

REDACTED - 8/2003

**SUMMARY OF INCIDENTS FOR FOURTH QUARTER 1998**

I-7375 - Badge Overexposure - KingTool Company - Longview, Texas

On September 30, 1998, the Licensee notified the Agency of a 10.055 rem exposure to an industrial radiographer during the August 20, 1998, through September 19, 1998, reporting period. The Licensee conducted an inspection and believed the exposure was to the badge only. An Agency investigation concurred with their findings. A deletion was granted and an assessment of 81 millirems, based on co-worker exposure, was accepted.

File Closed.

I-7376 - Misadministration - Conroe Regional Medical Center - Conroe, Texas

On September 29, 1998, the Registrant notified the Agency of a misadministration involving a linear accelerator that occurred on September 8, 1998. A dose of [REDACTED] was administered to the wrong [REDACTED] of the patient. The patient and referring physician were informed. To prevent a recurrence, the Registrant counseled the technologists and reviewed radiation therapy treatment procedures.

File Closed.

I-7377 - Dose Irregularity - Southwest General Hospital - San Antonio, Texas

On October 5, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED], that occurred on September 10, 1998. The [REDACTED] patient during [REDACTED]. The [REDACTED] were [REDACTED] to the Licensee that [REDACTED] them. Dose calculations were performed for the three operating room personnel who came into contact with the [REDACTED]. None of the personnel received exposures greater than regulatory limits.

File Closed.

I-7378 - Radioactive Material Found at Landfill - BFI Landfill - San Antonio, Texas

On October 5, 1998, a landfill notified the Agency of elevated radiation levels on a trash truck that occurred on October 3, 1998. An Agency investigation determined that the trash was iodine-131 from a nuclear medicine patient, but was unable to determine the source. The landfill was allowed to dispose of the trash.

File Closed.

I-7379 - Dose Irregularity - Campbell Hospital - Weatherford, Texas

On October 6, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on October 5, 1998. The technician injected the patient with a [REDACTED] dose that was sitting next to the intended [REDACTED] dose on the counter. 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 on failure to follow procedures which included not having two doses on the counter at one time and verifying the dose before injecting patients.

File Closed.

I-7380 - Radioactive Material in Scrap - Structural Metals - Seguin, Texas

On October 9, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on September 26, 1998. The scrap yard determined the radioactive material to be a flow measurement device containing a 13.8 millicurie cobalt-60 source. The source was disposed of through a licensed disposal company.

File Closed.

I-7381 - Dose Irregularity - Sierra Medical Center - El Paso, Texas

On October 19, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on October 13, 1998. The patient was supposed to receive [REDACTED], but was administered the wrong dose. 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 procedure was properly completed the same day. To prevent a recurrence, the Licensee counseled the technician and reviewed the policy and procedures with all personnel.

File Closed.

I-7382 - Dose Irregularity - Hendrick Medical Center/National Central Pharmacy - Abilene, Texas

On October 22, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on October 16, 1998. Due to a communication error at the pharmacy, the dose was labeled as [REDACTED] but contained [REDACTED] instead. 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 procedure was rescheduled for the patient. To prevent a recurrence, the pharmacy conducted an inservice on procedures and communication and instituted new procedures on the final label check.

File Closed.

I-7383 - Dose Irregularity - Plano Diagnostic Imaging Center/Mallinckrodt - Plano/Dallas, Texas

On October 19, 1998, the Licensee notified the Agency of a dose irregularity involving a [REDACTED] that occurred on September 28, 1998. The clinic originally ordered a [REDACTED] labeled [REDACTED] but caught the error before the patient was [REDACTED]. The patient was [REDACTED] with the [REDACTED]. To prevent a recurrence, the clinic counseled technicians on ordering radiopharmaceutical procedures.

File Closed.

I-7384 - Badge Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On November 11, 1998, the Licensee notified the Agency of a 13.21 rem exposure to an industrial radiographer during the September, 1998, monitoring period. The Licensee conducted an inspection and believed the exposure was to the badge only. An Agency investigation concurred with their findings. A deletion was granted and an assessment of 250 millirems, based on exposure history, was accepted.

File Closed.

I-7385 - Badge Overexposure - Seton Northwest Hospital - Austin, Texas

On October 19, 1998, the Registrant notified the Agency of a 23.521 rem exposure to an x-ray technician during the July 25, 1998, through August 24, 1998, reporting period. The Licensee conducted an inspection and believed the exposure was to the badge only. An Agency investigation concurred with their findings. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7386 - Lost Moisture/Density Gauge - Tolunay-Wong Engineers - Houston, Texas

On October 29, 1998, the Licensee notified the Agency of a lost moisture/density gauge containing a 10 millicurie cesium-137 sealed source and a 50 millicurie americium-241 sealed source that occurred on October 29, 1998. The gauge fell from the back of a truck during transportation. The Licensee notified the local police and filed a report. The gauge was found on November 5, 1998, by a member of the public. The gauge was intact and the sources were in the fully shielded position. No exposures greater than regulatory limits were received by the member of the public. Leak tests revealed no removable contamination. The Licensee was cited for loss of control of licensed radioactive material and was referred for escalated enforcement.

File Closed.

I-7387 - Misadministration - Providence Memorial Hospital - El Paso, Texas

On October 27, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] and [REDACTED] that occurred on October 26, 1998. The order from the referring physician was supposed to be a [REDACTED] and not a [REDACTED] procedure. The patient was [REDACTED] and received a [REDACTED]

[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. Because of the [REDACTED] of the patient and the handwritten order from the referring physician, the technologist performed the procedure he thought was ordered.

File Closed.

I-7388 - Dose Irregularity/Possible Exposure to Member of the Public - Corpus Christi Medical Center, Bay Area - Corpus Christi, Texas

On October 8, 1998, the Licensee notified the Agency of a dose irregularity and a possible exposure to a member of the public that occurred on September 21, 1998. A patient removed the [REDACTED] after [REDACTED]. The physician modified the [REDACTED] and the treatment continued as originally planned. During the procedure, a member of the public visited the patient and stayed for approximately five minutes within 50 centimeters of the implant area. The exposure to the member of the public did not exceed regulatory limits. To prevent a recurrence, the Licensee conducted an inservice to review appropriate visitation and brachytherapy patient procedures.

File Closed.

I-7389 - Leaking Sources - North Star Steel Texas - Beaumont, Texas

On October 28, 1998, the Licensee notified the Agency that two 2.3 millicurie cobalt-60 sealed sources were determined to be leaking on October 28, 1998. The removable contamination, which exceeded regulatory limits, consisted of 0.005 microcuries from one of the two sources. The manufacturer and a consultant were notified for assistance. The consultant confirmed that the two sources were leaking and that the source rods had contaminated the mold housings and the storage housings. Additional surveys determined the contamination was confined to the inside of the housings. The mold and storage housings were decontaminated and the leaking sources were taken out of service and prepared for disposal.

File Closed.

I-7390 - Laser Equipment Malfunction - Lucent Technologies - Mesquite, Texas

On October 30, 1998, the Registrant notified the Agency of a laser equipment malfunction that occurred on October 27, 1998. When the operator placed a new product on the laser marking machine, a pressure switch had failed to release and resulted in the laser being powered. The operator felt a tingle to the finger but no injury occurred. The operator failed to follow procedures by not verifying that the laser was not powered. The laser was removed from operation, was serviced, and the sticking switch was repaired. To prevent a recurrence, the pressure switch will be checked daily for proper operation.

File Closed.

I-7391 - Exposure to Member of the Public - Sterling Chemicals, Inc. - Texas City, Texas

On October 19, 1998, the Licensee notified the Agency of an exposure to two members of the public that occurred on October 17, 1998. Two contract employees entered a vessel although an eight millicurie cesium-137 sealed source had not been returned to the shielded position in the gauge. Calculations and reenactments determined that the worst possible exposure to one of the individuals was 95 millirem. Exposures did not exceed regulatory limits for members of the public. The area supervisor failed to notify the radiation safety officer to ensure all sources were fully shielded prior to the two contractor's entry into the vessel. The Licensee was cited for this violation. To prevent a recurrence, the Licensee will verify that all radioactive sources are shielded before working in vessels.

File Closed.

I-7392 - Radioactive Material Found at Landfill - BFI Landfill - San Antonio, Texas

On November 2, 1998, a landfill notified the Agency of elevated radiation levels on a residential trash truck that occurred on November 2, 1998. An Agency investigation determined that the trash was a diaper from a nuclear medicine patient but was unable to determine where it came from. The landfill was allowed to dispose of the trash.

File Closed.

I-7393 - Dose Irregularity - MD Anderson Cancer Center/ Mallinckrodt - Houston, Texas

On November 9, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on October 23, 1998. The clinic ordered [REDACTED] but received [REDACTED] instead. The correct dose was reordered. The patient was [REDACTED] with the correct dose. To prevent a recurrence, the pharmacy counseled the dispensing staff on filling prescriptions.

File Closed.

I-7394 - Lost Moisture/Density Gauge - Basse Truck Line - Laredo, Texas

On November 30, 1998, a gauge manufacturer notified the Agency of a missing moisture/density gauge containing a 10 millicurie cesium-137 sealed source and a 40 millicurie americium-241 sealed source that occurred while being transported from San Antonio, Texas, to Laredo, Texas, on November 30, 1998. The trucking company made 18 deliveries along the route. An Agency investigation included interviews and inspections at all delivery points. The gauge was not recovered.

File Inactive.

I-7395 - Lost Industrial Radiography Exposure Device - Technical Welding Laboratories, Inc. - Pasadena, Texas

On December 8, 1998, the Licensee notified the Agency of a missing industrial radiography exposure device containing a 104 curie iridium-192 sealed source that occurred on December 8, 1998. The exposure device was lost between the shop and a temporary job site. The camera was recovered at an apartment complex where one of the employees lived. A stop was made there on the way to the job site. An Agency investigation determined the exposure device was not damaged and that the source remained in the fully shielded position. The Licensee was cited for failure to secure an exposure device against unauthorized removal when left unattended on a vehicle, for failure to adequately block and brace a Type B package during transport on public highways, and failure to perform a survey of the vehicle prior to transport. To prevent a recurrence, the Licensee conducted a safety meeting for all employees and counseled the radiographer through administrative avenues. The incident was recommended for escalated enforcement.

File Closed.

I-7396 - Dose Irregularity - St Luke's Episcopal Hospital/Syncor - Houston, Texas

On December 2, 1998, the Licensee notified the Agency of a dose irregularity involving a shipment of various radiopharmaceuticals that occurred on December 2, 1998. The shipment was sent to the wrong hospital and no patients were injected. The pharmacy redelivered the nuclear medicine to the correct hospital. To prevent a recurrence, the pharmacy counseled delivery personnel.

File Closed.

I-7397 - Badge Overexposure - South West Hillcroft Medical Clinic - Houston, Texas

On November 18, 1998, an Agency inspector discovered a 29.46 rem exposure to a doctor during the January 10, 1996, through February 09, 1996, reporting period. An Agency investigation determined that the exposure was only to the badge. A deletion was not requested. The Registrant was cited for failure to submit a written report to the Agency within 30 days after discovery of an occupational exposure in excess of regulatory limits.

File Closed.

I-7398 - Stolen Radioactive Material - Alcon Laboratories - Fort Worth, Texas

On December 9, 1998, the Licensee notified the Agency of a stolen gas chromatograph, containing a 15 millicurie nickel-63 sealed source, that occurred between August 17, 1998, and December 1, 1998. The gas chromatograph was missing during a quarterly inventory performed on December 1, 1998. The unit has not been recovered. The Licensee was cited for failure to secure radioactive material from unauthorized removal or access. To prevent a recurrence, the Licensee is storing sources in an area under direct control of the radiation safety officer.

File Inactive.

I-7399 - Dose Irregularity - The Methodist Hospital - Houston, Texas

On November 23, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on November 16, 1998. The patient was scheduled for a [REDACTED] but was [REDACTED] for a [REDACTED] instead. 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 hospital held an inservice to emphasize verification of physician orders prior to injecting.

File Closed.

I-7400 - Dose Irregularity - St Luke's Episcopal Hospital/Syncor - Houston, Texas

On December 9, 1998, the Licensee notified the Agency of a dose irregularity involving a shipment of various radiopharmaceuticals that occurred on December 8, 1998. The shipment was sent to the wrong hospital and no patients were injected. The pharmacy redelivered the nuclear medicine to the correct hospital. To prevent a recurrence, the pharmacy counseled delivery personnel.

File Closed.

I-7401 - Misadministration - Sierra Medical Center - El Paso, Texas

On December 7, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] that occurred on December 3, 1998. The order from the referring physician was supposed to be a [REDACTED] and not a [REDACTED] procedure. The patient was [REDACTED] and received a [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 Licensee conducted an inservice on verification of physician's orders.

File Closed.

I-7402 - Stolen X-Ray Equipment - St. Paul Medical Center - Dallas, Texas

On December 10, 1998, the Registrant notified the Agency of a stolen x-ray machine that occurred on December 8, 1998. Two men stated that they were x-ray equipment repair personnel and stole the equipment. A police report was filed and the unit has not been recovered.

File Inactive.

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COMPLAINT SUMMARY FOR FOURTH QUARTER 1998

C-1347 - Regulation Violations - N-SPEC Quality Services, Inc. -  
Corpus Christi, Texas

On September 25, 1998, the Agency received an anonymous complaint alleging the Licensee was improperly storing radioactive material. An Agency investigation determined the Licensee; stored radioactive material in a location not authorized by the license, failed to post each room or area in which radioactive materials are used or stored, and failed to provide records to demonstrate that radiation doses received by members of the public do not exceed regulatory limits. The Licensee was cited for the violations.

File Closed.

C-1348 - Regulation Violations - Champions Electrolysis - Houston,  
Texas

On October 15, 1998, the Agency received an anonymous complaint alleging a laser facility was being operated under the auspices of a physician, but the physician was never present during operation of the laser. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1349 - Unauthorized Disposal - Waste Control Specialists, LLC -  
Andrews, Texas

On October 14, 1998, the Agency received an anonymous complaint alleging the Licensee received a 160 curie tritium shipment of waste and that the Licensee stated that the waste could be treated to where the tritium was below exempt quantities. An Agency investigation determined the Licensee was temporarily storing the material for another out of state waste processor until that facility could dispose of or transfer sufficient tritium so their inventory would not exceed their authorized activity of tritium. The Agency was unable to substantiate the allegation.

File Closed.

C-1350 - Failure to Provide Mammograms - Pennsylvania Avenue Imaging Center - Fort Worth, Texas

On October 22, 1998, the Agency received a complaint alleging the Registrant failed to provide original mammograms upon request with patient release. An Agency investigation determined the Registrant was not providing original mammograms. The Registrant was cited for the violation.

File Closed.

C-1351 - Unauthorized Radioactive Material Storage - Parts Smart - Dallas, Texas

On November 10, 1998, the Agency received an anonymous complaint alleging the company was storing depleted uranium at an unauthorized location. An investigation determined that radioactive material had been taken from another location and placed at this location. The material was taken back to the original location for storage.

File Closed.

C-1352 - Regulation Violations - Baylor/Richardson Medical Center - Richardson, Texas

On October 29, 1998, the Agency received an anonymous complaint alleging the Registrant; failed to perform calibration on a new CT unit, failed to supply visual indication to determine when the x-ray exposure was terminated, failed to provide continuous surveillance of the CT room, and failed to post appropriate radiation caution signs. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1353 - Unregistered Lasers - Advanced Laser & Cosmetics Surgery Dermatology - Houston, Texas

On October 27, 1998, the Agency received an anonymous complaint alleging lasers at a facility were not registered. An Agency investigation determined that the laser equipment at the facility was not registered with the Agency within 30 days of commencement of operation of the lasers. The Registrant was cited for the violation.

File Closed.

C-1354 - Contaminated Equipment - Associated Manufacturing, Inc. - Grand Prairie, Texas

On November 5, 1998, the Agency received an anonymous complaint referred from the U.S.N.R.C. alleging that the Department of Energy sold a contaminated machine to a manufacturing company. An Agency investigation included a survey of the machine and the facility which detected no contamination. The Agency was unable to substantiate the allegation.

File Closed.

C-1355 - Unauthorized Storage of Radioactive Waste - Supercollider Project - Waxahachie, Texas

On November 5, 1998, the Agency received an anonymous complaint referred from the U.S.N.R.C. alleging that radioactive waste was being stored in the tunnels of the canceled Supercollider Project. An Agency investigation determined all downhole shafts had been backfilled and that there was only one privately owned underground building with storage available, and there was no radioactive material stored in the building.

File Closed.

C-1356 - Regulation Violations - Ellis Chiropractic Center - Garland, Texas

On November 17, 1998, the Agency received an anonymous complaint alleging a Registrant was performing unauthorized veterinary x-ray procedures, failed to have a technique chart available, and allowed owners to hold animals during x-ray procedures without providing protective garments to the owners. An Agency investigation determined that the Registrant was performing unauthorized veterinary diagnostic procedures. The Registrant was cited for the violation. The Agency was unable to substantiate the other allegations.

File Closed.

C-1357 - Unregistered X-Ray Units - X-ray Xpress Corporation - Houston, Texas

On November 16, 1998, the Agency received an anonymous complaint alleging that a facility had unregistered x-ray units and that x-ray technicians were interpreting radiographs. An Agency investigation determined that the facility had two x-ray machines that were not registered. The Registrant was cited for the violation. The Agency was unable to substantiate the other allegation.

File Closed.

C-1358 - Unregistered X-Ray Units - La Bahia Clinic - Beeville, Texas

On November 16, 1998, the Agency received an anonymous complaint alleging that a facility had unregistered x-ray units and that x-ray technicians were uncredentialed. An Agency investigation determined that the facility had an unregistered x-ray unit and that one x-ray technician was uncredentialed. The Registrant was cited for the violations.

File Closed.

C-1359 - Regulation Violations - Humble MRI and Diagnostic - Humble, Texas

On November 18, 1998, the Agency received an anonymous complaint alleging the Registrant failed to have viewboxes to interpret mammograms and only used locum tenums to interpret mammograms. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1360 - Regulation Violations - East San Antonio Images, Inc. - San Antonio, Texas

On November 17, 1998, the Agency received an anonymous complaint alleging the Registrant operated x-ray equipment that did not function properly, failed to perform quality control, and failed to provide shielding of the x-ray room. An Agency investigation determined that the x-ray unit failed three separate beam limitation technical standards. The Registrant was cited for the violations. The Agency was unable to substantiate the other allegations.

File Closed.

C-1361 - Regulation Violations - Park Plaza Hospital - Houston, Texas

On December 10, 1998, the Agency received a complaint alleging the Registrant performed mammography with equipment which was not operating properly and that the mammography technician used excessive pressure during the procedure. An Agency investigation determined that the mammography unit was operable. The Agency was unable to substantiate the allegations.

File Closed.

C-1362 - Unregistered Laser - Bellaire Surgicare - Houston, Texas

On November 19, 1998, the Agency received an anonymous complaint alleging a laser facility was operating an unregistered laser. An Agency investigation determined that the laser was registered and that the facility was in regulatory compliance.

File Closed.

C-1363 - Unregistered Laser - Laser for Skin Restoration - Houston, Texas

On November 18, 1998, the Agency received an anonymous complaint alleging a laser facility was operating an unregistered laser. An Agency investigation determined that an application for registration of the laser had been submitted to the Agency and that the facility was in regulatory compliance.

File Closed.

C-1364 - Unregistered Laser - Thermolase Corporation - Houston, Texas

On November 19, 1998, the Agency received an anonymous complaint alleging a laser facility was operating an unregistered laser. An Agency investigation determined that an application for registration of the laser had been had been submitted to the Agency and that the facility was in regulatory compliance.

File Closed.

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INCIDENTS CLOSED SINCE THIRD QUARTER 1998

I-7342 - Equipment Malfunction - All American Maintenance, Inc. -  
San Antonio, Texas

A consultant calculated exposures and determined members of the public present in the auditorium received no doses that exceeded regulatory limits. This is a correction to the previous summary.

File Closed.

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**COMPLAINTS CLOSED SINCE THIRD QUARTER 1998**

There were no complaints closed since the third quarter 1998.

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES  
REPORTED DURING THE FOURTH QUARTER 1998

NO HOSPITAL OVEREXPOSURES WERE REPORTED FOR FOURTH QUARTER 1998

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SUMMARY OF RADIOGRAPHY OVEREXPOSURES  
REPORTED DURING THE FOURTH QUARTER 1998

NO RADIOGRAPHY OVEREXPOSURES REPORTED FOR FOURTH QUARTER 1998

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## APPENDIX C

### ENFORCEMENT ACTIONS FOR THIRD QUARTER 1998

#### Enforcement Conference: Radiographic Specialists, Inc. - Houston, Texas - Industrial Radiography

On December 1, 1998, an Enforcement Conference was held with representatives of Radiographic Specialist, Inc., holders of Radioactive Material License Number L02742. The conference was held to discuss an incident in Houston, Texas, at Jett Weld, Inc., on June 19, 1998. This incident resulted in a violation regarding failure to follow regulatory and procedural requirements resulting in the contamination of at least ten members of the general public and five radiographic personnel. After reviewing the violations and responses it was determined that each radiographic employee will review and sign Operating and Emergency Procedures and regulatory requirements, and Radiographic Specialists, Inc. will conduct quarterly refresher courses or in-house training on Operating and Emergency procedures. This will be added to the tie down condition as a license amendment, provided the amendment request is approved.

#### Enforcement Conference: Parkview Regional Hospital - Mexia, Texas - Mammography

On October 22, 1998, an Enforcement Conference was held with representatives of Parkview Regional Hospital, holder of Certification of Mammography Systems Number M00510. The conference was held to discuss the violations found during the inspection performed at the Registrants' facility on February 18, 1998. The violations included: failure to perform and document an ongoing quality assurance program specific to mammographic imaging, including processor performance evaluation; developer temperature; darkroom cleaning; screen cleaning; equipment observation check; compression device performance; screen-film contact, and screen artifact detection; and darkroom integrity. Other violations sited were: failure of the supervising physician to perform oversight and direction for all aspects of the quality assurance program; adequate training and continuing education; arranging staffing and scheduling so that adequate time is available to carry out the quality control tests and to record and interpret the results; failure to review the technologists' quarterly quality control test results; and reviewing the physician's results annually. The Radiation Safety Officer failed to maintain records and to ensure that personnel were complying with TAC rules, conditions of the Certificate of Mammography Systems, and operating, safety and emergency procedures of the registrant. Also: a complete technique chart was not in place for performing mammography; corrective action was not initiated within 30 days after the image quality

evaluation with phantom quality control test indicated non-compliance; when performing image quality test, the registrant failed to utilize identical technique settings; failed to ensure collimation was adequate; failed to notify the Agency within 30 days of changes in physician's ceasing to interpret mammograms; failed to notify the Agency of changes of operators performing mammography; failed to provide documentation of qualifications of physicians' interpreting mammograms; and failed to provide documentation of qualifications for a radiology technologist who operated mammographic equipment. These violations demonstrated what the Agency believed to be a deficiency in the supervision and quality control of the mammography department, and showed a need for improvements in Parkview Regional Hospital's radiation safety program. A review of the Registrants' response to those violations during the conference determined that Parkview Regional Hospital's designated Supervising Physician and a designated Alternative Physician will complete an eight-hour quality control training course within 90 days of receipt of the Enforcement Conference memo. Upon successful completion of the training course a certificate of completion will be provided to TDH-BRC Escalated Enforcement Program. It was also determined that the Supervising Physician will conduct a review of quality control items monthly, rather than quarterly, until such time as TDH-BRC notifies the Registrant in writing that this requirement has been withdrawn. Parkview Regional Hospital will be placed on an elevated inspection interval. These inspections will be unannounced and the results will determine whether additional enforcement actions are necessary. Parkview Regional Hospital's Supervising Physician, Alternative Physician, Radiation Safety Officer and one Radiographic Technician all successfully completed an eight hour quality control training course and provided documentation to TDH-BRC on February 16, 1999.

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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.