

REDACTED - 8/2003

SUMMARY OF INCIDENTS FOR FIRST QUARTER 1998

I-7245 - Badge Overexposure - Methodist Hospital - Lubbock, Texas

On December 22, 1997, the Licensee notified the Agency of a 127.79 rem extremity exposure to a technician during the November 1997 reporting period. An Agency investigation determined the exposure was only to the ring badge. A deletion was granted and an assessment of 250 millirems, based on co-worker exposure, was accepted.

File Closed.

I-7246 - Radioactive Material Lost - Baylor College of Medicine - Houston, Texas

On January 15, 1998, the Licensee notified the Agency that 1.0 millicurie of sulfur-35 was lost on January 14, 1998. The Licensee determined that laboratory personnel did not remove the radioactive material from its original packaging. Housekeeping picked up the package and forwarded it to a styrofoam recycling center. The Licensee was cited for failure to maintain control of radioactive material. Attempts to recover the radioactive material were unsuccessful. To prevent a recurrence, the Licensee retrained delivery personnel on the proper receipt of radioactive material.

File Closed.

I-7247 - Dose Irregularity - The Methodist Hospital/Mallinckrodt - Houston, Texas

On January 7, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on December 22, 1997. The biological distribution of the dose was not as expected. The manufacturer of the [REDACTED] was notified and was sent examples of images obtained. The altered biological distribution had been previously observed by other facilities. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7248 - Dose Irregularity - The Methodist Hospital/Syncor - Houston, Texas

On January 13, 1998, the Licensee notified the Agency of a dose irregularity that occurred on January 12, 1998. A patient was

injected with [REDACTED] instead of the intended [REDACTED]. The pharmacist assumed the order was for [REDACTED] because the hospital rarely orders [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacist was instructed to read labels and to verify orders and not to make assumptions.

File Closed.

I-7249 - Dose Irregularity - Columbia Hospital at Medical City Dallas/Syncor - Dallas, Texas

On January 12, 1998, the Licensee notified the Agency of a dose irregularity that occurred on January 7, 1998. A patient was injected with [REDACTED] instead of the intended [REDACTED]. The pharmacist drew the prescription from the wrong vial. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The hospital was cited for not reporting the dose irregularity within 30 days. To prevent a recurrence, the pharmacist was counseled to use only one kit at a time in the drawing station.

File Closed.

I-7250 - Overexposure - Radiation Technology, Inc. - Austin, Texas

On January 21, 1998, the Licensee notified the Agency of a 13.342 rem whole body exposure to a gauge installer during the October 1, 1997 to December 31, 1997 reporting period. The installer received the exposure while exchanging a two curie cobalt-60 source from a gauge. The source head was defective and the opening had to be filed smooth. The exposure occurred during this operation. The Licensee was cited for allowing an individual to receive exposures greater than the annual regulatory limits. To prevent a recurrence, the Licensee will use shielding to protect the installer in a similar situation.

File Closed.

I-7251 - Dose Irregularity - Radiology Associates/Syncor - Fort Worth, Texas

On January 19, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on January 13, 1998. The biological distribution of the dose was not as expected. All other doses from the same lot showed biological distributions as expected. The Pharmacy stated the vial may not have been properly sealed allowing air or moisture into the vial which could have caused the problem. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7252 - Unauthorized Disposal of Radioactive Material - McAllen Medical Center - McAllen, Texas

On January 23, 1998, a landfill notified the Agency of elevated radiation levels on a load of waste received on January 23, 1998. The medical center retrieved the radioactive part of the waste and determined the radioactive material was iodine-131. The radioactive material was returned to the hospital for decay. The remaining waste was buried by the landfill. An Agency investigation determined that the Licensee failed to store contaminated articles in storage until radioactive material had decayed to background levels; created an exposure in an unrestricted area that exceeded regulatory limits; failed to perform surveys of radioactive material prior to disposal; and transferred radioactive material other than authorized by regulation. The Licensee was cited for the violations.

File Closed.

I-7253 - Misadministration - Good Shepherd Medical Center - Longview, Texas

On January 29, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] that occurred on January 23, 1998. The wrong patient was [REDACTED] with the dose due to the clerical staff writing orders on the wrong patient's chart. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee instructed clerical staff to be more attentive when identifying patients with multiple procedures. Staff technologists reviewed quality assurance policy for confirming physician's orders and for injecting patients.

File Closed.

I-7254 - Uranium Spill - URI, Inc. - Kingsville, Texas

On January 22, 1998, the Licensee notified the Agency of a uranium spill involving 15,000 gallons of mine solution fluid containing 35 parts per million uranium that occurred on January 22, 1998. The spill occurred along an extraction line and was contained within the licensed area.

File Closed.

I-7255 - Laser Burn - Lucite Technologies, Inc. - Mesquite, Texas

On January 30, 1998, the Registrant notified the Agency of a laser burn to an employee's finger that occurred on January 17, 1998. The operator failed to turn off the power to the laser before starting the cleaning process. The burn completely healed. An Agency investigation determined the Registrant removed safety features designed to prevent exposure to laser operators and failed to install the laser in a controlled area. Also, the laser operator failed to immediately notify the Laser Safety Officer after receiving a laser burn injury. The Registrant was cited for the violations. To prevent a recurrence, the Registrant installed a revised sign to remind operators to turn off the power before cleaning, trained operators on wearing gloves during cleaning, and is seeking a different type of sensor to activate the laser. Also see complaint #1291.

File Closed.

I-7256 - Badge Overexposure - Baylor University Medical Center - Dallas, Texas

On January 22, 1998, the Registrant notified the Agency of a 10.78 rem exposure to a doctor during the November 1997 reporting period. An Agency investigation determined the film was incorrectly loaded in the badge. The individual worked with low energy x-rays only and the dose was based on high energy calculations and not low energy x-ray calculations. A deletion was granted and an assessment of 770 millirems, based on low energy calculations, was accepted.

File Closed.

I-7257 - Dose Irregularities - St. Elizabeth Hospital/Central Pharmacy Services - Beaumont/Orange, Texas

On January 19, 1998, the Licensee notified the Agency of several dose irregularities that occurred between November 20, 1997 and January 2, 1998. The Agency is investigating the incident.

File Open.

I-7258 - Overexpose - METCO, Inc. - Beaumont, Texas

On January 28, 1998, the Licensee notified the Agency of a 9.0 rem exposure to an industrial radiographer that occurred during the December 1997 reporting period. An Agency investigation could not determine that the exposure was only to the badge. The Licensee was cited for permitting an individual to receive radiation exposures greater than annual regulatory limits.

File Closed.

I-7259 - Badge Overexposure - North Houston Medical Center - Houston, Texas

On January 12, 1998, the Registrant notified the Agency of a 6.76 rem exposure to an x-ray technician during the August 1, 1997 to August 31, 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7260 - Uranium Spill - Cogema Mining, Inc. - Bruni, Texas

On February 5, 1998, the Licensee notified the Agency of a uranium spill involving 2500 gallons of disposal well fluid containing 7.2 parts per million uranium that occurred on February 4, 1998. The spill occurred at a waste retention pond transfer pump and was contained in the licensed area.

File Closed.

I-7261 - Dose Irregularity - Southwestern Medical Center/Syncor - Dallas, Texas

On January 23, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on January 20, 1998. The pharmacy inadvertently shipped [REDACTED] to the wrong hospital. The intended shipment of [REDACTED] went to another hospital and was not injected. The patient was [REDACTED] and the biological distribution was [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy counseled staff on packing boxes for delivery and the hospital staff was counseled on reading labels before injecting patients.

File Closed.

I-7262 - Dose Irregularity - Huebner Medical Center/Syncor - San Antonio, Texas

On February 2, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on January 30, 1998. The pharmacy inadvertently dispensed [REDACTED] instead of [REDACTED]. The label on the dose indicated the content was [REDACTED]. A patient was [REDACTED] and the biological distribution was [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy counseled pharmacists to verify prescriptions before dispensing.

File Closed.

I-7263 - Misadministration - Ben Taub General Hospital - Houston, Texas

On February 3, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] and [REDACTED] that occurred on January 29, 1998. The wrong patient was [REDACTED] with the dose when the technician failed to follow patient identification procedures. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled the technician and conducted an in service reviewing patient identification procedures.

File Closed.

I-7264 - Stolen Moisture/Density Gauge - Associated Testing Laboratories - Houston, Texas

On January 5, 1998, the Licensee notified the Agency of the theft of a moisture/density gauge containing a 6.5 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was stolen from the back of a pickup truck at an apartment complex. The lock had been cut from the chain securing the gauge. The Licensee notified the local police. The Licensee was cited for the loss of control of radioactive material. The gauge has not been recovered.

File Inactive.

I-7265 - Unauthorized Disposal - USAF Radioisotope Committee - San Antonio, Texas

On February 2, 1998, the NRC notified the Agency that a NRC Licensee had inadvertently discarded a box of radioactive biomedical waste containing 13 microcuries of iodine-125 on January 16, 1998. The material has not been recovered and the Licensee believes the waste has been incinerated by the waste contractor.

File Closed.

I-7266 - Radioactive Material Found - Dan Murphy - Dallas, Texas

On February 12, 1998, a member of the public notified the Agency he had found a radioactive source in a cabinet he had purchased. The source was reportedly labeled as 0.35 curies of tritium. An Agency investigation determined the source was a generally licensed tritium source. The source was wipe tested with no contamination detected. The source was transferred to the Agency for appropriate disposal.

File Closed.

I-7267 - Misadministration - All Saints Episcopal Hospital - Fort Worth, Texas

On February 9, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] that occurred on January 18, 1998. The patient was [REDACTED] with the dose due to the technician confusing the doctors order of a [REDACTED]. The order request is normally a [REDACTED], with a [REDACTED] normally for a [REDACTED]. The patient and referring physician were notified. The patient was given a [REDACTED] to [REDACTED]. The [REDACTED] was estimated at [REDACTED] and the [REDACTED] estimated at [REDACTED]. The patient was given the [REDACTED]. To prevent a recurrence, the Licensee improved procedures for scheduling and obtaining physician's written orders.

File Closed.

I-7268 - Radioactive Material Lost - Texas A&M University - College Station, Texas

On February 6, 1998, the Licensee notified the Agency of lost radioactive material involving 19.1 millicuries of krypton-85 gas that occurred between August 1997 and January 28, 1998. The gas was contained in a sealed carbonized glass ampule, over packed in a padded steel transport canister. A search by the Licensee did not locate the missing material. To prevent a recurrence, the Licensee counseled the staff on the importance of following procedures. The Licensee was cited for failure to maintain control of radioactive material.

File Closed.

I-7269 - Radioactive Material Lost - La Gloria Oil & Gas - Tyler, Texas

On February 20, 1998, the Licensee determined that a 500 millicurie level gauge source was missing from one of their units. An exhaustive search of the facility was performed by Licensee and Bureau of Radiation Control personnel. The source was not found. Two facilities, that had received coke from the Licensee between the last time the source was inventoried and the time it was discovered lost, were also surveyed. The source was not located. Railcars and trucks used to transport the coke to its users were then located and surveyed. Again the source was not found. The source is now believed to have been melted and vaporized, in one of the two facilities that used coke from the Licensee. The kilns operated at temperatures up to 2000 degrees Fahrenheit and vented through exhaust towers at up to 200,000 cubic feet per minute. The Licensee checked their other five gauges. Two were found to have broken or cracked welds and were replaced. The other three were intact and will be replaced as necessary. The Licensee changed their monitoring procedures to include visual inspections and surveys of the sources to insure they are intact.

File Closed.

I-7270 - Source Abandoned Downhole - Western Atlas International, Inc. - Houston, Texas

On February 17, 1998, the Licensee notified the Agency that a 2.0 curie cesium-137 source was abandoned downhole on February 10, 1998. Attempts to retrieve the source were unsuccessful. The source was abandoned at a depth of 6,410 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25TAC289.253.

File Closed.

I-7271 - Badge Overexposure - North Houston Medical Center - Houston, Texas

On February 12, 1998, the Registrant notified the Agency of a 38.16 rem exposure to an x-ray technician during the December 1, 1997 to December 31, 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7272 - Dose Irregularity - Coastal Cardiology Association/ Syncor - Corpus Christi, Texas

On February 9, 1998, the Licensee notified the Agency of a dose irregularity that occurred on February 6, 1998. A patient was injected with [REDACTED] instead of the intended [REDACTED]. The pharmacist drew the prescription from the wrong vial. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy staff was counseled on verifying the doses when setting up and at the time of filling.

File Closed.

I-7273 - Dose Irregularity - Trinity Medical Center/Mallinckrodt - Carrollton/Dallas, Texas

On February 9, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED], that occurred on February 5, 1998. The biological distribution of the dose was [REDACTED]. The Licensee believes the cause could be purely patient related. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7274 - Radioactive Material in Scrap - Structural Metals, Inc./ Gary Wilkinson Iron and Metals - Sequin/Laredo, Texas

On February 26, 1998, the scrap yard notified the Agency that radioactive material was found in a bundle of scrap metal. An Agency investigation determined the material was a piece of NORM pipe reading 90 microrem per hour. The Agency explained to the company the authorization for storage and possession of NORM under a general license.

File Closed.

I-7275 - Radioactive Material Found - Dell Johnson - Waco, Texas

On February 25, 1998, a member of the public notified the Agency that she was in possession of radioactive material that her husband had used in his medical practice. An Agency investigation determined that the radioactive material was approximately 60 millicuries of radium-226 that was used in a nasal applicator. The material was stored in a shielded container in the garage and the container had radiation levels of 600 millirem per hour on contact. Swipes of the container and surrounding area showed no radioactive contamination. The Agency secured the material in a large shielded container and returned it to the Agency for storage and eventual disposal.

File Closed.

I-7276 - Radioactive Material at Landfill - BFI Waste Systems - San Antonio, Texas

On March 6, 1998, a landfill administrator notified the Agency that a garbage truck activated a radiation detector at the landfill on March 6, 1998. An Agency investigation found several disposable diapers containing iodine-131. The diapers were separated from the garbage and allowed to be buried due to the short half life of iodine-131.

File Closed.

I-7277 - Unauthorized Disposal of Radioactive Material - Brackenridge Hospital/BFI - Austin, Texas

On March 20, 1998, a landfill notified the Agency of elevated radiation levels on a dumpster received on March 20, 1998. The hospital retrieved the waste and returned it to the hospital for decay-in-storage. An Agency investigation determined that the Licensee failed to store contaminated articles in storage until radioactive material had decayed to background levels; failed to perform surveys prior to disposal; and transferred radioactive material other than authorized by regulation. The Licensee was cited for the violations.

File Closed.

I-7278 - Radioactive Material Lost - MD Anderson Cancer Center - Houston, Texas

On February 6, 1998, the Licensee notified the Agency that 150 microcuries of phosphorus-32 was unaccounted for on January 12, 1998. The Licensee's attempts to locate the radioactive material were unsuccessful. The Licensee was cited for failure to maintain control of radioactive material. The Licensee believes no individuals were exposed to radiation due to the missing radioactive material. To prevent a recurrence, the Licensee improved its storage and security of radioactive material.

File Closed.

I-7279 - Dose Irregularity - University Medical Center/Syncor - Lubbock, Texas

On March 13, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on March 11, 1998. The pharmacist failed to dispense [REDACTED] into the prescription causing the [REDACTED] in the patient. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, only one dispensing vial will be allowed in the drawing station and the elution vials will be kept away from the dispensing area.

File Closed.

I-7280 - Dose Irregularity - St. Michael Health Care Center - Texarkana, Texas

On March 10, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on March 4, 1998. A patient was injected with [REDACTED] instead of [REDACTED]. The nuclear medicine technician failed to follow label verification procedures. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the technician was counseled and retrained on checking vials twice before injecting patients.

File Closed.

I-7281 - Fire Involving Radioactive Material - Exxon Company - Baytown, Texas

On March 24, 1998, the Licensee notified the Agency of a fire involving two x-ray fluorescence analyzers; one containing a 45 millicurie iron-55 source, a 5 millicurie cadmium-109 source and a 5 microcurie americium-241 source, and the other containing a 45 millicurie iron-55 source and a 5 millicurie cadmium-109 source; that occurred on February 22, 1998. Radiation levels were monitored during firefighting efforts and no levels above background were detected. After removing the analyzers from the debris, a survey of the area indicated some contamination. The charcoal debris was placed in a 55-gallon drum and stored in the Licensee's radioactive materials storage building. The two analyzers were sent back to the manufacturer and leak tests results were less than 0.05 microcuries.

File Closed.

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## COMPLAINT SUMMARY FOR FIRST QUARTER 1998

### C-1285 - Exposure to the Public - All Metals Processing - Houston, Texas

On December 15, 1997, the Agency received a complaint alleging a metal's worker had been contaminated with radiation while performing water soda blasting of metal during September 1997. An Agency investigation determined that radiation levels were below regulatory limits, respiratory protection and protective clothing were worn while performing water soda blasting, and that the individual's clothing was not contaminated.

File Closed.

### C-1286 - Regulation Violations - Parkview Regional Hospital - Mexia, Texas

On January 8, 1998, the Agency received an anonymous complaint alleging a Registrant failed to perform quality control tests on mammography machines. An Agency investigation determined that the supervising physician and radiation safety officer failed to perform required tasks, the Registrant failed to perform and document an on-going quality assurance program; failed to have a completed technique chart in place; failed to initiate corrective action within 30 days after quality control tests indicated non-compliance; failed to utilize identical technique settings; failed to ensure collimation of the mammography unit; failed to notify the Agency, within 30 days, of the change in interpreting physicians and operators; failed to provide documentation of qualifications for interpreting physicians; and failed to provide documentation of qualifications of mammography unit operators. The Registrant was cited for the violations. A cease and desist order was issued. Upon achieving regulatory compliance, the cease and desist order was rescinded.

File Closed.

C-1287 - Regulation Violations - GCT Inspection - South Houston, Texas

On December 15, 1997, the Agency received an anonymous complaint alleging the Licensee failed to perform field audits, allowed an employee to wear an expired film badge, and allowed radiographic operations to be performed with an exposure device that wouldn't lock in the secured position. An Agency investigation determined that the Licensee permitted performance of radiographic operations at temporary job sites without, as a minimum, two radiographers or, alternatively a radiographer trainer and a radiographer trainee or radiographer; and failed to maintain a record of storage container surveys. The Licensee was cited for the violations. The Agency was unable to substantiate the other allegations.

File Closed.

C-1288 - Failure to Perform Calibration - South Austin Cancer Center - Austin, Texas

On January 7, 1998, the Agency received an anonymous complaint alleging the Registrant failed to calibrate a linear accelerator after replacing the ion chamber in September 1997. An Agency investigation determined an ion chamber was replaced in October 1997 and was calibrated the same day.

File Closed.

C-1289 - Unregistered X-Ray Equipment - Webb County Jail - Laredo, Texas

On January 21, 1998, the Agency received an anonymous complaint alleging a doctor was performing medical radiography with an unregistered x-ray unit. An Agency investigation determined the x-ray equipment was not registered within 30 days of commencement of operation. The doctor registered the x-ray equipment and he was cited for the violation.

File Closed.

C-1290 - Regulation Violations - Superior Inspection & Technology - Barker, Texas

On January 5, 1998, the Agency received an anonymous complaint alleging a Licensee was storing industrial radiography cameras overnight at an unauthorized location and that radiography was being performed at field locations without barriers, posting, personnel dosimetry, and surveys. An Agency field inspection of the radiography field location noted no violations and an investigation of the alleged unauthorized storage location indicated no storage of radiographic sources.

File Closed.

C-1291 - Regulation Violations - Lucent Technologies, Inc. - Mesquite, Texas

On January 27, 1998, the Agency received a complaint alleging the Registrant operated laser equipment in an uncontrolled area, that the on/off mechanism was wired to a contact sensor, and that the housing and safety interlocks had been removed resulting in a laser burn to an employee on January 17, 1997. An Agency investigation determined that the operator did not turn the power off to the laser prior to cleaning and the operator did not notify the Laser Safety Officer of the laser burn. The burn completely healed. The Registrant was cited for the procedure violations. See incident #7255.

File Closed.

C-1292 - Radioactive Material Contamination - Port of Beaumont - Beaumont, Texas

On January 14, 1998, the Agency received a complaint alleging the port was receiving radioactive metal railroad rails from Russia. An Agency investigation determined the railroad rails had properly cleared customs and had been shipped on to another site. A survey of the area determined no signs of radioactive contamination.

File Closed.

C-1293 - Regulation Violations - Accident and Back Pain Center - Ft. Worth, Texas

On January 21, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed technologists to perform medical radiography; failed to provide personnel monitoring devices; failed to post radiation area signs; and failed to provide lead aprons. An Agency investigation determined the Registrant allowed an uncredentialed technologist to perform medical radiography; failed to provide a written copy of operating and safety procedures; failed to document or implement a radiation protection program; failed to perform preventive maintenance on x-ray equipment; failed to perform quality assurance testing since 1996; failed to provide personnel monitoring; failed to perform a general public survey; and failed to post the x-ray room with a caution radiation area sign. The Registrant was cited for the violations.

File Closed.

C-1294 - Regulation Violations - Animal Clinic - El Paso, Texas

On December 15, 1998, the Agency received a complaint alleging the Registrant failed to post a technique chart; allowed minors to operate x-ray machines; and allowed a technician to hold an x-ray patient without a lead apron or personnel monitoring device. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1295 - Regulation Violations - Edward Tomaneng, M.D. - San Marcos, Texas

On January 30, 1998, the Agency received an anonymous complaint alleging the Registrant failed to provide personnel monitoring devices for three years, failed to check the output of the x-ray unit, and allowed uncredentialed technologists to perform medical radiography. An Agency investigation determined that records of annual tests to determine adequacy of protective aprons were not available. The Registrant was cited for the violation. The Agency was unable to substantiate the original complaint.

File Closed.

C-1296 - Unregistered Mammography Equipment - Crystal Women's Foundation/Texas Mobile Health - Houston, Texas

On February 12, 1998, the Agency received an anonymous complaint alleging the Registrant was operating out of an unregistered mobile mammography van and that the Registrant was running quality control films for each month in one day. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1297 - Uncredentialed Technician - Conroe Regional Medical Center - Conroe, Texas

On February 17, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed Registered Nurses to perform fluoroscopic x-ray procedures. The complaint was forwarded to the Texas Department of Health, Professional Licensing & Certification Division for appropriate action.

File Closed.

C-1298 - Uncredentialed Technician - Spring Branch Medical Center - Houston, Texas

On February 17, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed Registered Nurses to perform fluoroscopic x-ray procedures. The complaint was forwarded to the Texas Department of Health, Professional Licensing & Certification Division for appropriate action.

File Closed.

C-1299 - Failure to Provide Personnel Monitoring - Integrated Health Services - Houston, Texas

On February 17, 1998, the Agency received a complaint alleging the Registrant refused to provide personnel monitoring from November 1997 through January 1998. An Agency investigation determined the Registrant failed to provide personnel monitoring to an employee who could possibly receive an occupational exposure in excess of ten percent of the regulatory limits. The Registrant was cited for the violation.

File Closed.

C-1300 - Uncredentialed Technician - West Houston Heart Center - Houston, Texas

On February 18, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed Registered Nurses to perform fluoroscopic x-ray procedures. The complaint was forwarded to the Texas Department of Health, Professional Licensing & Certification Division for appropriate action.

File Closed.

C-1301 - Regulation Violations - Village Medical Center - Arlington, Texas

On February 20, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed technicians to perform medical radiography, failed to use protective equipment, and took excessive repeat radiographs. An Agency investigation included interviews and a review of records. The Agency was unable to substantiate the allegations.

File Closed.

C-1302 - Regulation Violations - X-Ray Service Source - Richardson, Texas

On February 24, 1998, the Agency received a complaint alleging the Registrant violated regulations in the practice of x-ray machine calibration during October 1997. An Agency investigation was unable to substantiate the allegations. The complaint was forwarded to the Texas Department of Health, Professional Licensing and Certification Division.

File Closed.

C-1303 - Regulation Violations - Imaging Dynamics - Dallas, Texas

On March 3, 1998, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform medical radiography; failed to have a radiation safety officer; and failed to notify the Agency of the change of office address. An Agency investigation failed to substantiate the allegations.

File Closed.

C-1304 - Unauthorized Disposal - University of Texas, El Paso - El Paso, Texas

On March 3, 1998, the Agency received a complaint alleging the Licensee burned tritium in an incinerator causing a health hazard on January 7, 1998. An Agency investigation determined that the incinerator malfunctioned while burning waste containing 0.1 millicuries of tritium (below exempt quantity). Smoke escaped through the front door of the incinerator setting off alarms. Wipe tests were performed near the incinerator door and low levels of contamination were identified. The Licensee cleaned the contamination before allowing incinerator maintenance personnel to enter. The incinerator was repaired and no further problems were encountered.

File Closed.

C-1305 - Radioactive Material Contamination - Isotag Specialists, Inc. - Midland, Texas

On March 11, 1998, the Agency received an anonymous complaint alleging the Licensee failed to follow procedures while performing oil well tracer study screenouts. An Agency investigation included interviews and a review of records and determined no unusual screenouts had occurred. The Agency was unable to substantiate the allegations.

File Closed.

C-1306 - Regulation Violations - Accident and Wellness Chiropractic - Dallas, Texas

On March 10, 1998, the Agency received a complaint alleging the Registrant was using an x-ray machine that failed compliance tests on patient x-ray examinations. An Agency investigation determined the Registrant failed to monitor the occupational exposure to radiation of an employee; failed to perform film processing quality assurance tests; failed to perform surveys of radiation levels in unrestricted areas to demonstrate compliance with dose limits for members of the public; failed to develop, document, and implement a radiation protection program; failed to make available a written copy of the operating and safety procedures; and used an x-ray machine on patient examinations that failed compliance testing. The Registrant was cited for the violations.

File Closed.

C-1307 - Regulation Violations - Hendrick Medical Center - Abilene, Texas

On March 16, 1998, the Agency received a complaint alleging the Licensee falsified records with regards to radiation surveys and wipe tests, failed to use syringe shields, and allowed an uncredentialed technologists to perform nuclear medicine. An Agency investigation determined that radiation surveys and wipe tests were not being performed and recorded and that syringe shields were not being used by nuclear medicine technicians. The Licensee was cited for the violations. The Agency was unable to substantiate the allegations of uncredentialed technologists.

File Closed.

**INCIDENTS CLOSED SINCE FOURTH QUARTER 1997**

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COMPLAINTS CLOSED SINCE FOURTH QUARTER 1997

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES  
REPORTED DURING FIRST QUARTER 1998

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APPENDIX B

SUMMARY OF RADIOGRAPHER OVEREXPOSURES  
REPORTED DURING FIRST QUARTER 1998

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## APPENDIX C

### ENFORCEMENT ACTIONS FOR FIRST QUARTER 1998

#### Enforcement Conference: Dolly Vinsant Memorial Hospital, San Benito, Texas - Mammography

On January 8, 1998, an Enforcement Conference was conducted to discuss an inspection performed at the Licensee's facility which identified two Severity Level I violations and one Severity Level II violation. In addition, numerous other violations of the Texas Regulations for Control of Radiation (TRCR) were noted. The violations included: failure to use only qualified physicians for the interpretation of mammographic images; failure to have only qualified operators of mammographic equipment perform mammography; failure to cease performing mammography after their Certificate of Mammography Systems had expired; failure to cease clinical image processing when analysis of quality control tests indicated the limits of the TRCR were exceeded; failure to perform quality control items at the correct time intervals; failure to ensure the collimation of the mammographic unit was adequate; failure to ensure the chest wall edge of the compression paddle of the mammographic unit was aligned with the chest wall edge of the image receptor as required; failure to provide documentation of qualifications of a physician who interpreted mammograms; and failure to notify the Agency within 30 days of a change in radiation safety officer, supervising physician and interpreting physician. The Agency issued an Emergency Cease and Desist Order to this facility on October 2, 1997. After the Conference, the Agency required the Registrant to have their machine serviced for adequate collimation and proper compression paddle alignment and provide copies of the service report to the Agency; provide an additional response as to why mammography was performed after the certification had expired; and provide additional responses to other violations noted during the inspection. The Registrant must also notify all affected patients of the failure to use only qualified operators and all films interpreted by an unqualified interpreting physician must be read by a qualified interpreting physician and if discrepancies in the interpretation are noted, the patient(s) must be notified of the discrepancies and the failure to use a qualified interpreting physician. The Agency will also increase the number of unannounced inspections.

#### Enforcement Conference: IHS Geotech and CMT, San Antonio, Texas - Moisture Density Gauge

On January 13, 1998, an Enforcement Conference was conducted to discuss an investigation performed at the Licensee's facility which identified numerous violations, one of which was a Severity Level I violation and two Severity Level II violations of the Texas Regulations for Control of Radiation. In addition, the license had

expired and the Licensee failed to respond to the Agency's Notice of Violation and additional correspondence within the requested time frame. The more severe violations included: records not accurate and factual in that the utilization log had a gauge checked in and out during a time period in which the gauge was actually in the possession of the Texas Department of Health; failure to notify the Agency by telephone immediately upon knowing of the loss or theft of a portable moisture/density gauge; and radioactive material stored at a location not authorized on the license. The Agency required the licensee to divest themselves of radioactive material immediately and provide written notification of the transfer of radioactive material until a new license is issued by the Agency. The new license will be limited to four radioactive sources and the Licensee will be on an accelerated inspection schedule.

Enforcement Conference: Bellaire General Hospital, Houston, Texas - Mammography

On March 20, 1998, an Enforcement Conference was conducted to discuss an inspection performed at the Registrant's facility which identified numerous violations, one of which was a Severity Level I violation. In addition, three Severity Level II violations and two Severity Level IV violations of the Texas Regulations for Control of Radiation (TRCR) were noted. The more severe violations included: failure to maintain accurate and factual quality control records; failure to cease clinical image processing when quality control tests indicated the TRCR limits were exceeded; failure to initiate necessary corrective actions within 30 days after quality control tests indicated non-compliance; and failure to do processor performance evaluations on a daily basis. The Agency has reduced the inspection interval for this Registrant for at least the next year. In addition, the Registrant must commit to have a certified medical physicist review the mammography program every three months for a period of one year, provide proof of quality control training specific to mammography for a technologist prior to him/her performing quality control duties, and conduct patient notification for all patients affected between March 12, 1997, and September 11, 1997.

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| NOTE: Items within these summaries have been redacted (blackened out) due to confidential medical information under the Medical Practice Act and The Texas Public Information Act.

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