

First Quarter 2002 Summary of Incidents, Complaints, 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). The text of these summaries will not appear in this report.”

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SUMMARY OF INCIDENTS FOR FIRST QUARTER 2002

I-7845 - Transportation Accident - Computalog - Fort Worth, Texas

On November 29, 2001, the news media notified the Agency of a transportation accident involving a vehicle transporting radioactive material on an interstate highway. An Agency investigation determined the wireline vehicle left the road, to avoid an accident with an out of control vehicle, on an icy highway. Due to the angle of the shoulder of the road, the heavy vehicle rolled onto its right side. Four well logging sources onboard were: a 20 microcurie radium-226 sealed source; a 2 curie cesium-137 sealed source; a 572 millicurie americium-241/beryllium sealed source; and a 19 curie americium-241/beryllium sealed source. All sources were secured and remained in approved transport containers during the accident. A survey of the vehicle onsite determined no abnormal radiation levels and detected no leakage from the sources. All sources were leak tested on November 30, 2001, with no leakage detected.

File Closed.

I-7846 - Stolen Gauge - Rabba-Kistner - San Antonio, Texas

On January 11, 2002, the Licensee notified the Agency that a moisture density gauge, containing a 40 millicurie americium-241 source and an 8 millicurie cesium-137 source, was stolen on January 10, 2002. The operator parked in a parking lot and reported to a job. The gauge was secured in the rear of a truck. The lock on the transport container was cut and the gauge stolen. The theft was reported to the San Antonio Police Department. The next morning the police department recovered the gauge and called the Licensee. The Licensee took possession of the gauge and performed a radiation survey. The radiation readings were normal. The gauge was sent to the manufacturer for inspection.

File Closed.

I-7847 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7848 - Equipment Damaged - Qualitex - Odessa, Texas

On November 8, 2001, the Licensee notified the Agency that a radiography device was damaged during a transportation accident on November 7, 2002. A truck caught fire and burned with the device on board. The device contained a 37 curie iridium-192 source that remained intact and did not leak. The device and source were returned to the manufacturer.

File Closed.

I-7849 - Radioactive Material Leaking - Anheuser Busch - Houston, Texas

On January 18, 2002, the General Licensee notified the Agency that two of 178, 15 curie, tritium-filled, self-powered exit signs, being prepared for shipment to and recycling by the manufacturer, were leaking. The signs had been removed from use and stored for approximately one and a half years. Wipe samples of the 178 signs being prepared for shipment, confirmed the leakage of only two signs. The two leaking signs contaminated 11 additional signs. The 11 contaminated signs were decontaminated and packaged with the rest of the signs and shipped for recycling. The two leaking signs, and waste from the decontamination effort, were packaged in sealed containers and shipped to a contractor's facility in California. Bioassay samples, taken from workers involved in the packaging, shipping, and decontamination processes, were normal.

File Closed.

I-7850 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7851 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7852 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On January 25, 2002, the Licensee notified the Agency of a 5,074 millirem exposure to an employee during the October, 2001, monitoring period. Upon further review, the Licensee determined the dose was an estimate, based on a computer calculation. The actual badge reading was reported by the badge processor as minimal. The Agency concurred with the Licensee's decision to record the minimal reading, obtained from the processor, on the employee's permanent radiation exposure history.

File Closed.

I-7853 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7854 - Overexposure - Radiation Technology, Inc. - Odessa, Texas

On January 14, 2002, the Licensee notified the Agency of a 7,289 millirem exposure to an employee during the first three quarters of the 2001 monitoring period. An Agency investigation determined the exposure resulted from the performance of numerous source change-outs in relatively inaccessible areas. The Licensee was cited for allowing an employee to receive an exposure in excess of regulatory limits; failure to submit a written report to the Agency within 30 days and ten other violations found during the investigation. To prevent a recurrence, the Licensee will use shadow shielding between the worker and the sources. The incident was referred for escalated enforcement. Ten of the violations were contested by the Licensee.

File Closed.

I-7855 - Source Abandoned Downhole - Schlumberger Technology Corporation - Edinburg, Texas

On February 5, 2002, the Licensee notified the Agency that a 16 curie americium-241/beryllium source was abandoned downhole after unsuccessful recovery attempts. The source was abandoned at a depth of 10,565 feet and immobilized with red dyed cement at a depth of 10,265 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7856 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7857 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7858 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7859 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7860 - Damaged Equipment - Terra Mar - Irving, Texas

On February 10, 2002, the Licensee notified the Agency that a gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source was damaged on February 10, 2002. A technician placed the gauge on the tailgate of a pickup truck. When the technician backed up the truck, the gauge fell from the tailgate and was run over and damaged. The sources remained in their protective shielding and no contamination or leakage occurred. The gauge was returned to the manufacturer for repairs. The Licensee was cited for failure to keep a licensed source of radiation, in an unrestricted area, secured from unauthorized removal or access and for not keeping the gauge under constant surveillance.

File Closed.

I-7861 - Damaged Moisture Density Gauge - APEX Geoscience, Incorporated - Longview, Texas

On February 14, 2002, the Licensee notified the Agency of damage to a moisture density gauge that occurred at a construction site when a dump truck backed over the gauge. The gauge was damaged and the control rod was bent. A site survey demonstrated that all sources remained intact. The gauge was moved to temporary storage and secured pending disposition. A leak test indicated no leakage. The gauge was returned to the manufacturer for repair or disposal.

File Closed.

I-7862 - Source Abandoned Downhole - Schlumberger - Sugar Land, Texas

On March 6, 2002, the Licensee notified the Agency that a 1.7 curie cesium-137 source and a 16 curie americium-241/beryllium source were abandoned downhole on February 9, 2002. The sources were abandoned at a depth of 14,796 feet and 14,778 feet, respectively, and immobilized with 327 feet of red dyed cement. The sources were abandoned in accordance with the Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation 25 TAC §289.253.

File Closed.

I-7863 - Source Abandoned Downhole - Pro-Technics - Houston, Texas

On February 7, 2002, the Licensee notified the Agency that a 250 microcurie americium-241/beryllium source would be abandoned downhole because recovery attempts were unsuccessful. The source was abandoned on February 14, 2002, at a depth of 17,125 feet and immobilized with red dyed cement at a depth of 16,640 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7864 - Overexposure - Technical Welding - Pasadena, Texas

On December 26, 2001, the Licensee notified the Agency of a 5,785 millirem exposure to a radiographer during the March 11, 2001, through the November 19, 2001, monitoring period. The Licensee determined the radiographer did not use good safety practices and terminated his employment. An Agency investigation determined the radiographer performed radiography at various fabrication shops and the monitoring records indicated the exposures were accumulated monthly. The Licensee and the radiographer were cited for allowing a radiation exposure greater than regulatory limits. The Licensee was cited for failure to submit a written report to the Agency within 30 days of determining the exposure.

File Closed.

I-7865 - Radioactive Materials at Landfill - Trinity Oak Landfill - Dallas, Texas

On February 9, 2002, a landfill notified the Agency that a truck had activated their radiation gate monitor. The landfill surveyed the truck with a handheld meter and obtained readings, in excess of 200 millirem, at the truck surface. The Agency identified multiple bags of contaminated medical waste. The source of the medical waste could not be determined. The waste was buried in a shallow pit for decay, barricaded, and marked to indicate the contaminated waste site. No violations were cited.

File Closed.

I-7866 - Radioactive Material Lost & Found - Baker Atlas - Pearland, Texas/Houma, Louisiana

On February 14, 2002, the Licensee notified the Agency that a neutron generator instrument containing a one curie tritium source was lost during transport on January 3, 2002. The loss was not realized until January 31, 2002. There were eight sections in the shipment of two instruments. When the shipment arrived at destination, the night dispatcher erroneously acknowledged receipt of eight sections. The sections were placed in storage where they stayed until their return was requested for a logging job. When the sections were being prepared for the return shipment, it was realized that one section was missing and presumed lost during transport. Local authorities, the transport company, scrap yards, and state and federal agencies were notified to assist with the search for the missing section. On March 13, 2002, an individual notified the Licensee that he found the instrument on the side of a road and had kept it for several weeks. He identified the owner by markings on the housing. The Licensee took possession of the instrument the following day. No excessive exposures were received during the incident.

File Closed.

I-7867 - Badge Overexposure - Midwest Inspection Services - Perryton, Texas

On January 14, 2002, the Licensee notified the Agency of a 55,632 millirem exposure to a radiographer trainer during the fourth quarter, 2001. The radiographer dropped his badge while performing radiography in Kansas on December 14, 2001. The radiographer's pocket dosimeter registered a 50 millirem exposure. The lost badge was reported to the radiation safety officer on December 19, 2001. The radiation safety officer performed calculations and decided against immediate processing of the badge because of the pocket dosimeter reading and impending holidays and badge change at the end of the year. The processed badge indicated a 55,632 millirem exposure. The Agency granted a deletion of the exposure and accepted a 235 millirem assessment, based on past average exposure, to be added to the radiographer's exposure history.

File Closed.

I-7868 - Dose Irregularity - Mallinckrodt/COR Specialty - Dallas, Texas

On February 28, 2002, the Licensee notified the Agency of six radiopharmaceutical doses that did not perform as expected on February 28, 2002. The nuclear pharmacy indicated an initial quality control test showed results within acceptable limits. However, a followup test showed an increased quantity of free pertechnetate. The manufacturer concluded the kit used to prepare the doses was of proper quality. The cause of the product breakdown could not be determined. Although the doses showed an unexpected biodistribution during imaging, the patient studies were completed in a satisfactory manner. The clinic did not submit a written report to the Agency within 30 days of the incident and was cited for the violation.

File Closed.

I-7869 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7870 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7871 - Dose Irregularity - Austin Radiological Association - Bailey Square - Austin, Texas

On March 11, 2002, the Licensee notified the Agency of a dose irregularity that occurred when a technologist failed to verify a patient's name and the correct radiopharmaceutical and administered the wrong dose. The error was discovered by the technologist during the imaging phase of the procedure. The study was terminated and rescheduled at the patient's convenience. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence of this event, the technologists were counseled to verify pertinent information on all container labels before injecting patients. In addition, the technologists were required to maintain patient doses in specifically designated areas until the time of use. The facility was cited for failure to comply with license tie down conditions requiring double checking of a dose, for correct patient identification and radionuclide, prior to administration.

File Closed.

I-7872 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7873 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7874 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7875 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7876 - Therapy Event - Don and Sybil Harrington Cancer Center - Amarillo, Texas

On June 19, 20, 21, 2001, the Licensee treated the wrong treatment site due to failure to follow written procedures and the hurry to treat the patient, who was not on the schedule. The therapist mistook the central ray tattoo marking for the superior marking while making port films. Port films were not reviewed before treatment was conducted. Treatments were repeated for three consecutive days utilizing the incorrect port films. The treatment resulted in an exposure to an area that would have been blocked under the prescribed treatment plan. Other organs were unintentionally exposed. The Registrant failed to make the required 24 hour notification to the Agency and failed to submit a written report within 15 days of the event. The Registrant was cited for the violations.

File Closed.

I-7877 - Source Abandoned Downhole - Pro-Technics - Houston, Texas

On March 14, 2002, the Licensee notified the Agency that a 200 microcurie americium-241/beryllium source was abandoned downhole after unsuccessful recovery attempts. The source was abandoned at a depth of 12,021 feet and immobilized with red dyed cement at a depth of 11,772 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7878 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7879 - Dose Irregularity - Mallinckrodt, Inc. / Kelsey-Seybold Clinic - Houston, Texas

On March 26, 2002, the Licensees notified the Agency of a dose irregularity that occurred on February 27, 2002, when two doses of the same radiopharmaceutical were ordered by the clinic. After administration of the first dose, an irregular biodistribution was noted during imaging. The second dose was not administered and the nuclear pharmacy was notified. The second dose was returned to the pharmacy where quality control testing confirmed the wrong radiopharmaceutical had been dispensed. The pharmacist who had prepared the drug was interviewed and counseled on preparation procedures. To prevent a reoccurrence of this incident the pharmacy reviewed in-house procedures and made procedural changes. The pharmacy was cited for providing a mislabeled product. The pharmacy was referred to the Texas State Board of Pharmacy for possible action under their regulations.

File Closed.

I-7880 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7881 - Damaged Source - CKS Packaging, Inc. - Fort Worth, Texas

On March 28, 2002, the General Licensee notified the Agency of a damaged source. A static eliminator device was damaged when a bolt, attaching the device to a blow molding machine, came loose during operation, dropping the static elimination bar into the jaws of the machine. The device was damaged and the gold foil source was missing and could not be located. The remains of the static elimination device were packaged and returned to the manufacturer, who advised the General Licensee to notify the Agency. The Agency determined the 1.2 millicurie polonium-210 source had melted onto one of the thermocouples of the machine. An Agency survey detected contamination levels of 500-800 counts-per-minute behind the thermocouple's safety enclosure. The plant voluntarily removed the thermocouple for disposal. No violations were cited.

File Closed.

I-7882 - Overexposure - Technical Welding - Pasadena, Texas

On April 10, 2002, the Licensee notified the Agency of a 70,000 millirem exposure to a radiographer earlier that morning, as calculated by the Licensee. The radiographer failed to return a 35 curie cobalt-60 source to the shielded position before changing film and guide tube positions for a radiograph. The radiographer, reportedly, was inches from the source for 30 to 40 seconds. An Agency reenactment was inconclusive as to exposure length and distance. The radiographer had blood samples taken for CBC differentiation studies by a local physician and a blood sample for chromosome cytogenetic assessment by the Armed Forces Radiobiology Research Institute. The cytogenetic assessment indicated the radiographer received a minimum 70,000 millirem exposure and a maximum 152,000 millirem exposure. The radiographer: failed to use a collimator provided by the Licensee; failed to do a lock-out survey before moving the radiographic device; failed to wear an individual radiation monitor; and failed to wear an alarming ratemeter during radiographic operations. The incident was referred for escalated enforcement.

File Closed.

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COMPLAINT SUMMARY FOR FIRST QUARTER 2002

C-1643 - Regulation Violations - Carla Emery, D.P.M. - Austin, Texas

On January 9, 2002, the Agency received a complaint alleging the Registrant did not provide lead shields or aprons or personnel monitoring to technologists performing radiographs. An Agency investigation determined the Registrant had lead shields and aprons available for technologist and patient use. Personnel monitoring had been discontinued at the facility in 1998, due to the historical exposures being below Agency required monitoring limits. However, during the investigation it was determined that: the Registrant had not informed the Agency of a change of radiation safety officer within 30 days after the change; the Registrant failed to make surveys of radiation levels in unrestricted areas to demonstrate compliance with dose limits to the public after an x-ray machine was moved; and the Registrant could not provide evidence documenting annual testing of protective devices for defects. The Registrant was cited for the violations.

File Closed.

C-1644 - Regulation Violation - Phymed - Dallas & Fort Worth, Texas

On December 3, 2001, the Agency received several complaints alleging a Registrant had gone out of business and was no longer providing mammography films to patients for comparison. An Agency investigation substantiated the allegation. The Registrant had closed its operations and filed for bankruptcy. The films remained locked in the buildings where the Registrant previously operated. The Registrant failed to make provisions for retrieval of films for patients nor were the films transferred to a viable company. The Agency intervened to provide some assistance with the retrieval of mammography films. The complaint was referred for escalated enforcement.

File Open.

C-1645 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1646 - Inadequate Shielding - 3D Imaging - Austin, Texas

On January 11, 2002, the Agency received an anonymous complaint alleging a company was using radiation next door to an elementary school. An Agency investigation determined a company located next to the school was operating a computed tomography x-ray scanner unit. The scanner was located in a room shielded with two feet of concrete. The Agency performed surveys outside the building while the unit was energized. No readings above background were detected in the direction of the school.

File Closed.

C-1647 - Regulation Violation - Frost Chiropractic Clinic - Atlanta, Texas

On January 25, 2002, the Agency received an anonymous complaint alleging that: the Registrant used x-ray equipment not repaired to Agency required standards; the Registrant failed to supply lead aprons or a lead shield for protection during radiographic exposures; the Registrant failed to provide personnel monitoring; the physician stands too close to the x-ray tube while performing radiographs; and the darkroom chemicals are improperly handled, resulting in spills of hazardous chemicals. An Agency investigation determined a new x-ray machine had been installed on March 3, 2002, and meets all machine requirements of Agency regulations. A new processor had been installed, and during its initial operations, a faulty water tank pressure gauge caused water, not hazardous chemicals, to overflow from the equipment. A serviceable lead apron and portable lead shield were available. The investigation determined the Registrant had not provided personnel monitoring after the change of x-ray equipment and had no documentation of determination of doses to either occupationally exposed personnel or the public. The facility was cited for the personnel monitoring violation and another violation unrelated to the complaint.

File Closed.

C-1648 - Regulation Violation - Austin Radiological Association - Austin, Texas

On February 7, 2002, the Agency received a complaint alleging a Registrant lost an individual's mammography films. An Agency investigation determined the Registrant was unable to locate the individual's films for 2000 and 2001. The Registrant became aware the films were missing when the films were requested for comparison with current mammography films. A thorough search of several facilities did not locate the films. The Registrant was cited for failure to maintain mammography films in a permanent medical record for a minimum of five years.

File Closed.

C-1649 - Regulation Violation - Texas Mobile Health/Crystal Woman Foundation/Better Solutions - Seabrook, Texas

On February 15, 2002, the Agency received a complaint alleging a company, responsible for maintaining mammography films for two closed mammography facilities, had made an unauthorized transfer of mammography films to a company, that had used the two closed companies' services for their employees. An Agency investigation determined the maintenance company had: failed to maintain, and make available to patients, their original mammography films; made an unauthorized transfer of original films; and records were forwarded to an unauthorized, unregistered facility that could not maintain the films in accordance with Agency rules. The former Registrants had failed to maintain mammography films and reports in a permanent medical record for a required period of time. The complaint was referred for escalated enforcement action.

File Closed.

C-1650 - Unlicensed Source - TruGlo, Incorporated - Dallas, Texas

On January 23, 2002, the U.S. Nuclear Regulatory Commission, Region IV, forwarded a complaint to the Agency alleging a Texas firm was in possession of and using tritium to manufacture bow sights, without a specific license issued by the State of Texas. The Agency was aware of the firm, that was in the process of completing their specific license for possession and use of the radioactive material.

File Closed.

C-1651 - Unsafe Radiation Safety Practices - Gulf Coast Welding Specialists - Orange, Texas

On February 28, 2002, the Agency received a complaint alleging the Licensee allowed unsafe radiation safety practices by a radiography trainer while performing industrial radiography and during transportation of radioactive materials. It was alleged these complaints had been lodged with both the company owner and the radiation safety officer, with no actions taken. An Agency investigation, involving interviews with radiography personnel, records reviews, and two site inspections, could not substantiate the allegations.

File Closed.

C-1652 - Regulation Violations - Biotech Pharmacy - El Paso, Texas

On February 20, 2002, the New Mexico Radiation Control Agency forwarded a complaint to the Agency alleging a Texas Licensee delivered technetium generators to customers that, when eluted, did not produce the expected activity. Allegedly, the generators were used, then sold to customers as full. An Agency investigation substantiated the allegation. This routine occurred weekly for two regular accounts located in New Mexico. The Licensee was cited for failure to perform independent assays of generator activities upon dispensing the used generators to second owner medical facilities. The Licensee was also cited for failure to develop, document, and implement a radiation protection program.

File Closed.

C-1653 - Uncredentialed Technologist - Beauford Basped - Fort Worth, Texas

On March 1, 2002, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation determined facility employees positioned the patients, but the physician performed all radiographs. The employees and the physician both stated the physician would not allow anyone else to perform the radiographs. The allegation could not be substantiated.

File Closed.

C-1654 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1655 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1656 - Uncredentialed Technologist - Weslaco Advanced Medical - Weslaco, Texas

On March 6, 2002, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform computed tomography procedures. An Agency investigation determined the procedures were performed by a credentialed technologist. A complete inspection was performed and no items of noncompliance were found.

File Closed.

C-1657 - Regulation Violations - Real Inspection Training Engineering - Houston, Texas

On February 27, 2002, the Agency received an anonymous complaint alleging the Licensee allowed uncredentialed radiographers to perform radiography operations and that a radiography drive cable mechanism could not be disconnected from the exposure device. An Agency investigation determined that all radiographers employed by the Licensee had appropriate qualification, training, and State Certification. The Licensee had been having difficulty disconnecting a drive cable from the exposure device. However, the cable could be disconnected and functioned properly. The allegations could not be substantiated.

File Closed.

C-1658 - Regulation Violations - 21st Century Technologies, Inc. - Fort Worth/Haltom City, Texas

On March 19, 2002, the U.S. Nuclear Regulatory Commission forwarded to the Agency a complaint alleging a Texas Licensee had improperly submitted samples for termination of their facility. The Agency performed confirmation sampling of the site on November 15, 2001. No contamination was detected and the site was released to unrestricted use on March 15, 2002. An Agency letter was sent to the U. S Nuclear Regulatory Commission detailing Agency involvement in the termination of the site and expressing both the lack of contamination and the unrestricted release of the site.

File Closed.

C-1659 - Regulation Violations - Nuclear Sources and Service, Inc. - Houston, Texas

On March 16, 2002, the Texas Natural Resource Conservation Commission (TNRCC) forwarded a complaint to the Agency alleging exposure to the Licensee's radioactive waste and heavy metal waste had resulted in the cancer and death of an employee within 6 - 12 months of employment at the facility. The complainant also expressed concern over possible soil contamination that might be disturbed due to proposed expansion of the Licensee's facility. A joint investigation by the Agency and the TNRCC determined that background levels of Naturally Occurring Radioactive Material only were present in the soil. The complaint was not substantiated.

File Closed.

C-1660 - Uncredentialed Technologists - Diagnostic/Neuroimaging, L.P. - Arlington, Texas

On March 27, 2002, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed technologists to perform radiographs. An Agency investigation determined that all technologists performing x-ray procedures at the facility were properly credentialed. The allegation could not be substantiated.

File Closed.

C-1661 - Regulation Violations - Community Diagnostics - Dallas, Texas

On March 27, 2002, the Agency received an anonymous complaint alleging: the Registrant allowed uncredentialed technologists to perform radiographs; the radiation safety officer had left the facility without a required change to the Certificate of Registration; the x-ray equipment was not being properly maintained; and equipment performance checks by a licensed physicist were not current. An Agency investigation determined that all technologists were properly credentialed, and the radiation safety officer had been changed and not reported to the Agency within 30 days. The physicist reports for the facility's equipment were current. A routine inspection of a fluoroscopic unit determined the minimum x-ray field was not in accordance with Agency requirements. The facility was cited for failure to notify the Agency within 30 days of information that rendered the Certificate of Registration incorrect and for the equipment violation.

File Closed.

C-1662 - Regulation Violations - Cyvon Imaging - Dallas, Texas

On March 27, 2002, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform mammography and the radiation safety officer and lead interpreting physician was changed without notification to the Agency. An Agency investigation determined the radiation safety officer and lead interpreting physician had been changed without appropriate notification to the Agency and the Registrant could not provide documentation of qualification for one technologist. The Registrant was cited for the violations.

File Closed.

C-1663 - Regulation Violations - George Wooming, M.D. dba Liposculpture & Laser Center of Dallas / MEDNET Systems, Inc - Dallas / Sunnyvale, Texas

On March 29, 2002, the Agency received an anonymous complaint alleging: an unregistered laser was in operation; the laser was provided by an unregistered provider of equipment; and the facility had burned five patients through the improper use of the laser. An Agency investigation determined the facility was unregistered but had recently submitted an application for laser registration. The supplier of the rented laser was determined to be a registered provider of laser equipment. No evidence was found to indicate any patient had been burned. The facility was cited for not registering within 30 days of the commencement of operation. The provider of equipment was cited for providing equipment, for more than 30 days, to a facility not registered with the Agency.

File Closed.

C-1664 - Regulation Violations - ACD-SA, Limited dba Sendero Imaging & Treatment Center - San Antonio, Texas

On March 25, 2002, the Agency received an anonymous complaint alleging the Registrant did not: post a Notice to Employees; complete an annual protective device log; perform equipment performance evaluations for computed tomography, x-ray/fluoroscopic equipment, and C-Arm units; monitor the occupational exposure of employees and maintain records of occupational exposure of former employees; maintain film processing records; perform annual surveys of fluoroscopy equipment; perform radiation safety officer (R.S.O.) quarterly audits; or perform a dose to the public survey of the facility. An Agency investigation determined none of the allegations were valid except for the lack of R.S.O. audits, which was deleted from Agency regulations during the 2000 calendar year and is no longer required.

File Closed.

C-1665 - Radiation Exposure - Altivia - Houston, Texas

On March 21, 2002, the Agency received a complaint alleging the complainant had been exposed to radioactive material in scrap metal that had been detected by a local scrap processor and returned to the facility. The complainant was injured in an accident at the facility and his physician believed his injuries were slow to heal due to radiation exposure. An investigation determined that a large filter element returned from mining operations in Guyana, South America had less than 0.1 millirem levels of NORM contamination. No other radioactive materials were detected at the facility.

File Closed.

INCIDENTS CLOSED SINCE FOURTH QUARTER 2001

I-7464 - Stolen Moisture/Density Gauge - Texas Department of Transportation - Houston, Texas

On January 28, 2002, the Houston Fire Department, Hazardous Materials Unit notified the Agency that a moisture density gauge had been recovered from a rental garage in Houston, Texas. The gauge had been reported stolen on the evening or morning of April 21-22, 1999, from a temporary construction site in Houston, Texas. The gauge and case had minor cosmetic damage and the gauge was inoperative due to dead batteries. It was leak tested on January 30, 2002, with no leakage detected. The gauge has been placed in storage until repairs are made.

File Closed.

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COMPLAINTS CLOSED SINCE FOURTH QUARTER 2001

NO COMPLAINTS WERE CLOSED SINCE THIRD QUARTER 2001

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE FIRST QUARTER 2002

NO HOSPITAL OVEREXPOSURE REPORTED DURING FIRST QUARTER 2002

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING FIRST QUARTER 2002

Odessa, Texas

Radiation Technology, Inc. 1

Pasadena, Texas

Technical Welding 2

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APPENDIX C

ENFORCEMENT ACTIONS FOR FIRST QUARTER 2002

Enforcement Conference: Smithville Regional Hospital, Smithville, TX - Mammography

On January 29, 2002, an Enforcement Conference was held with Smithville Regional Hospital, holder of Certificate of Mammography No. M00488. The Smithville Regional Hospital representative attending the conference was Ms. Kelly Vitek, Supervisor of Radiology. Agency representatives attending the conference were Mr. Jerry Cogburn (Chairman), and Madames Alice Rogers and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on November 1, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

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

1. The Agency requested a written letter of commitment from the lead interpreting physician acknowledging he has reviewed 25 TAC §289.230(k)(1)(A), and acknowledges the responsibilities of the lead interpreting physician. The Registrant shall provide this information to the Agency within 30 days from the date of this Enforcement Conference summary.
2. The Registrant will add to their policy and procedures that a designated party will meet with the lead interpreting physician on a monthly basis to review the quality assurance program. This review will be conducted on a monthly basis for the first year, and then on a quarterly basis thereafter. The records will be made available for Agency review at the next inspection.
3. The Registrant will develop a system to analyze medical outcomes for patients seen within the past 12-month period. Subsequent audits will be conducted on an annual basis. The outcomes will be reviewed with each individual physician. A copy of the medical outcomes audit system will be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

4. An in-service will be provided to all mammography technicians addressing the quality control standard that has to be met in order to continue performing mammography. This in-service shall be documented on a sign off sheet, added to the policy and procedure manual, and made available for Agency review at the next inspection.
5. The Registrant will designate, in the policy and procedure manual, a hospital employee to review the mammography reports for final assessment of finding. A copy of this policy shall be submitted to the Agency within 30 days from the date of this Enforcement Conference summary.
6. The Registrant will provide the Agency with a request to change the radiation safety officer (R.S.O.) within 30 days from the date of this Enforcement Conference summary.
7. The newly designated R.S.O. will provide the Agency with a signed statement of understanding indicating the R.S.O. has reviewed the responsibilities of the R.S.O. This statement shall be provided to the Agency within 30 days of the date of this Enforcement Conference summary.
8. The Registrant will notify Cathy McGuire prior to resuming mammography operations.
9. The Registrant's inspection frequency will be increased.
10. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, should any severity level I, II or repeat violations be cited, administrative penalties may be assessed at that time.

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

Enforcement Conference: Presbyterian Hospital, Kaufman, TX - Mammography

On February 5, 2002, an Enforcement Conference was held with Presbyterian Hospital of Kaufman, holder of Certificate of Mammography No. M00341. Presbyterian Hospital of Kaufman representatives attending the conference were Messrs Kirk King and Michael S. Davis and Ms. Dani Morales. Agency representatives attending the conference were Messrs Jerry Cogburn (Chairman), and Jack England and Madames Jo Turkette and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on November 12, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

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

1. The Agency requested a written letter of commitment from the lead interpreting physician acknowledging that he has reviewed 25 TAC §289.230(k)(1)(A), and TAC §289.230(l) and (m) pertaining to the quality control program records review, and acknowledging the responsibilities of the lead interpreting physician as applicable to these subsections. The Registrant shall provide this information to the Agency within 30 days from the date of this Enforcement Conference summary.
2. The Registrant will provide a written policy giving the quality control technician the authority to terminate mammography procedures should any quality control limits be exceeded.
3. The Registrant will provide a copy of the policy regarding Continuing Education Units to all temporary mammography technicians.
4. The Registrant's inspection frequency will be increased.
5. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, should any severity level I, II or repeat violations be cited, administrative penalties may be assessed at that time.

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

Enforcement Conference: Omni Equity Ltd. Co., Lubbock, TX – Laser

On February 12, 2002, an Enforcement Conference was held with Omni Equity Ltd. Co., dba Llano Laser and Aesthetic Center, holder of Certificate of Laser Registration No. Z01507. The Llano Laser and Aesthetic Center representative attending the conference was Mr. Tom King, Managing Member, L.S.O. Agency representatives attending the conference were Messrs Jerry Cogburn (Chairman), Thomas Cardwell, James Ogden, and Tom Brinck, representing Drugs and Medical Devices Division, and Madames Alice Rogers and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on October 18, 2001. This was a joint facility investigation conducted by the Bureau of Radiation Control and the TDH Drugs and Medical Devices Division. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

A conference call was made to Mr. Tom Brinck, Chief, to address issues relative to the Bureau of Food and Drug Safety. Mr. Brinck asked if Llano Laser and Aesthetic Center was still in operation and was told it was closed. Mr. Brinck asked whether Mr. King had received the Code of Federal Regulations regarding requirements for prescription devices, and explained the Code requires supervision by a licensed practitioner in the State of Texas. This also applies to the Texas Food, Drug, and Cosmetics Act, which requires adequate supervision by a licensed practitioner for use of prescription devices such as lasers, or intense pulse light devices. Mr. Brinck also addressed the fact that Rejuvi was not approved by the Food and Drug Administration, and was not legal for use in the State of Texas. Mr. King indicated that he would not be using this product again. Mr. Brinck then terminated the conference call.

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

1. The Agency requested a written request for termination of Llano Laser and Aesthetic Center's registration, and a written statement indicating the laser is stored and can not be utilized. This request shall be provide to the Agency within 30 days from the date of this Enforcement Conference summary.
2. No Administrative penalties will be assessed at this time

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

Enforcement Conference: Coulter Imaging Center, Amarillo, TX – X-Ray Medical

On February 14 2002, an Enforcement Conference was held with Coulter Imaging Center, L.L.C., holder of Certificate of Registration No. R13716. Coulter Imaging Center, L.L.C. representatives attending the conference were Mr. David Allison, Esq. And Ms. Anita Tilden. Agency representatives attending the conference were Messrs Thomas Cardwell (Chairman), Jerry Cogburn and Jack England and Madames Alice Rogers, Nancy Ivester, and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on December 28, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

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

1. The Registrant will check the manufacturer's recommendation on the type of film, film speed, film screen combination, developer, replenishment rates, and recommended processor temperature.
2. The Registrant will provided the Agency a written statement from the radiation safety office indicating he reviewed the radiation safety officer duties in 25 TAC §289.252(f) and is committed to carrying out those duties. This shall be provided to the Agency within 30 days from the date of this Enforcement Conference summary.
3. The Registrant will develop a new technique chart and submit a copy to the Agency within 30 days from the date of this Enforcement Conference summary.
4. The Registrant will have a physicist perform an annual equipment performance evaluation and provide a copy of the evaluation to the Agency for the years 2002 and 2003.
5. The Registrant will be placed on an increased unannounced inspection frequency.
6. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are cited.

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

Enforcement Conference: Geoscience Engineering & Testing, Inc. – San Antonio, TX – Industrial Gauge

On March 14, 2002, an Enforcement Conference was held with Geoscience Engineering & Testing, Inc., holder of License No. L05180. The Geoscience Engineering & Testing, Inc. representative attending the conference was Mr. James Ellis, Vice-President. Agency representatives attending the conference were Messrs. William Silva (Chairman), and Robert Green, and Ms. Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of two facility inspection conducted on March 20, and March 24, 2001. These inspections determined the number and severity level and repetitiveness of the violations noted during these inspections have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

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

1. The Licensee's inspection frequency will be increased and unannounced inspections will be conducted at an interval of not more than every two years at all three sub sites. Following the second inspection at all the sub sites, if no severity level I, II or repeat violations are cited, the Licensee will revert back to the normal inspection interval.
2. Pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

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

Enforcement Conference: Pro-Log – Denver City, TX – Well Logging

On March 19, 2002, an Enforcement Conference was held with Pro-Log, holder of License No. L01828. Pro-Log representatives attending the conference were Messrs. W.R. Flippin, President, and Donnie Philips. Agency representatives attending the conference were Madames Alice Rogers (Chairman), and Cathy McGuire and Messrs. William Silva and Robert Green.

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

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

1. Violation #1, listed on the Notice of Violation dated February 14, 2002, would be removed due to information, provided at the conference, indicating the gauge had not left the facility for transport to another location.
2. The Licensee's inspection frequency will be increased and unannounced inspections will be conducted.
3. The Agency requested the Licensee develop a written checkout procedure and submit it to the Agency as a license amendment within 30 days from the date of this Enforcement Conference summary.
4. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

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

Enforcement Conference: Good Shepherd Medical Center – Longview, TX – Nuclear Medicine

On March 26, 2002, an Enforcement Conference was held with Good Shepherd Medical Center, holder of License No. L02411. Good Shepherd Medical Center representatives attending the conference were Madames Jane Chandler and Debbie Jester, Dr. Kim Howard, and Mr. Rita Gould. Agency representatives attending the conference were Madames. Alice Rogers (Chairman), and Cathy McGuire and Messrs. Arthur Tate and David Wood.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of two facility inspections conducted on January 8, and January 10, 2001. These inspections determined the number and severity level and repetitiveness of the violations noted during these inspections have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

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

1. The Agency requested the Licensee formalize their administrative control procedures as related to 25 TAC §289.202(nn), (1), (p), and (y), License Condition 20, and the Licensee's procedures, in writing. The Licensee shall develop methods of auditing these procedures, and submit them to the Agency within 30 days from the date of this Enforcement Conference summary.
2. The Licensee's inspection frequency will be increased and unannounced inspections will be conducted.
3. In reference to the disposal of the trash from the stress labs, the Licensee will train all technicians and submit documentation to the Agency within 30 days from the date of this Enforcement Conference summary. Should the Licensee wish to change the procedure to add a trash container to the Stress Lab, they must have a license amendment granted prior to instituting this change.
4. The Licensee's radiation safety officer (R.S.O.) will review the duties of the R.S.O. in 25 TAC Section 289.256(g) and provide the Agency with a written statement indicating the duties have been review and understood, and the R.S.O. will adhere to these regulations.

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

Enforcement Conference: Bowie Hospital Authority, Bowie, TX - Mammography

On January 18, 2002, an Enforcement Conference was held with Bowie Hospital Authority, holder of Certificate of Mammography No. M00515. Bowie Hospital Authority representatives attending the conference were Mr. Daniel Pruitt, Director of Radiology, and Ms. Joyce Crumpler, Administrator. Agency representatives attending the conference were Messrs. Jerry Cogburn (Chairman), and Jack England and Madames Alice Rogers, Nancy Ivester, and Cathy McGuire.

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

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

1. The Registrant's lead interpreting physician and mammography technician will attend an Agency approved 8-hour mammography training course and provide a copy of the certificate of completion to the Agency within 90 days of the date of this Enforcement Conference summary. The course curriculum shall be submitted to the Agency for approval prior to attending the course.
2. The Agency requested a signed written commitment from the lead interpreting physician stating the quality assurance program will be reviewed monthly beginning in February 2002. This signed commitment will also include an acknowledgment the lead interpreting physician has reviewed 25 TAC §289.230(k)(1)(A) and acknowledges the responsibilities of the lead interpreting physician. The Registrant shall provide this information to the Agency within 30 days from the date of this Enforcement Conference summary.
3. The Registrant will be placed on an increased unannounced inspection frequency.
4. Pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

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

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