

**REDACTED**

**First Quarter 2003 Summary of  
Incidents, Complaints, and Enforcement Actions**

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

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**TABLE OF CONTENTS**

SUMMARY OF INCIDENTS FOR FIRST QUARTER 2003  
..... 3

SUMMARY OF COMPLAINTS FOR FIRST QUARTER 2003  
..... 18

ENFORCEMENT ACTIONS FOR THE FIRST QUARTER 2003  
..... 31

## SUMMARY OF INCIDENTS FOR FIRST QUARTER 2003

### I-7964 - Source Leaking - Spectro - Marble Falls, Texas

On January 7, 2003, the Licensee notified the Agency of two sealed sources found to have removable activity in excess of the 0.005 microcurie regulatory limit on January 6, 2003. Each source, manufactured by AEA Technology (Amersham) and installed in ASOMA (SPECTRO) Model 200 x-ray fluorescence instruments, contained 50 millicuries of iron-55. One source had 0.13 microcuries of removable contamination. The other source had 0.4 microcuries of removable contamination. The contamination was found during a routine leak test of the sources prior to servicing the machines. The Licensee notified the manufacturer of the leaks. The contamination was confined to the face of the sources. Other interior components and exterior surfaces were wipe tested and found to have no contamination above the minimum detection limit of 360 picocuries. The sources were removed and placed in storage pending disposal.

File Closed.

### I-7965 - RAM Found - Trinity Waste Services - Fort Worth, Texas

On October 30, 2002, the Agency received notification of a waste truck activating gate monitors two days prior and still showing activity above background. An Agency inspector traveled to the site and measured radiation levels at the exterior of the truck. The highest reading noted was 1.5 millirem per hour. The truck contents were dumped in an attempt to isolate the source of radiation. Material from the truck seemed to be dirt and trash. The unshielded waste had measured levels of 2.2 millirem per hour. Approximately one-third yards of dirt was isolated and secured for decay. A determination of the radioisotope was not made at this time. On January 8, 2003, the isolated material was determined to have radiation levels exceeding the background of approximately 8,000 counts-per-minute and was measured at 10,000 counts-per-minute. An Agency inspector was sent to the site to determine the radioisotope. At this time no levels above background were measured with a side-window GM probe. Use of a multi-channel analyzer did detect the familiar peak of iodine-131. Calculations, performed on-site, determined that the waste had passed through approximately 9.4 half lives since discovery. The waste had decayed to normal background radiation levels and was buried at the landfill. The waste truck was determined to have come from a residential neighborhood. An exact determination of the origin of the waste could not be made.

File Closed.

I-7966 - Overexposure - Southern Technical Services - Clute, Texas

On January 13, 2003, the licensee reported an overexposure to a radiographer of 5,060 millirem for the 2002 monitoring period. The dose was received cumulatively from radiography work performed during the year. The radiographer's work involved radiographing pipe and vessels in fabrication shops. In some situations, the work was in confined and tight spaces. A heavy workload contributed to the exposure. The Licensee removed the radiographer from work involving radiation in November 2002. To prevent a recurrence, the Licensee counseled the radiographer to limit his exposure. The Licensee was cited for allowing an exposure in excess of regulatory limits.

File Closed.

I-7967 - Source Disconnect - Goolsby Testing Laboratories, Inc. - Humble, Texas

On January 7, 2003, the Licensee notified the Agency of a source disconnect of a radiography camera during industrial radiography operations on December 30, 2002, at a fabrication shop in Cypress, Texas. A radiography trainer and radiography trainee were conducting radiography operations on site and took a break of approximately two hours and twenty minutes to allow a welder to complete a weld. During the break, the radiographers removed the restrictive barriers and allowed welders into the area. When the radiographers began radiography operations again, their first exposure failed. At this time a survey meter determined the source was not in the camera. An Agency investigation conducted on January 3, 2003, determined that during operations the radiographers had not used their survey meter to determine that the source was fully retracted and shielded before moving the equipment between shots and were not wearing either the alarming ratemeters or the pocket dosimeters during radiography operations. In addition, it was determined that the radiographers failed to perform visual and operational checks on the radiographic exposure device which would have revealed that the connector ball on the drive cable was extremely worn and was determined to be the cause of the source disconnect. The radiographer trainer performed a retrieval of the 53 curie, iridium-192 sealed source without prior authorization from this Agency. The Licensee failed to report the incident within 24 hours to the Agency. The Licensee was cited for the violations and escalated enforcement actions were recommended.

File Closed.

I-7968 - Radioactive Material Stolen - Geotech Engineering and Testing - Houston, Texas

On January 16, 2003, the Licensee notified the Agency that a nuclear density gauge was stolen on January 16, 2003. The gauge contained a 40 millicurie americium-241 source and an eight millicurie cesium-137 source. The gauge was stolen from the back of a pickup truck parked at a job site at a downtown location. The gauge was in a transport case and chained and locked onto the truck. The operator had finished work

and was making rounds with the construction supervisor. When he returned to the truck and left the construction site, he noticed the gauge was missing. The local police were notified. The gauge has not been recovered. To prevent a recurrence, the Licensee held an in-service meeting with the gauge operators. Operators were instructed to minimize the time gauges were left locked in vehicles and to notify surrounding workers to watch for suspicious activity.

File Inactive.

I-7969 - Radioactive Material Lost/Found - Fugro South, Inc. - San Antonio, Texas

On January 20, 2003, the Licensee notified the Agency of a nuclear moisture density gauge that was lost when a company employee left a construction site with the uncased gauge sitting on the tailgate of a company pickup truck. The employee realized that he had not secured the gauge, noted that it was missing and returned to the site to search for the gauge. After re-tracing his route and a fruitless search for the gauge, he notified the Licensee who sent other employees to assist in the search while local authorities were notified. Contact with the construction supervisor determined that the gauge had been found by another contractor departing the site and was secured for the evening in the contractor's office. The gauge was returned to the Licensee the next morning. No visible damage was noted and radiation levels were as expected. A precautionary leak test confirmed the source was not leaking. The gauge was returned to service.

File Closed.

I-7970 - Overexposure - Non-Destructive Testing Corporation - Lake Jackson, Texas

On December 23, 2002, the Licensee notified the Agency of a 5,718 millirem exposure to an employee during the 2002 annual monitoring period. The Licensee did not allow the radiographer to perform jobs involving radioactive material after the November badge report indicated the overexposure. An Agency investigation determined the exposure was received as a result of working conditions involving long hours and no use of shielding. The radiographer was cited for receiving the exposure. The Licensee was cited for permitting an individual to receive radiation exposures greater than the annual limits. To prevent a recurrence, the Licensee built shielding using high-density concrete blocks at the contracted job sites.

File Closed.

I-7971 - Lost Generally Licensed Devices - Lone Star Beverage Company LLC - Fort

## Worth, Texas

On January 23, 2003, the General Licensee notified the Agency that it could not locate two fill level inspection systems that had been removed from a bottling line on March 11, 2002. The systems had not been returned to the manufacturer but could not be located in the plant. Agency inspectors conducted an inspection on January 29, 2003, but could not locate the units. Each system contained an americium-241 source with a nominal activity of 100 millicuries. The General Licensee was cited for failure to notify the Agency or disposal of the device within 30 days and failure to appoint an individual responsible to ensure day-to-day compliance with appropriate Agency requirements. The instruments were not located.

File Inactive.

## I-7972 - Badge Overexposure - Professional Services Industries, Inc. - Clute, Texas

On January 24, 2003, the Licensee notified the Agency of an 8,266 millirem exposure to a radiographer during the November 11, 2002 - December 12, 2002 monitoring period. The Licensee believes the exposure was only to the badge. The radiographer indicated the badge was left in an area where it was exposed by a radiography crew performing concrete rebar radiography with long exposure times. An Agency investigation determined the Licensee did not present sufficient evidence to substantiate an exposure only to the badge. The Licensee was cited for allowing an exposure in excess of the regulatory limits. The Licensee has disputed the exposure, however, a written request to delete the exposure has not been received from the Licensee.

File Open.

## I-7973 - Stolen RAM - Giles Engineering Associates, Inc. - Dallas, Texas

On January 24, 2003, the Licensee notified the Agency that a nuclear density gauge was stolen from a company vehicle parked overnight at the residence of the gauge operator. The Licensee had already notified the Duncanville Police Department of the theft. The gauge, transport case and other assorted tools and clothing had been stolen from the parked vehicle. Additional vehicles parked in the area had also been burglarized. The gauge was recovered by the Dallas Police Department on January 26, 2003. All marking and labels had been removed or defaced. The gauge appeared to be intact and all components were still present. A leak test was performed and the case was re-marked and re-labeled awaiting results of the leak test. Leak test results were reported on February 12, 2003. No leakage was detected. As corrective actions, the Licensee counseled the gauge operator on failure to follow company operating and safety procedures with regard to storage of gauges at the permanent authorized storage location when in the Dallas-Fort Worth local work area. The gauge operator has been restricted from checking out gauges and from overnight travel with a nuclear gauge. The licensee is in the process of modifying Operating and Safety Procedures to more

definitively cover storage of gauges while operators are at temporary job sites where the gauge cannot be returned to permanent storage each night. Modifications to company vans are being considered for installation of storage cages that could not be defeated by bolt cutters and would therefore necessitate theft of the entire vehicle. The Licensee was cited for failure to keep the gauge under constant surveillance and failure to maintain positive control of the device in an unrestricted area, not storage.

File Closed.

I-7974 - Medical Event - UT Southwestern Medical Center - Fort Worth, Texas

On January 23, 2003, the Registrant notified the Agency of a medical event that occurred on January 23, 2003. A patient was administered a therapy treatment to the wrong area. To prevent a recurrence, the therapist was counseled to follow procedure of setup and double-check positioning prior to treatment. The Licensee is considering the acquisition of a treatment couch with position indexing and is reviewing tighter limits on couch positioning.

File Closed.

I-7975 - Leaking Source - The University of Texas at Austin - Austin, Texas

On January 31, 2003, the Agency was notified by the Licensee that a leaking source had been discovered during unpacking operations at the Nuclear Engineering Teaching Laboratory (NETL) on January 30, 2003. The sodium-22 positron source was leaking based on contamination levels of 0.015 microcuries. The manufacturer of the source was contacted and requested the return of the newly manufactured source for evaluation. The source was repackaged but could not be immediately shipped as the South African manufacturer only had an export license. The import license has been applied for and the shipment will commence when the license is in place. No violations were cited.

File Closed.

I-7976 - Badge Overexposure - The University of Texas Medical Branch - Galveston, Texas

On January 24, 2003, the Registrant notified the Agency of a 10,004 millirem exposure to a technologist during the September 1, 2002 to October 31, 2002 monitoring period. The Registrant believes the exposure is only to the personnel monitoring badge because the badge was left in a fluoroscopy room. The badge processor noted the exposure was static, indicating the badge was not worn during the exposure. The technologist usually assists with and performs fluoroscopy and general radiography examinations. During this wear period, the technologist performed mainly clerical duties and did not wear the badge. The residents and radiology students performed

radiography. A deletion was allowed and a minimal assessment, based on past average exposures, was accepted.

File Closed.

I-7977 - Overexposure - Non-Destructive Inspection Corporation - Lake Jackson, Texas

On January 28, 2003, the Licensee notified the Agency of a reported annual overexposure to an industrial radiography trainee. The trainee exceeded 5 rem for calendar year 2002, when he received a dose of 5,106 millirem on the personnel monitoring badge for the December monitoring period. An Agency investigation confirmed the individual's 2002 annual exposure was a total of 8,711 millirem. Since the Licensee informed the trainee of the December badging results, the trainee has not returned to work. The trainee had no explanation for the high badge reading. The Licensee was cited for allowing the trainee to exceed annual limits. No corrective actions have been taken in this case since the individual has not returned to work.

File Closed.

I-7978 - Badge Overexposure - Non-Destructive Inspection, Corporation - Lake Jackson, Texas

On January 28, 2003, the Licensee notified the Agency of a 182,606 millirem exposure to a radiographer's badge during the October 20, 2001 through the November 19, 2001 monitoring period. On December 28, 2002, the radiographer was involved in an accident while driving a company owned vehicle. The Licensee terminated the radiographer's employment. During the retrieval of equipment from the accident, the Licensee found a current wear date badge and a second badge for a wear date in 2001. Both badges were sent for processing. An Agency investigation concurred that the exposure to the 2001 badge was only to the badge. A deletion was allowed and a 0.417 rem assessment, based on a regulatory provision, was accepted.

File Closed.

I-7979 Overexposure - Non-Destructive Inspection Corporation - Lake Jackson, Texas

On January 28, 2003, the Licensee notified the Agency of a reported annual overexposure to an industrial radiographer. The radiographer received an annual dose of 5,439 millirem while employed by this Licensee and an additional dose of 834 millirem from another Licensee during the annual 2002 monitoring period. The total dose of 6,273 millirem exceeded the annual limits. An Agency investigation confirmed the calculations. The radiographer admitted to having re-zeroed his pocket dosimeter when it approached going off scale during daily operations. The Licensee was cited for allowing the radiographer to exceed annual limits. The company has required the

radiographer to review company Operating and Emergency procedures and to re-take the company's written examination on these procedures. In addition the radiographer is scheduled to attend a safety meeting with the Radiation Safety Officer to discuss ALARA procedures and to inform him that it is not company policy to recharge pocket dosimeters and continue working.

File Closed.

I-7980 - Overexposure - Southern Services, Inc. - Lake Jackson, Texas

On January 22, 2003, during a routine inspection, the Agency became aware of a 5,256 millirem exposure to a radiographer during the 2001 monitoring period. An Agency investigation determined the dose was received cumulatively from radiography work performed during the year. The radiographer received 2,459 millirem of the dose while in a previous employment. The Licensee had obtained the previous occupational exposure history but had not added it to the annual exposure. The radiographer is no longer in the employ of either Licensee. The Licensee was cited for allowing an exposure in excess of the regulatory limits.

File Closed.

I-7981 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7982 -\* Health and Safety Code-Chapter 241.051(d)

File Closed

I-7983 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7984 - Space Shuttle Disaster - Public Health Regions 3, 4, 5, & 7, Texas

On February 1, 2003, the Agency was notified of the Space Shuttle Disaster by a telephone call from the Agency's 24-hour Radiological Emergency Assistance answering service. The Agency returned a call to a city dispatcher who requested technical assistance. Personnel from the city's fire department were guarding numerous pieces of the space shuttle debris that fell on property within the city. Officials were concerned for the safety of their emergency workers, but recognized the need to safeguard the items. The workers had been advised not to touch the items and to maintain a safe distance from them in case the pieces presented a radiation hazard. The Agency advised the city that

workers should perform radiation surveys to determine the dose-rates and if any areas were found that exceeded 2 millirems per hour, then set up barriers to prevent emergency workers and members of the public from entering the areas. Areas in the path of the shuttle's descent were in possession of calibrated radiation monitoring instruments supplied routinely by the Agency's Radiological Emergency Preparedness Program. An area hospital requested and was provided information regarding personnel monitoring and protective actions for monitoring a patient being admitted who may have come into contact with shuttle debris. No radioactive contamination was found on the patient. Communications were made with agency staff, the Texas State Emergency Operations Center, and the Texas Department of Public Safety's Division of Emergency Management regarding the incident. A National Aeronautics Space Agency (NASA) telephone number was provided as a source of information on shuttle debris. The Environmental Protection Agency notified the Agency that the shuttle had several low-level radioactive sources on board containing a total activity of about 12 microcuries. The sources consisted of americium-241 in smoke detectors and one calcium-45 button source. Exempt quantities of tritium and calcium-45 were contained in shuttle laboratory experiments. There were no reactors or radioisotopic thermal generators on board. The radioactive inventory provided from a NASA contractor confirmed there were twenty-two sources in smoke detectors distributed throughout the shuttle. Eighteen detectors contained americium-241 sources, each with an activity of 0.3 microcuries, four contained americium-241 sources, each with an activity of 0.5 microcuries. Laboratory experiments contained 3.2 microcuries of tritium and 0.13 microcuries of calcium-45. NASA's inventory indicated another radioisotope on board was curium-244 with an activity of 1 microcurie. None of the radioisotopes on board were considered a health hazard. The radioisotopes posed no health threat to the civilian population in the path of the shuttle's descent. Based on information reviewed by the Agency, the materials were exempt quantities under the Bureau of Radiation Control's regulations, Chapter 25, Part 289 of the Texas Administrative Codes. On February 3, 2003, the Agency responded to a request for monitoring assistance by sending a radioactive materials inspector to the Operations Center in Lufkin, Texas. The inspector found only background levels of radioactivity.

File Closed.

I-7985 - Leaking Sealed Source - SPECTRO - Marble Falls, Texas

On February 13, 2003, the Licensee notified the Agency of a leaking sealed source. The 20 millicurie Am-241 sealed source manufactured by AEA Technology had been installed in an ASOMA/SPECTRO Model 200, was discovered by a leak test during routine service. The source was encapsulated in and returned to the manufacturer for evaluation. All other interior and exterior surfaces of the instrument were wipe tested and found uncontaminated. No violations were cited.

File Closed.

I-7986 - Labeling Error - Syncor Pharmacy Services - Austin, Texas

On January 6, 2003, the Licensee notified the Agency of a labeling error that occurred on January 6, 2003. After injecting a radiopharmaceutical, a technologist determined the shield label and the syringe label did not match. The pharmacy believes a contributing factor for the error was the introduction of a new label format at the pharmacy. The pharmacy was cited for failure to label the syringe shield with the accurate name of the radioactive drug contained inside. To prevent a recurrence, the pharmacy will hold an in-service and remind staff to verify labels. The patient and the referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7987 - Labeling Error - Cardinal Health dba Syncor Pharmacy Services / RTPS Acquisition Company LLC dba Southeast Texas Cardiology Associates - Houston / Orange, Texas

On January 31, 2003, the radiopharmacy reported that the receiving hospital believed a dose delivered that date was incorrectly labeled, as the images from the dose did not produce diagnostic quality images. From available records, it was ascertained that the dose was administered approximately one and a half hours later than the calibration time. The pharmacy insists that the radiopharmaceutical was the correct formulation. It is likely that the hospital injected a dose that was calibrated for use at that time which was correctly labeled but was not the dose prescribed for the procedure and would have resulted with the images that were achieved. Since the syringe was not returned to the pharmacy no proof of labeling error could be confirmed. The radiopharmacy has agreed to color code certain radiopharmaceutical prescriptions to make identification at the hospital easier. No violations were cited.

File Closed.

I-7988 - RAM Stolen - Engineering Consultant Services - San Antonio, Texas

On February 19, 2003, the Licensee notified the Agency of the theft of a moisture density gauge that occurred on February 18, 2003. The gauge contained an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. At the end of the work day, a gauge operator locked the gauge handle, placed the gauge in a transportation case, and locked the case with a chain to a projection inside a Conex container. The Conex was then closed and padlocked for the evening. When the operator arrived on site the following morning, he discovered that all of the contractor Conexes had been broken into and the contents stolen. The Houston Police Department was notified, arrived on site, and took statements from all affected personnel. The gauge was recovered on February 21, 2003. The gauge did not appear damaged, however, the case was broken and the gauge was wet. The gauge was returned to the manufacturer for leak testing and recalibration prior to placing the gauge back in use. The leak test indicated the sources were not leaking. To prevent a recurrence, the Licensee held training classes to reinforce increased awareness of security. The site's General

Contractor hired 24 hour security for the jobsite.

File Closed.

I-7989 - Dose Irregularity - Mallinckrodt, Inc. / Kelsey-Sebold Clinic / Digirad Imaging Solutions, Inc. - Houston, Texas

On February 10, 2003, the nuclear pharmacy notified the Agency of several doses of a radiopharmaceutical that failed to perform as expected on January 21 and 24, 2003. Initial quality control indicated that the doses from the kit prepared on January 21, 2003 were within quality control specifications. However, imaging did not confirm proper uptake. An analysis of the kit showed breakdown. The patients and the referring physicians were notified of the error. The patients' whole body doses were less than 5 rem and no organ received greater than 50 rad. No violations were cited.

File Closed.

I-7990 - Leaking Source - SPECTRO - Marble Falls, Texas

On February 24, 2003, the Licensee notified the Agency of a sealed source found to have removable activity in excess of the 0.005 microcurie regulatory limit on February 24, 2003. The source 13 millicurie curium-244 source had 0.0077 microcuries of removable contamination. The contamination was found during a routine leak test of the source prior to servicing an analytical instrument. The contamination was confined to the face of the source. Other interior components and exterior surfaces of the instrument were wipe tested and found to have no contamination above the minimum detection limit of 360 picocuries. The source was removed and was returned to the vendor for evaluation.

File Closed.

I-7991 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7992 - Radioactive Material Stolen - PSI - Houston, Texas

On March 8, 2003, the Licensee notified the Agency of the theft of a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. The Licensee reported that the gauge was stolen from the back of a company truck that was parked at a construction site. The Licensee promptly notified the local police and offered a monetary reward for the return of the gauge. On March 11, 2003, the Agency was notified of the recovery of the gauge. The gauge was not stolen but had fallen from the back of the truck while the gauge operator drove to another part of the job site. A driver behind the truck saw the gauge fall onto the roadway but was

unable to stop the operator. The gauge was recovered in its locked transportation case and appeared to be in good condition. A leak test confirmed the source was not leaking. The Licensee was cited for failure to secure the gauge. The Licensee terminated the technician's employment. To prevent a recurrence, the Licensee conducted a department-wide safety briefing to re-emphasize the significance of security and control of licensed material, and the incident was focused on in the Licensee's safety newsletter for all of the Licensee's sites.

File Closed.

I-7993 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7994 - Dispensing Error - Valley Nuclear Inc. - Mission, Texas

On February 18, 2003, the Licensee notified the Agency of a dispensing error that occurred on February 10, 2003. The error resulted in a patient being administered the wrong drug. The Licensee was cited for failure to label a vial containing a radiopharmaceutical with the accurate name of the radioactive drug the vial contained. To prevent a recurrence, the Licensee counseled the pharmacist and will store radioisotopes into two different bins to lessen mixups.

File Closed.

I-7995 - Illegal Disposal - Nuclear Sources and Services, Inc. Houston, Texas

On January 17, 2003, the Agency was notified by the Arkansas Department of Health of a shipment of waste that contained radioactive material which had been rejected by a waste handling firm located in Arkansas. An Agency investigation determined the shipment of 79 fifty-five gallon drums of paint sludge waste were slated for incineration. A single pallet of four fifty-five gallon drums had detectable radiation above background levels. Of the drums, one contained no radioactive materials, a second had only a Yellow II Transport Index label with no radioactive content, a third drum had a small piece of cobalt-60 on a piece of vermiculite, and the final drum was determined to have a spectrum demonstrating the presence of either natural uranium or thorium waste. The Licensee failed to survey the drums prior to loading for disposal. The Licensee was cited for failure to make or cause to be made surveys that are necessary to evaluate the magnitude and extent of radiation levels on drums sent for disposal on January 14, 2003.

File Closed.

I-7996 - Dispensing Error - SYNCOR/SETCA - Houston/Orange, Texas

On February 17, 2003, the Licensee notified the Agency of a dispensing error that occurred on January 31, 2003. The error resulted in a patient being administered the wrong drug. The Licensee was cited for failure to label a vial containing a radiopharmaceutical with the accurate name of the radioactive drug the vial contained. To prevent a recurrence, the pharmacy will highlight prescriptions to make identification of the correct drug easier.

File Closed.

I-7997 - Laser Injury - Texas Tech University Health Science Center - El Paso, Texas

On March 17, 2003, the Agency was notified by the Registrant of a medical laser injury that occurred on February 7, 2003, when a surgical drape ignited after laser surgery causing minor injury to the patient. The Registrant immediately extinguished the burning drape and treated the injury to the patient. Corrective actions were instituted by the Registrant which include: education of all staff involved in use of medical laser systems of typical hazards and protective measures in the event of unusual occurrences; use of wet surgical sponges around the area of clinical interest during medical laser procedures; placement of paper drapes currently in use on the abdomen of the patient instead of near the area of clinical interest; placement of a basin of water within reach of the medical laser procedure; revision of departmental policy and procedures to incorporate the preceding items; and utilization of a fire-retardant drape as soon as one can be identified and obtained from a vendor. Violations were cited for failure to report the event within specified notification time frames.

File Closed.

I-7998 - Excessive Package Levels - Texas A&M/Southwest Research Institute - Bryan/San Antonio, Texas

On March 18, 2003, the Licensee reported receiving a cask from the Texas A&M Nuclear Science Center with surface contamination. Initial wet wipe indicated contamination levels above limits allowed on package exteriors. A dry wipe of the wooden transport pallet also found contamination. The Licensee moved the cask into a hot cell with appropriate ventilation. Wet wipes of the forklift forks and pallet jack forks revealed no detectable radiation levels above background. The transport truck was called back to check for radioactive contamination. The truck, pallet jack, dolly, and driver's hands were determined to be free of radioactive contamination. Also, the plywood boards on and by the cask were free of radioactive contamination. Dry wipes were taken on the entire surface of the cask and pallet. The wipes on top of the cask and pallet revealed loose radioactive contamination. The sides of the cask and pallet revealed no loose radioactive contamination. An Agency inspector investigated the incident at the Licensee's facility. The radioisotope contaminating the exterior of the cask was scandium-46 and was not associated with the contents of the cask. The cask was intact and the shipment contained 24.6 millicuries of iron-55, 46 millicuries of iron-

59, and 2,100 millicuries of chromium-51. In the process of unloading the cask, a small amount of radioactive contamination, predominantly bromide-82, was identified on a rubber gasket. The external contamination on the cask/pallet originated from the Texas A&M Nuclear Science Center. Texas A&M believes the cask was contaminated by airborne radioactive material while inside the Science Center waiting for transport. Further investigation determined the contamination did not exceed the allowable limits. The Science Center determined that no personnel contamination occurred during transport. Corrective actions were addressed by the US Nuclear Regulatory Commission during an inspection of their Licensee, the Texas A&M Nuclear Science Center.

File Closed.

I-7999 - Stolen Gauge - Law Engineering & Environmental Services Inc. - Fort Worth, Texas

On March 21, 2003, the Licensee reported the theft of a moisture density gauge from the bed of a company pickup truck parked at the residence of the gauge operator. The gauge operator had taken the gauge home while he ate breakfast. When he returned to his truck to take the gauge to secure storage, he noted that the gauge was missing. He reported the theft to the Radiation Safety Officer. This is the second gauge this operator has had stolen from his residence. The operator was issued a counseling statement for failure to obey company policy concerning storage of gauges and was suspended from work for a period of one week. No violations were issued as the gauge had been secured in the operators truck. The gauge has not been recovered.

File Inactive.

I-8000 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-8001 - Radioactive Material Contamination - Baker Atlas, Houston

On March 27, 2003, the Licensee notified the Agency of an incident that occurred when a pressurized reservoir performance monitor was removed from a logging tool. While attempting to extract the tool component subassemblies, excessive force was used by two employees removing the tank. The tritium tube exploded ejecting glass shrapnel out the end of the housing. These fragments injured an employee near the discharge end of the housing. Treatment at a local hospital determined the patient was contaminated with tritium. Tritium contamination in the disassembly building was wet wiped. Smear wipes of the area determined that the clean-up was sufficient to meet regulatory standards. To prevent a recurrence of this incident the Licensee has developed written procedures to be followed in the case of another similar incident. In addition the Licensee has developed a remote extraction tool that will not require

employees to be in the vicinity of the tank and housing. If the tool is unsuccessful in extracting the tank, the tool will be cut to allow the safe discharge of pressure in the containment vessel. No violations were cited.

File Closed

### **SUMMARY OF COMPLAINTS FOR FIRST QUARTER 2003**

#### C-1730 - Regulation Violation - Kui Fei Skin Care - Dallas, Texas

On January 2, 2003, the Agency received a complaint transferred from the Texas Board of Medical Examiners alleging a facility was performing laser hair removal procedures without the involvement of a licensed medical practitioner. An Agency investigation found no laser onsite at the facility. The facility owner denied any use of a laser, even on a temporary or demonstration basis. The owner denied recognition of a brochure advertising the use of YAG laser equipment provided by the complainant and none of the brochures were observed onsite. The owner indicated the facility is considering adding the use of lasers. An Agency investigator provided a registration packet and explained a licensed practitioner of medicine must be associated with the use of medical lasers. Other non-laser machines for hair removal and permanent makeup removal were observed onsite. These were not regulated by the Bureau of Radiation Control. An inspector from the Texas Department of Health's Medical Devices Branch accompanied on the investigation and carried out compliance actions associated with the non-laser machines in use.

File Closed.

#### C-1731 - \* Health and Safety Code-Chapter 241.051(d)

File Closed.

#### C-1732 - Regulation Violation - East Side Imaging - San Jacinto, Texas

On December 16, 2002, the Agency received a complaint alleging the quality control technologists in a mammography facility did not always perform the required daily quality control testing. An Agency investigation substantiated the allegation. The Registrant failed to perform the image quality evaluation with the phantom at the correct time intervals and failed to perform darkroom fog quality control at the correct intervals. The Registrant was cited for the violations.

File Closed.

C-1733 - Regulation Violation - Fannin Street Imaging - Houston, Texas

On December 4, 2002, the Agency received information that the facility was failing to perform quality control items at the correct time intervals. An Agency investigation was performed on December 16, 2002, which determined that the facility had failed to perform image quality evaluation with a phantom since October 29, 2002. The facility was cited for the violation and recommended for Escalated Enforcement action.

File Closed.

C-1734 - Uncredentialed Technologists - Lawrence B. McNally, M.D. - Dallas, Texas

On January 15, 2002, the Agency received a complaint alleging the Registrant: allowed uncredentialed technologist to perform radiographs; failed to provide personnel monitoring; and failed to provide appropriate safety equipment and instruction. An Agency investigation substantiated the allegations. The Registrant was cited for the violations.

File Closed.

C-1735 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1736 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1737 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1738 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1739 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1740 - Uncertified Technologist - Memorial MRI Diagnostic - Houston, Texas

On January 31, 2003, the Agency received a complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs. An Agency inspection substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1741 - Regulation Violations - Pro Inspection - Odessa, Texas

On February 6, 2003, the Agency received a complaint alleging the Licensee performed radiography at several fabrication shops in the area without following regulations. The radiographers were allegedly not wearing personnel monitors nor ratemeters, were not using survey meters, and were not posting or securing the areas at temporary job sites. Allegedly, a radiography camera was left unattended while the radiographers left a site to obtain more film. An Agency inspection found the following violations of Agency regulations. The Licensee permitted individuals to conduct radiography operations prior to fulfilling all training requirements. Radiographers failed to conduct a physical radiation survey of each restricted area during the first radiographic exposure and record the results. Radioactive material was transported on public highways without complying with the Department of Transportation marking and labeling requirements. All employees involved in the transport of radioactive material were not provided hazardous materials training. Annual records of personnel monitoring did not include all exposures received by a radiographer. Personnel monitoring devices were not always returned to the supplier within 14 days following the end of the prescribed wear period. The Licensee failed to test radiographic exposure devices for depleted uranium contamination at intervals not to exceed 12 months. Records of annual radiation exposures to employees did not always include all required information. Records of an inspection/maintenance program covering all exposure devices and related equipment were insufficient to document performance at intervals not to exceed three months. Records of quarterly physical inventories did not include all required information. The Licensee was cited for the violations.

File Closed.

C-1742 - Regulation Violations - Longview Inspection - Longview, Texas

On February 7, 2003, the Agency received a complaint alleging radiographers were not setting up boundaries in compliance with Agency regulations. Allegedly, radiation levels in unrestricted areas were measured at 3.4 to 12 millirems per hour. The complainant indicated the Agency would be contacted when the Licensee performed radiography at the site again. The Agency was not made aware of any further jobs on site by the company.

File Closed.

C-1743 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1744 - Regulation Violations - Cobblestone Engineering - Harlingen, Texas

On February 12, 2003, the Agency received a complaint alleging a Licensee stored radioactive material at an unauthorized site. An Agency investigation substantiated the allegation. Two nuclear density gauges had been stored at an unauthorized location since June 2002. The Licensee was cited for the violation.

File Closed.

C-1745 - Regulation Violation - Harmonix of Texas LP dba Harmonix Hair and Skin Clinic - Plano / Las Colinas, Texas

On February 12, 2003, the Agency received an anonymous complaint alleging that the Laser Registrant had operated Class IV lasers without a licensed practitioner on staff from October through December 2002. An investigation of both facilities was conducted on March 4, 2003, that determined the facilities had operated without a staff physician/medical director from September 26, 2002 through January 2, 2003. In addition, it was determined that the licensed practitioner does not prescribed patient treatment before treatment is commenced by laser technicians. The facilities were cited for a prohibited act, allowing individuals to be intentionally exposed to laser radiation without the authorization of a licensed practitioner. The facility also operated beyond the scope of laser practice by operating without the supervision of a licensed practitioner during laser procedures. The facility also failed to notify this Agency of change of licensed practitioner within 30 days. Additional violations were cited for failure to maintain required records, improper signage, and failure to adequately control access to Class IV indoor controlled areas when lasers were in use.

File Closed.

C-1746 - Regulation Violation - Laser Light Show - Pavilion Stadium - Houston, Texas

On February 13, 2003, the Agency received an anonymous complaint transferred from the United States Food and Drug Administration (FDA) alleging a laser light show was scheduled without an approved FDA variance and the operator may not be authorized to operate lasers in Texas. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1747 - Regulation Violation - Mount Carmel Water Treatment Plant - Waco, Texas

On February 13, 2003, the Agency received a complaint alleging that the facility, a General Licensee, had disposed of a Generally Licensed device as scrap without first removing the radioactive source, and had failed to return the source to the manufacturer. An Agency investigation was conducted on February 24, 2003, which determined that all Generally Licensed devices owned and operated by the facility for the last three years were accounted for and present on the site. The complaint was not substantiated.

File Closed.

C-1748 - Uncredentialed Technologist - Randall Medical Clinic - Lufkin, Texas

On February 19, 2003, the Agency received a complaint alleging a Registrant allowed uncredentialed technologists to perform radiographs. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1749 - Regulation Violation - Radiology Clinic of Laredo - Laredo, Texas

On February 27, 2003, the Agency received a complaint alleging that the facility was unclean and apparently in violation of regulations concerning infection control. An Agency investigation was performed on April 28, 2003, which could not confirm the allegations. The facility had a protocol for cleaning equipment after each mammogram which appeared to be effective at the time of the inspection. No violations were cited.

File Closed.

C-1750 - Regulation Violation - H & H X-Ray - Tyler/Streetman, Texas

On February 27, 2003, the Agency received a complaint alleging a Licensee stored radioactive material at an unauthorized location. An Agency investigation substantiated the allegation. A radiographer stored a radiographic camera containing an iridium-192 source on board a truck parked at his residence. The radiographer's residence was located in a region of the state different than the Licensee's facility. The radiographer had worked from his residence for more than a year. The Licensee was cited for knowingly permitting the unauthorized storage of radioactive material.

File Closed.

C-1751 - Unregistered Mobile X-Ray - Medical Services LLC - Salt Lake City, Utah

On March 7, 2003, the Agency received a complaint alleging that an unregistered mobile x-ray service was performing services at a local hotel in Tyler on March 7-9, 2003. The company was employed by a legal firm conducting unauthorized screening x-rays for lung disorders caused by asbestos or silica. An Agency investigation was conducted on March 7, 2003, which determined that in fact two mobile x-ray facilities were parked in the hotel parking lot (See Complaint C-1757). This mobile unit was performing PA and lateral chest x-rays without the supervision of a licensed practitioner authorized and licensed by the State of Texas. The mobile van was not registered in the State of Texas and was not operating under a reciprocal agreement. When informed of the potential violations, the facility voluntarily ceased operations. The facility was cited for providing mobile radiation machine service prior to receipt of a Certificate of Registration and for deliberately applying radiation to human beings with authorization of a licensed practitioner of the healing arts. As corrective action the facility immediately contacted the Agency Registration Program and was directed to apply for a registration as a Provider of Equipment under an industrial Radiation Machine and Services registration.

File Closed.

#### C-1752 - Regulation Violations - Jay A. Workman - Livingston, Texas

On March 4, 2003, the Agency received a complaint alleging a facility using x-ray units was not registered with the Agency. The complainant further alleged the x-ray technologist was not credentialed and was not supplied with personnel monitoring. An Agency investigation determined the individual who operated the x-ray unit was not credentialed and records to show personnel monitoring of occupationally exposed individuals were unavailable. The facility had recently registered the x-ray units. The facility was cited for the violations along with other violations found during the inspection.

File Closed.

#### C-1753 - Radioactive Material Abandoned - Paragon - Bryan, Texas

On March 4, 2003, the Agency received a complaint alleging that the Licensee had broken a lease on property used to store radioactive material. The property owner could not contact the Licensee. The Agency contacted the Licensee's son who confirmed that the sources were still in storage on the property and that his father was incapable of performing any radiation duties. Attempts to dispose of the sources were fruitless. The Licensee was cited for abandoning five sources of radiation. The property owner was cited for storage of radioactive material without a license. The sources were order impounded by this Agency and were picked up by Agency personnel of April 23, 2003. The sources have been placed in Agency storage, pending

disposal.

File Closed.

C-1754 - Regulation Violations - Health South Diagnostic Center - Clearlake/Webster, Texas

On March 6, 2003, the Agency received a complaint alleging a Registrant used a stereotactic breast biopsy unit without calibrations being performed on the unit. An Agency investigation determined the allegation was unsubstantiated. A review of medical physicists' reports, service receipts, and quality control performed by the stereotactic technologist found no items of non-compliance.

File Closed.

C-1755 - Regulation Violation - Ultrascan (MRI) - Dallas, Texas

On March 7, 2003, the Agency received a complaint alleging that the Registrant used uncredentialed staff to perform radiographs when the only MRT is out of the office. An Agency investigation was conducted on March 31, 2003, which determined that the facility's only MRT had credentials that expired on December 31, 2002. No one else currently employed by the facility was presently performing radiographs. However, it was determined that the facility's licensed practitioner/Radiation Safety Officer had left the facility more than 30-days ago. The facility was cited for having an uncredentialed operator of the x-ray equipment, and for failing to notify the Agency in writing within 30 days of the change of Radiation Safety Officer,

File Closed.

C-1756 - Regulation Violation - Don Krall, DDS - Odessa, Texas

On March 12, 2003, the Agency received a complaint transferred from the Texas Board of Dental Examiners alleging a Registrant was using an x-ray unit that was duct taped together, wrapped with aluminum foil, had exposed wires, and may not be functioning properly. An Agency inspection found twelve violations of Agency regulations. The control panel of the x-ray unit was not equipped with the proper indication of milliamperage techniques prior to exposure. The Registrant failed to conduct equipment performance evaluations at the required four year interval. The last evaluation was performed on April 6, 1998. A technique chart or manual was not located at the control panel of the x-ray unit. The exposure timing device of the x-ray unit was not within 10% of the indicated setting. The output of the x-ray unit was not reproducible. A written copy of the operating and safety procedures was not available. The Registrant failed to conduct the remote self-inspection. The Radiation Safety Officer: failed to have a thorough knowledge of management policies and

administrative procedures of the Registrant, failed to maintain records as required by this chapter, failed to ensure that personnel are adequately trained and complying with Agency regulations, the conditions of the certificate of registration, and the operating and safety procedures of the Registrant. Manual film processing did not meet requirements, in that, films were not developed in accordance with the time-temperature relationships recommended by the film manufacturer, darkroom light leak tests were not performed at the required six month interval, lighting for film processing was not maintained with the filter, or bulb wattage recommended by the film manufacturer. Documentation of chemical replacement for film processing was not maintained. A "Notice to Employees" was not posted. The Registrant failed to properly post, or post by reference, relevant regulations, the certificate of registration, any notice of violation, any documentation of correction of any violations. The Registrant was cited for the violations and recommended for escalated enforcement actions.

File Closed.

C-1757 - Regulation Violation - Occupational Medical Resources, Inc. - Houston, Texas

On March 7, 2003, the Agency received a complaint alleging that an unregistered mobile x-ray facility was operating from the parking lot of a local hotel in Tyler, Texas on March 7-9, 2003. When an Agency inspector arrived at the hotel she discovered not one but two mobile x-ray vans providing services from the parking lot of the hotel in support of law firms performing screening x-rays for lung disorders caused by asbestos and silica. This van was properly registered and was only providing mobile x-ray service on the date of March 7, 2003. However, the mobile x-rays were being provided by two Limited Medical Radiologic Technologists (LMRT) not authorized to perform mobile or portable x-rays in accord with the Medical Radiologic Technologist Program as Dangerous and Hazardous Procedures. The facility was cited for only that violation despite their understanding that the equipment was fixed to the floor of the mobile van and considered by the Registrant as stationary equipment.

File Closed.

C-1758 - Regulation Violation - Production Facilities Equipment - Magnolia, Texas

On February 1, 2003, the Agency received a complaint alleging exposure to Naturally Occurring Radioactive Material ( NORM). The individual worked as a welder on vessels used in the oil and gas industry. The investigation did not identify any violations of Agency regulations. The radiation levels found in the vessels were exempt from Agency regulations and were not considered a health and safety hazard. Agency regulations exempts equipment containing NORM scale with radiation levels of less than 50 microrems per hour. The facility receives heat vessels from oil companies for refurbishing. The vessels are surveyed when received and typically rejected if radiation levels are above five microrems per hour. Not all of the incoming vessels have NORM on the internal components. The first step in refurbishing the vessels involves water

blasting and sand blasting the internal surfaces. After blasting, residual material is removed and any NORM found is packaged in 55 gallon drums and returned to the customer. Any cutting with welding torches occurs after blasting. A typical step involves using a welding or blowtorch to remove externally affixed thermometers that are repaired and then re-affixed to the heating vessel. An Agency inspector surveyed the 35 heat vessels found at the company and several waste-containing drums. The refurbished vessels had no radiation levels above background. One vessel set aside not to be refurbished had radiation levels of 15 microrems per hour on contact. The drums had less than five microrems per hour on contact. All radiation levels found at the company were below the exemption limit.

File Closed.

C-1759 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1760 - Regulation Violations - Radiation Oncology of the South Plains - Lubbock, Texas

On March 14, 2003, the Agency received a complaint alleging a contractor was exposed to radiation while unclogging a toilet containing contaminated urine from patients who were injected with radiopharmaceuticals at a PET facility. The complainant further alleged: the facility deviated from construction plans submitted to the Agency on shielding; the general public was deliberately exposed to a source; and general public workers were allowed inside a room during installation of a PET scanner and its calibration using a radioactive source. An Agency investigation determined the Licensee failed to perform surveys or evaluations to ensure members of the general public would not be exposed to radioactive contamination resulting from a backflow from a toilet used by patients who had been injected with fluorine-18 FDG. The Licensee estimated the probable level of contamination in the toilet at 0.125 millicuries in 5 liters of water and concluded the level of exposure to the contractor was insignificant. The Agency concurred the described radiation level is not a significant health threat. The allegation of deliberate exposure could not be substantiated. The investigation also determined the original facility plans were altered without prior approval from the Agency; the proper protective clothing was not worn by the technologist; and the technologist was not credentialed. The Licensee was cited for nine violations of Agency regulations and referred for escalated enforcement actions. A follow-up inspection found thirteen violations of regulations, one of severity that resulted in a recommendation for the assessment of an administrative penalty.

File Closed.

C-1761 -\* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1762 - Radioactive Material Contamination - Gulf Nuclear - Houston, Texas

On March 18, 2003, the Agency received a complaint alleging exposure to the public from airborne releases of americium-241 from an Environmental Protection Agency cleanup site. An Agency investigation determined there were no releases offsite. The property perimeter is monitored and nearby facilities are monitored. The monitoring results indicated there was no apparent contamination hazard to the public.

File Closed.

C-1763 - Unauthorized Disposal - Lexicon Genetics - The Woodlands, Texas

On January 31, 2003, the Agency received a complaint alleging that the Licensee was improperly handling radioactive materials during experiments and performing illegal disposal of radioactive waste. An Agency investigation was conducted on February 12, 2003, that determined the Licensee's experiments conducted with radioactive materials were following detailed procedures and did not exceed applicable radiation limits. In addition, waste processed at the facility was appropriately disposed of in the sanitary sewer, with documentation demonstrating that monthly waste disposal records reached only a fraction of the limits established by this Agency. No impact on the environment is expected from the activities conducted by the Licensee. The allegations could not be proved. No violations were cited.

File Closed.

C-1764 - Unauthorized Disposal - Cardinal Health (Syncor) - Corpus Christi, Texas

On February 10, 2003, the Agency received a complaint alleging lead shielding was sold to the public by a nuclear pharmacy Licensee may have been contaminated with radioactive material. An Agency investigation determined the Licensee surveyed and wipe tested lead shielding in compliance with procedures and Agency regulations. Disposal records indicated no residual contamination and no shipment or release to any other company.

File Closed.

C-1765 - Uncredentialed Operator - Advanced Foot Centers - Spring/Houston, Texas

On April 2, 2003, the Agency received a complaint alleging that uncredentialed operators were operating x-ray equipment at the Registrant's facilities. Agency investigations were conducted at the facilities on May 8 and 9, 2003. Two uncredentialed operators were determined to have worked at both facilities. The facilities were cited for the violation.

File Closed.

## **ENFORCEMENT ACTIONS FOR THE FIRST QUARTER 2003**

### **Enforcement Conference: Alan E. Delgado, DC, Pasadena, Texas**

On January 9, 2003, an enforcement conference was held with Alan E. Delgado, D.C., holder of Certificate of Registration no. R06120. Dr. Dana Hermes was the representative from Alan E. Delgado, D.C. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on September 16, 2002. The violations stated in the Notice of Violation issued on September 24, 2002, and the responses to the violations were reviewed.

After reviewing the violations and the responses, the Agency reviewed the following recommendations with Dr. Hermes:

1. Alan E. Delgado, D.C. will provide the Agency with a copy of the light leak and protective device logs within 30 days from the date of the enforcement conference summary.
2. The Radiation Safety Officer for Alan E. Delgado, D.C. will read the rules applicable to chiropractic x-rays in §289.226, §289.227 and §289.231. The radiation safety officer shall submit a written statement indicating that these rules have been reviewed. The radiation safety officer shall also submit a copy of the checklists that are developed to use to ensure the facility's compliance.
3. The Radiation Safety Office shall also review the requirements of 25 TAC §289.226(w)(2) and provide the Agency with a written statement that the R.S.O. has reviewed, understands, and will abide by this rule. The written statement shall be provided to the Agency within 30 days from the date of the enforcement conference summary.
4. The Agency has increased the inspection frequency and unannounced inspections will be conducted. Please note that the Radiation Safety Officer will only be available in the Pasadena office on Monday and Fridays. On Tuesday, Wednesday, and Thursday's the R.S.O. will be at the San Antonio office.
5. No administrative penalties will be assessed at this time, however, upon follow up inspection, should any severity level, I, II or repeat violations be cited, administrative penalties may be assessed.

Dr. Dana Hermes agreed to the above recommendations and the conference was concluded.

### **Enforcement Conference: East Side Imaging, Inc., Houston, Texas**

On April 8, 2003, an enforcement conference was held with East Side Imaging Inc., holder of Certification No. M00567. Mr. Todd Richey was the representative from East Side

Imaging Inc. The conference was held as a result of the number, type and severity of violations noted during the inspections conducted on December 16, 2002. The violations stated in the Notice of Violation issued on January 7, 2003, and responses to violations were reviewed.

After reviewing violations and responses, the Agency made the following recommendations:

1. The Radiation Safety Officer for East Side Imaging, Inc., shall review 25 TAC §289.226(w)(2) and provide Texas Department of Health/Bureau of Radiation Control with a statement indicating the R.S.O. has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
2. The Lead Interpreting Physician for East Side Imaging, Inc., shall review 25 TAC Section 289.230(k)(1)(A), and provide the Texas Department of Health/Bureau of Radiation control with a statement indicating that the Lead Interpreting Physician has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
3. East Side Imaging, Inc., shall perform patient notification to include patients who received mammograms during the period November 5, 2002 to December 16, 2002.

As indicated in §289.230(cc)(7)(A-C) the patient notification letter shall contain the following information; A) inform the patient that the mammography system failed to satisfy the agency's certification standards; B) recommend that the patient have another mammogram performed at a facility with a certified mammography system; and C) list the three facilities closest to the original testing facility that have a certified mammography system. A draft of patient notification letter shall be provided to the Agency for review and approval within 30 days from the date of the summary. The notifications shall be mailed no later than 30 days after receipt of the Agency's approval of the draft letter.

4. East Side Imaging, Inc., shall provide evidence of the Lead Interpreting Physician's quarterly review of the quality control test results performed in accordance with the requirements of Section 289.230(k)(1)(A)(ii) for the last quarter of 2002, within 30 days of the date of this Enforcement Conference Summary.
5. East Side Imaging, Inc., shall provide notification of renewal of its accreditation with the American College of Radiology no later than 30 days from the date of this Enforcement Conference Summary.
6. The Agency has increased the inspection frequency and unannounced inspections will be conducted. If no Severity Level I, II, or repeat violations are cited upon follow

up inspection, then East Side Imaging, Inc., will return to the routine inspection interval.

7. No administrative penalties will be assessed against East Side Imaging, Inc., at this time. However, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are noted.

East Side Imaging, Inc., agreed to the above recommendations and the conference was concluded.

### **Enforcement Conference: Fannin Street Imaging, Inc., Houston, Texas**

On April 8, 2003 an enforcement conference was held with Fannin Street Imaging, Inc., holder of Certification No. M00567. Mr. Todd Richey was the representative from East Side Imaging Inc. The conference was held as a result of the number, type and severity of violations noted during the inspections conducted on December 16, 2002.

After reviewing violations and responses the Agency made the following recommendations:

1. The Radiation Safety Officer for Fannin Street Imaging, Inc., shall review 25 TAC §289.226(w)(2) and provide Texas Department of Health/ Bureau of Radiation Control with a statement indicating the R.S.O. has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
2. The Lead Interpreting Physician for Fannin Street Imaging, Inc., shall review 25 TAC Section 239.230(k)(1)(A), and provide the Texas Department of Health/Bureau of Radiation control with a statement indicating that the Lead Interpreting Physician has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
3. Fannin Street Imaging, Inc., shall perform patient notification to include patients who received mammograms during the period November 5, 2002 to December 16, 2002. As indicated in §289.230(cc)(7)(A-C) the patient notification letter shall contain the following information: A) inform the patient that the mammography system failed to satisfy the agency's certification standards; B) recommend that the patient have another mammogram performed at a facility with a certified mammography system; and C) list the three facilities closest to the original testing facility that have a certified mammography system. A draft of patient notification letter shall be provided to the Agency for review and approval within 30 days from the date of the summary. The notifications shall be mailed no later than 30 days after receipt of the Agency's approval of the draft letter.
4. Fannin Street Imaging, Inc., shall provide evidence of the Lead Interpreting

Physician's quarterly review of the quality control test results performed in accordance with the requirements of Section 289.230(k)(1)(A)(ii) for the last quarter of 2002, within 30 days of the date of this Enforcement Conference Summary.

5. The Agency has increased the inspection frequency and unannounced inspections will be conducted. If no Severity Level I, II, or repeat violations are cited upon follow up inspection, then Fannin Street Imaging, Inc., will return to the routine inspection interval.
6. No administrative penalties will be assessed against Fannin Street Imaging, Inc., at this time. However, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are noted.

Fannin Street Imaging, Inc., agreed to the above recommendations and the conference was concluded.

### **Enforcement Conference: Hereford Regional Medical Center, Hereford, Texas**

On January 16, 2003, an Enforcement Conference was held with Hereford Regional Medical Center, holder of Certificate of Mammography No. M00408. The representative from Hereford Regional Medical Center attending the conference was Claudia Smith. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on August 15, 2002. The violations stated in the Notice of Violation issued on September 27, 2002, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency made the following recommendations:

1. Provide the Agency with copies of continuing education certificates for Shannon Alejandre, MRT and Michelle Zamora, MRT for courses taken during the 36-month period preceding the inspection on August 15, 2002. Claudia Smith shall stop taking mammograms until she has completed the necessary continuing education requirements.
2. Shannon Alejandre shall attend a quality control training class within 90 days from the date of the enforcement conference summary. Upon completion, Hereford Regional Medical Center shall provide the Agency with a copy of her completion certificate.
3. Hereford Regional Medical Center shall re-train all mammography technicians on the 7-day time period requirement for image quality evaluation with phantom, and submit documentation of this training within 30 days of the date of this summary.

4. The Lead Interpreting Physician, Claudia Smith, and the Quality Control Technician will meet on a monthly basis to review quality control results for a period of 12 months. A log or record of these meetings will be kept and available for review at the next inspection.
5. A complete audit review and analysis shall be performed for the period beginning April 1999 through April 1, 2000, and April 28, 2000 through 2001. Hereford Regional Medical Center staff shall pull all mammography medical reports with positives findings; analyze film in accordance with the rules, and provide a copy of the analysis to the Agency within 180 days from the date of the enforcement conference summary.
6. Hereford Regional Medical Center shall rerun the cassette film screen contact test covering 100% of the clinically exposed area on the cassette, and shall provide a copy of this test to the Agency within 30 days from the date of this enforcement conference summary.
7. Hereford Regional Medical Center shall provide the Agency with a copy of the calibration certificates for the densitometer and sensitometer within 30 days from the date of this enforcement conference summary.
8. Hereford Regional Medical Center shall re-evaluate the darkroom light for extraneous light sources. This will be checked at the next Agency inspection.
9. The inspection interval for Hereford Regional Medical Center will be increased and unannounced inspections will be conducted.
10. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections if any severity level I, II, or repeat violations are cited, administrative penalties may be assessed.
11. Hereford Regional Medical Center shall submit a written statement of commitment from the Lead Interpreting Physician acknowledging that he has reviewed 25 TAC §289.230(k)(1)(A), and acknowledges the responsibilities of the Lead Interpreting Physician. The Radiation Safety Officer will provide the Agency with a signed statement of understanding, indicating the Radiation Safety Officer has reviewed 25 TAC §289.226(w)(2) and acknowledges and understands the responsibilities of the Radiation Safety Officer. The statement will be provided to the Agency within 30 days from the date of the enforcement conference summary.

The representative from Hereford Regional Medical Center agreed to the above recommendations and the Conference was concluded.

## **Enforcement Conference: Liberty-Dayton Hospital, Inc., Liberty, Texas**

On March 27, 2003, an enforcement conference was held with Liberty-Dayton Hospital, holder of Certification No. M00571. Mr. Sean Stricker, and Ms. Tiffany Warner were the representatives from Liberty-Dayton Hospital. The conference was held as a result of the number, type and severity of violations noted during the inspections conducted on December 11, 2002. The violations stated in the Notice of Violation issued on January 6, 2003, and responses to violations were reviewed.

After reviewing violations and responses, the Agency made the following recommendations:

1. The Radiation Safety Officer for Liberty-Dayton Hospital, Inc., shall review 25 TAC §289.226(w)(2) and provide Texas Department of Health/Bureau of Radiation Control with a statement indicating the R.S.O. has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
2. The Lead Interpreting Physician for Liberty-Dayton Hospital, Inc., shall review 25 TAC Section 289.230(k)(1)(A), and provide the Texas Department of Health/Bureau of Radiation control with a statement indicating that the Lead Interpreting Physician has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
3. Liberty-Dayton Hospital, Inc., shall perform patient notification to include patients who received mammograms 30 days prior to December 11, 2002. As indicated in §289.230(cc)(7)(A-C) the patient notification letter shall contain the following information; A) inform the patient that the mammography system failed to satisfy the agency's certification standards; B) recommend that the patient have another mammogram performed at a facility with a certified mammography system; and C) list the three facilities closest to the original testing facility that have a certified mammography system. A draft of patient notification letter shall be provided to the Agency for review and approval within 30 days from the date of the summary. The notifications shall be mailed no later than 30 days after receipt of the Agency's approval of the draft letter.
4. The Licensed Medical Physicist, Quality Control Technologists, and the Hospital Administrator shall review 25 TAC §289.203, §289.204, §289.205, §289.226, §289.230 and §289.231 and provide the Agency with a written statement indicating this review has occurred. The statements shall be submitted to the Agency within 30 days from the date of the enforcement conference summary.
5. Liberty-Dayton Hospital, Inc.'s Lead Interpreting Physician shall conduct a quality control review on a monthly basis for the next year.

6. Liberty-Dayton Hospital, Inc., shall post image quality and processor performance evaluations, and provide training to technologists in order to provide a better understanding of what these records are and why they are used. This information shall be provided to the Agency within 30 days from the date of the enforcement conference summary.
7. The Agency has increased the inspection frequency and unannounced inspections will be conducted. If no Severity Level I, II, or repeat violations are cited upon follow up inspection, then Liberty-Dayton Hospital, Inc., will return to the routine inspection interval.
8. Administrative penalties will be assessed against Liberty-Dayton Hospital, Inc., at this time.
9. The Liberty-Dayton Hospital's Mammography Quality Control technologist shall attend a quality control training class within 6 months from the date of the enforcement conference summary.

Liberty-Dayton Hospital, Inc., agreed to the above recommendations and the conference was concluded.

#### **Enforcement Conference: Mandes Inspection & Testing Service, Houston, Texas**

On January 30, 2003, an enforcement conference was held with Mandes Inspection and Testing Services, holder of license no. L05220. The representatives from Mandes Inspection and Testing Services were Mr. Arthur Mandes, Ms. Mildred Mandes, and Laurie McGowen. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on June 7, 2002. The violations stated in the Notice of Violation issued on August 22, 2002, and the responses to the violations were reviewed.

After reviewing the violations and the responses, the Agency made the following recommendations:

1. Mandes Inspection and Testing Services shall submit a request to the Agency to remove Arthur Mandes, as a Trainer, from their license for a period of six months. Arthur Mandes shall not reapply for Trainer status for a period of six months. (This request has been received and forwarded to Licensing for processing.)
2. Arthur Mandes will take a 40 hour Radiography Training class within 60 days from the date of the enforcement conference summary, and submit a copy of the certification of completion to the Agency.

3. The Agency has requested Arthur Mandes take at least a 16 hour Radiation Safety Officer training course and submit a copy of the certificate of completion to the Agency upon successful completion of the course. This course shall be taken within 60 days of the enforcement conference summary.
4. Mandes Inspection shall submit a syllabus of safety and Department of Transportation safety courses to the Agency on a quarterly basis for the next year. Include a list of attendees, tests and results, and the name of the course presenter.
5. Mandes Inspection shall provide in written form the addition information provided to the Agency at the enforcement conference.
6. Mandes Inspection shall provide a list of field site locations and dates of any jobs that last over 30 days. This information shall be provided to the Agency for a period of one year.
7. No administrative penalties will be assessed at this time.

Mandes Inspection and Testing Services agreed to the above recommendations and the conference was concluded.

### **Enforcement Conference: Memorial Hermann Executive Wellness, Houston, Texas**

On March 11, 2003, an enforcement conference was held with Memorial Hermann Executive Wellness Program. The representatives from Memorial Hermann Executive Wellness Program attending the conference were Jeff Brizzolara, Clinical Director and Ron Scheele. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on December 18, 2002. The violations stated in the Notice of Violation issued on January 7, 2003, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency made the following recommendations:

1. The Agency shall issue a Preliminary Report for Assessment of Administrative Penalties to Memorial Hermann Executive Wellness Program.
2. The inspection frequency for Memorial Hermann Executive Wellness Program shall be increased and unannounced inspections will be conducted.

3. Memorial Hermann Executive Wellness Program shall modify their patient log to include the name of the referring physician.
4. Memorial Hermann Executive Wellness Program's Radiation Safety Officer shall review §289.226, paying special attention to §289.226 (j) and (w), and provide the Agency with a written statement indicating he has reviewed, and understands the additional requirements for facilities conducting screening and/or research, and will carry out the duties of the Radiation Safety Officer as stated in this section of the regulations.

The representatives from Memorial Hermann Executive Wellness Program agreed to the above recommendations and the Conference was concluded.

### **Enforcement Conference: Presbyterian Hospital of Kaufman, Kaufman, Texas**

On March 20, 2003, an enforcement conference was held with Presbyterian Hospital of Kaufman, holder of Certification No. M00273. Ms. Kathy Ehrenburger and Teresa Grimes were the representatives from Presbyterian Hospital of Kaufman. The conference was held as a result of the number, type and severity of violations noted during the inspections conducted on November 7, 2002. The violations stated in the Notice of Violation issued on November 22, 2002, and responses to violations were reviewed.

After reviewing violations and responses, the Agency made the following recommendations:

1. The Radiation Safety Officer for Presbyterian Hospital of Kaufman shall review 25 TAC §289.226(w)(2) and provide Texas Department of Health/Bureau of Radiation Control with a statement indicating the R.S.O. has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
2. Kathy Ehrenberger, R.T. of Presbyterian Hospital of Kaufman shall take at least 8 hours of mammography quality control training within 60 days of the date of the enforcement conference summary. If available, Presbyterian Hospital of Kaufman's current consultant can provide the necessary training.
3. Kathy Ehrenberger of Presbyterian Hospital of Kaufman shall visit at least one other hospital that is currently using the MRS system to see how they are using the system. Ms. Ehrenberger shall provide the Agency with a copy of a signed statement from the visited hospital within 60 days of the date of the enforcement conference summary.

4. The Administrator of Presbyterian Hospital of Kaufman, shall address with the medical staff at the next medical staff meeting the informational needs of the mammography department. The Administrator shall provide the Agency with a copy of the record of attendance within 30 days from the date of the Enforcement Conference Summary.
5. The Agency has increased the inspection frequency and unannounced inspections will be conducted. If no Severity Level I, II, or repeat violations are cited upon follow up inspection, then Presbyterian Hospital of Kaufman will return to the routine inspection interval.
6. No administrative penalties will be assessed at this time.

Presbyterian Hospital of Kaufman agreed to the above recommendations and the conference was concluded.

#### **Enforcement Conference: Scott & White Memorial Hospital, Temple, Texas**

On March 13, 2003, an enforcement conference was held with Scott and White Memorial Hospital and Clinic, holder of certification No. M00273. Mr. Wayne Stockburger, Ms. Judith Hays, Dr. Debra Monticciolo, and Ms. Libby Turner were the representatives from Scott and White Memorial Hospital and Clinic. The conference was held as a result of the number, type and severity of violations noted during the inspections conducted on December 5, 2002 and February 5, 2003. The violations stated in the Notice of Violation issued on December 12, 2002, and February 27, 2003, and the responses to the violations were reviewed.

After reviewing violations and responses, the Agency made the following recommendations:

1. The Lead Interpreting Physician for Scott and White Memorial Hospital and Clinic shall review 25 TAC §289.230(k)(1)(A). A written statement will be provided to the Agency indicating the Lead Interpreting Physician has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
2. Scott and White Memorial Hospital and Clinic shall perform patient notification to include patients who received mammograms 30 days prior to the December 5, 2002 inspection. As indicated in §289.230(cc)(7)(A-C) the patient notification letter shall contain the following information: A) inform the patient that the mammography system failed to satisfy the agency's certification standards; B) recommend that the patient have another

mammogram performed at a facility with a certified mammography system; and C) list the three facilities closest to the original testing facility that have a certified mammography system. The patient notification letter shall be provided to the Agency for review and approval within 30 days from the date of the summary.

4. Scott and White Memorial Hospital and Clinic shall provide a copy of the job description to determine minimum qualifications for Mammography Technician Assistants who have just completed school. This information shall be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
5. The Agency shall down grade Violation #2 on the December 5, 2002 inspection to failure to have documentation.
6. Scott and White Memorial Hospital and Clinic shall request removal of the Lorad MIII equipment from the Mammography Certification. This request shall be made within 30 days from the date of the Enforcement Conference Summary.
7. The Agency has increased the inspection frequency and unannounced inspections will be conducted. If no Severity Level I, II, or repeat violations are cited upon follow up inspection, then Scott and White Memorial Hospital and Clinic will return to the routine inspection interval.
8. Administrative penalties will be assessed and a Preliminary Report for Assessment of Administrative Penalties will be issued to Scott and White Memorial Hospital and Clinic.

Scott and White Memorial Hospital and Clinic agreed to the above recommendations and the conference was concluded.

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

On February 13, 2003, an enforcement conference was held with Dolly Vinsant Memorial Hospital. The representatives from Dolly Vinsant Memorial Hospital attending the conference were Wade Terrell, Administrator, and Eileen Fox. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on October 23, 2002. The violations stated in the Notice of Violation issued on November 1, 2002, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency made the following recommendations:

1. The Agency shall issue a Preliminary Report for Assessment of Administrative Penalties to Dolly Vinsant Memorial.
2. The inspection frequency for Dolly Vinsant Memorial Hospital shall be increased and unannounced inspections will be conducted.
3. Upon follow up inspection, should any severity level I, II or repeat violations be cited, the Agency may issue a Complaint to Revoke Dolly Vinsant Memorial Hospital's mammography certification.
4. Prior to resuming mammography operations, Dolly Vinsant Memorial Hospital shall submit 5 days of quality assurance data for review and approval by the Agency.

The representatives from Dolly Vinsant Memorial Hospital agreed to the above recommendations and the Conference was concluded.

#### **Enforcement Conference: Texoma Cancer Center, Wichita Falls, Texas**

On January 28, 2003, an enforcement conference was held with Texoma Cancer Center, holder of Certificate of Registration no. R24887. Mr. Allan Weikell, Mr. Jeff Colvin, and Ms. Jan Rose were the representatives from Texoma Cancer Center. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on December 3, 2002. The violations stated in the Notice of Violation issued on December 18, 2002, and the responses to the violations were reviewed.

After reviewing the violations and the responses, the Agency made the following recommendations:

1. The Radiation Safety Officer for Texoma Cancer Center shall review 25 TAC §289.226(w)(2), §289.229, and §289.231. A written statement will be provided to the Agency indicating the R.S.O. has reviewed, understands, and will comply with the rules. This statement shall be provided to the Agency within 30 days from the date of the enforcement conference summary.
2. Texoma Cancer Center shall provide the Agency with a list of physicists, to include name and license number, used from the time period beginning June 1, 2002 through present. This list shall be provided on a quarterly basis until such time that a permanent health physicist is hired.

3. Texoma Cancer Center shall provide the Agency with a written spot check procedure as described in 25 TAC §289.229(h)(3)(c)(ii)(V). This procedure shall include a statement of what tolerance has been defined by the Licensed Medical Physicists.
4. The Agency has increased the inspection frequency and unannounced inspections will be conducted.
5. No administrative penalties will be assessed at this time, however, upon follow up inspection, should any severity level, I, II or repeat violations be cited, administrative penalties may be assessed.

Texoma Cancer Center agreed to the above recommendations and the conference was concluded.

### **Enforcement Conference: X-ray Inspection Inc., Beaumont, Texas**

On February 27, 2003, a management conference was held with X-Ray Inspection, Inc.. The representatives from X-Ray Inspection, Inc. attending the conference were Byron Duplechain, David McNeese, Clint Nugent, and Chris Powell. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on August 7-8, 2002. The violations stated in the Notice of Violation issued on September 18, 2002, December 3, 2002 and December 9, 2002, and the responses to the violations were reviewed.

After reviewing the violations and responses, the Agency made the following recommendations:

1. The inspection frequency for X-Ray Inspection, Inc. shall be increased and unannounced inspections will be conducted.
2. The Agency commended X-Ray Inspection, Inc. for their proactive approach in taking preventative corrective actions prior to the Management conference.
3. The Agency reminded X-Ray Inspection, Inc. that any repeat violations will be elevated to the next higher severity level.
4. The Agency requested X-Ray Inspection, Inc. review their current license and request removal of any Trainers that are currently no longer employed with the facility.

The representatives from X-Ray Inspection, Inc. agreed to the above recommendations and the Conference was concluded.

