenbaugh Veterinary Hospital, P.C. - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging: a Registrant allowed employees to hold animals during radiographs without wearing protective clothing; personnel monitoring was not supplied to employees; and lead aprons were not checked annually for defects. An Agency inspection at the facility noted no violations associated with the annual test of protective lead aprons, the utilization of protective clothing, or with the use of personnel monitoring devices. The allegations were not substantiated. The inspection determined the Registrant did not have documentation to show that a darkroom light leak test had been performed and an x-ray unit in use at the facility was not registered. The Registrant was cited for the violations.

File Closed.

C-1629 - Regulation Violations - Crossroads Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging an unregistered veterinary facility was operating x-ray equipment. The complaint also alleged the facility did not have safety aprons or gloves for use by staff when holding animals during radiographic procedures and did not provide personnel dosimetry for staff members taking radiographs. An investigation determined the facility was not registered and had been using x-ray equipment since 1997. It was determined, through a records check, that personnel monitoring had been in use since February 1997. The facility did provide protective aprons and gloves for use during x-ray exposures. However, the required annual inspection of these devices had not been performed. The Registrant was cited for the violations.

File Closed.

C-1630 - Regulation Violations - Copperfield Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant does not provide personnel dosimetry or lead aprons or gloves. An Agency inspection noted no violations of regulations regarding personnel dosimetry or lead aprons and gloves. The allegation was not substantiated.

File Closed.

C-1631 - Regulation Violations - Vet Pets - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging an unregistered veterinary facility was operating x-ray equipment and did not provide lead aprons and gloves or personnel dosimetry. An Agency investigation determined the facility was unregistered and using x-ray equipment. The facility provided lead aprons and gloves and personnel monitoring. The facility was cited for being unregistered.

File Closed.

C-1632 - Regulation Violations - Bear Creek Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging: the Registrant allowed employees to hold animals during radiographs without wearing lead aprons or gloves; personnel monitoring was not supplied to employees; and lead aprons were not checked annually for defects. An Agency investigation determined the Registrant provided lead aprons and gloves and personnel monitoring. Annual tests for defects in protective aprons and gloves were not performed. The Registrant was cited for the violation.

File Closed.

C-1633 - Regulation Violations - Kingsland Boulevard Animal Clinic - Katy, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant does not provide lead aprons and gloves or personnel monitoring. An Agency investigation did not substantiate the allegations.

File Closed.

C-1634 - Regulation Violations - Glencairn Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging: the Registrant allowed employees to hold animals during radiographs without wearing protective clothing; personnel monitoring was not provided to employees; and lead aprons were not checked annually for defects. An Agency inspection noted no violations associated with the annual test of protective lead aprons, the utilization of protective clothing, or with the use of personnel monitoring devices. The allegations were not substantiated.

File Closed.

C-1635 - Regulations Violations - Clay Road Animal Clinic - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging an unregistered veterinary facility was operating x-ray equipment. It was also alleged the facility did not provide lead aprons or gloves or personnel dosimetry. An Agency investigation determined the facility was unregistered and was using x-ray equipment and not providing personnel monitoring. The Registrant provided lead aprons and gloves. The facility was cited for being unregistered and for not providing personnel monitoring.

File Closed.

C-1636 - Regulation Violations - Katy Veterinary Clinic - Katy, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging the Registrant: allowed employees to hold animals during radiographs without wearing protective clothing; did not provide personnel dosimetry; and lead aprons were not checked annually for defects. An Agency inspection determined the Registrant provided lead aprons and gloves and personnel dosimetry. Annual tests for defects in lead aprons and gloves were not documented. Further, the operating and safety procedures were incomplete and there was no documentation to show darkroom light leak tests were performed. The Registrant was cited for the violations.

File Closed.

C-1637 - Regulation Violations - Tanner Lake Animal Hospital - Houston, Texas

On November 28, 2001, the Agency received an anonymous complaint alleging an unregistered veterinary facility was operating x-ray equipment. It was also alleged the facility did not provide lead aprons or gloves or personnel dosimetry. It was determined the facility was registered in February 2002. An Agency inspection noted no violation of regulations.

File Closed.

C-1638 - Regulation Violations - Manchester Tank & Equipment - Lubbock, Texas

On December 4, 2001, the Agency received an anonymous complaint alleging a radiographer performed a hand x-ray on another radiographer using a radiography camera. An Agency investigation determined that neither radiographer was on the premises at the time of the alleged incident. The complaint was not substantiated.

File Closed.

C-1639 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1640 - Regulation Violations - Speciality Pharmacy Services, Inc. - Temple, Texas

On December 10, 2001, the Agency received a complaint alleging that a non-pharmacist was performing duties as a pharmacist and documents and records for the period 1996-1998 were being forged to include the initials of a licensed pharmacist. An investigation, consisting of a detailed review of records and interviews with current and former employees, did not substantiate the allegations.

File Closed.

C-1641 - Uncredentialed Technologist - Rockport Lab Techs - Rockport, Texas

On November 12, 2001, the Agency received an anonymous complaint alleging an uncredentialed technologist performed radiographs while wearing the personnel monitoring badge assigned to another technologist at the facility. An Agency investigation determined the uncredentialed technologist only performed patient positioning for the physician while exposures were performed by a credentialed Limited Medical Radiologic Technologist (LMRT). During the investigation the Agency determined the Registrant failed to maintain records of credentialed operators at the authorized use location, and the facility Operating and Safety Procedures did not adequately address required credentialing of x-ray equipment operators. The facility was cited for the violations.

File Closed.

I-1642 - No Authorized Radiation Safety Officer - 21st Century Technology - Fort Worth, Texas

On October 11, 2001, the US Nuclear Regulatory Commission forwarded a complaint to the Agency alleging the Licensee did not have an authorized radiation safety officer. An Agency investigation substantiated the allegation. The Licensee was cited for the violation.

File Closed.

THIS PAGE IS INTENTIONALLY BLANK

INCIDENTS CLOSED SINCE THIRD QUARTER 2001

NO INCIDENTS WERE CLOSED SINCE THIRD QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

COMPLAINTS CLOSED SINCE THIRD QUARTER 2001

NO COMPLAINTS WERE CLOSED SINCE THIRD QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE FOURTH QUARTER 2001

NO HOSPITAL OVEREXPOSURE REPORTED DURING FOURTH QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING FOURTH QUARTER 2001

NO RADIOGRAPHY OVEREXPOSURE REPORTED DURING FOURTH QUARTER 2001

THIS PAGE IS INTENTIONALLY BLANK

APPENDIX C

ENFORCEMENT ACTIONS FOR THE FOURTH QUARTER 2001

Enforcement Conference: Kell West Regional Hospital - Wichita Falls, Texas - Mammography

On October 12, 2001, an Enforcement Conference was held with Kell West Regional Hospital, holder of Certificate of Mammography No. M00691. Kell West Regional Hospital representatives attending the conference were Mr. Tony German, C.E.O. and Ms. Connie Smith. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman), Thomas Cardwell and Jerry Cogburn and Ms. Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on June 21, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. The Registrant's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested a signed written commitment from the lead interpreting physician the quality assurance program will be reviewed monthly through March 2002. The review can return to a quarterly basis thereafter. This signed commitment shall be provided to the Agency within 30 days of the date of this Enforcement Conference.
2. The Registrant shall provide the Agency with a copy of the minutes from the Performance Improvement Committee meetings through March, 2002. This information shall be provided to the Agency within 30 days of each meeting.
3. The Registrant shall provide a policy to the Agency on how the Performance Improvement Committee shall oversee the responsibilities of the mammography lead interpreting physician. This policy shall be provided to the Agency within 30 days of the date of this Enforcement Conference.

4. The Registrant's Performance Improvement Committee shall review the qualifications of all regulated mammography personnel at intervals not to exceed six months, beginning December 1, 2001. This will be confirmed by the Agency inspector at the next on-site inspection.
5. The Registrant shall provide proof of the analysis of the medical outcomes data by the lead interpreting physician and documentation the analysis has been reviewed with each interpreting physician. This shall be provided to the Agency within 30 days of the date of this Enforcement Conference.
6. The Registrant shall provide a copy of the infection control policy to the Agency within 30 days of the date of this Enforcement Conference.
7. The Registrant will be placed on an increased inspection frequency.
8. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

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

Enforcement Conference: Texas Department of Transportation - Austin, Texas - Nuclear Gauge

On November 6, 2001, an Enforcement Conference was held with The Texas Department of Transportation, holder of License No. L00197. The Texas Department of Transportation representatives attending the conference were Messrs. Timothy Owen, Richard Williammee, Jeff Seiders, Joe Canfield, and Alan Easterling. Agency representatives attending the conference were Messrs. Bob Green (Chairman), Rick Muñoz, Michael Dunn and Ruben Cortez and Ms. Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on May 16, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Cathy McGuire reviewed the violations, and the responses to the violations. The Licensee's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Licensee's representatives were excused while the Agency representatives held a caucus. During the caucus the following was determined:

1. Radioactive material shall not be stored at any Licensee's office until it has been designated as an authorized storage site on the license.
2. The Licensee shall provide standard operating procedure training for employees that are District NSOs, submit a syllabus of training specific to their operating procedures, and maintain records of this training for review by the Agency.
3. The Licensee shall provide the Agency with an organizational chart for Radiation Safety Authority showing chain-of-command.
4. The Licensee shall provide the Agency with the maximum length of time a gauge can be stored at a construction site within 60 days of the date of this Enforcement Conference.
5. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

After the caucus, the Licensee's representatives returned to the conference room and were informed of the items discussed during the caucus. The Licensee requested that following any inspection a conference call be made to include the Agency's inspector, the District RSO and Joe Canfield, or his alternate, to allow all parties to discuss the inspection findings. This is agreeable with the Agency, provided the request for a conference call is made during the inspection. The Licensee's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Skin Technology, Inc., Irving, Texas - Laser

On November 11, 2001, an Enforcement Conference was held with Skin Technology, Inc., holder of Laser Registration No. Z01496. The Skin Technology, Inc. representative attending the conference was Ms. Sherry Smith. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman), and Thomas Cardwell and Madames June Ayers, Chrissie Toungate and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility investigation conducted on June 7, 11, 21, and 22, 2001. These inspections determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. June Ayers reviewed the violations, and the responses to the violations. The Registrant's representative responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. The Registrant voluntarily requested termination of the facility's laser registration and agreed this would be requested within 30 days of the date of the Enforcement Conference. The Registrant shall provided a statement to the Agency agreeing she will never register any laser equipment under her name with this Agency. The Registrant's representative agreed to these items and the conference was concluded.

Enforcement Conference: South Texas Medical Clinics, P.A., Wharton, Texas - Mammography

On December 4, 2001, an Enforcement Conference was held with South Texas Medical Clinics, P.A., holder of Mammography Certification No. M00305. The South Texas Medical Clinics, P.A. representative attending the conference was Ms. Amy Schoppe. Agency representatives attending the conference were Messrs. Jerry Cogburn (Chairman), and Jack England and Madames Jo Turkette and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspections conducted on May 2, 2001 and August 8, 2001. These inspections determined the number and severity level and repetitiveness of the violations noted during these inspections have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jack England reviewed the violations, and the responses to the violation. The Registrant's representative responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant shall provide a written policy to the Agency entailing what circumstances would cause the facility to suspend mammography operations. This policy shall also include a signature sheet indicating the policy has been read and understood by each person affiliated with mammography operations. The policy shall be submitted to the Agency within 30 days of the date of this Enforcement Conference.
2. The Registrant shall provide a written commitment from Dr. Montoya indicating she will perform quarterly quality control reviews. This shall be provided to the Agency within 30 days of the date of this Enforcement Conference and will be reviewed at the next Agency inspection.
3. The inspection frequency will be increased for both the Wharton and Bay City locations.
4. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

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

Enforcement Conference: Giles Engineering Associates, Inc. - Dallas, Texas - Gauge

On December 12, 2001, an Enforcement Conference was held with Giles Engineering Associates, Inc., holder of License No. L04919. Giles Engineering Associates, Inc. representatives attending the conference were Messrs. Douglas Dayton, Randy Harvey, Andrew Gonzales and Charlie Gresser. Agency representatives attending the conference were Messrs. William Silva (Chairman), Ruben Cortez and Bob Green and Ms. Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on May 17, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Bob Green reviewed the violations and the responses to the violations. The Licensee's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The inspection frequency will be increased and the inspections will be unannounced.
2. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

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

Enforcement Conference: Grapevine Imaging & Pain Management - Grapevine, Texas - Mammography

On December 11, 2001, an Enforcement Conference was held with Grapevine Imaging & Pain Management, holder of Certificate of Mammography No. M00724. The Grapevine Imaging & Pain Management representative attending the conference was Ms. Angie Colbert. Agency representatives attending the conference were Messrs. Thomas Cardwell (Chairman), and Mr. Jerry Cogburn and Madames Shirley Gerber, Jo Turkette and Cathy McGuire.

The purpose and the procedures of conducting the Conference were explained. The conference was held as a result of a facility inspection conducted on September 20, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. The Registrant's representative responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested a revised lay letter be submitted to the Agency for review within 30 days of the date of this Enforcement Conference.
2. The Registrant shall provide all necessary information to the Agency, required to add Dr. Waters to their registration as the lead interpreting physician, within 30 days of the date of this Enforcement Conference.
4. The Registrant shall contact by letter the patient who was imaged on January 19, 2001, to return for a new mammogram.
5. An amended Notice of Violation will be sent to the Registrant that will include an addition violation citing the facility for failure to add Dr. Timothy P. Sullivan, M.D., and Dr. Gustavo L. Isuani, M.D. to the Registration 30 days prior to the time they began reading mammograms.
6. The Registrant's President and the Lead Interpreting Physician shall review quality control on a monthly basis for the next 12 months. Documentation shall be provided for inspector review at the time of the next inspection.
7. The Registrant's inspection frequency will be increased and will be unannounced.

8. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level 1, 2, or repeat violations are cited.

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