

REDACTED - 8/2003

SUMMARY OF INCIDENTS FOR SECOND QUARTER 1998

I-7282 - Radioactive Material in Scrap - Structural Metals -
Sequin, Texas

On July 13, 1997, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on July 13, 1997. The scrap yard isolated the radioactive material which appeared to be a device from a military airplane. The United States Air Force took possession of the device on April 20, 1998.

File Closed.

I-7283 - Radioactive Material in Scrap - Commercial Metals/ Spoetzl
Brewery - Austin/Shiner, Texas

On January 13, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on January 13, 1998. An Agency investigation determined the radioactive material was a 12 millicurie cesium-137 sealed source used in a flow measurement device. The source was disposed of through a licensed disposal company.

File Closed.

I-7284 - Radioactive Material in Scrap - Commercial Metals -
Austin, Texas

On December 19, 1997, a scrap yard notified the Agency that radioactive material was found in a load of scrap metal on December 19, 1997. The scrap yard determined the radioactive material was a 1.5 millicurie radium-226 source. The scrap yard disposed of the source through a licensed disposal company.

File Closed.

I-7285 - Radioactive Material in Scrap - Commercial Metals - Austin, Texas

On December 9, 1997, a scrap yard notified the Agency that radioactive material was found in a load of scrap metal on December 5, 1997. The scrap yard determined the radioactive material was a 34 microcurie radium-226 needle. The scrap yard disposed of the source through a licensed disposal company.

File Closed.

I-7286 - Dose Irregularity - Methodist Hospital/Syncor - San Antonio, Texas

On March 26, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on March 26, 1998. A patient was [REDACTED] instead of the intended [REDACTED]. The pharmacist drew the dose from the wrong vial. This was the only dose drawn from that vial. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy conducted an inservice to remind pharmacists to verify the proper dispensing vial is used.

File Closed.

I-7287 - Uranium Spill - URI, Inc. - Kingsville, Texas

On March 18, 1998, the Licensee notified the Agency of a uranium spill consisting of approximately 2 cups of yellowcake slurry that occurred in the parking lot of a Corpus Christi, Texas, construction company on March 18, 1998. The yellowcake slurry seeped past a flange on a slurry tank. Bioassay results for all personnel in the vicinity were negative and the spill was cleaned by the Licensee. To prevent a recurrence, the Licensee improved inspection procedures for flanges on slurry tanks and conducted training for yellowcake transportation spill response.

File Closed.

I-7288 - Radioactive Material Lost - Spoetzl Brewery - Shiner, Texas

On March 10, 1998, the Licensee notified the Agency that two generally licensed level gauges each containing 25 millicuries of cesium-137 have been unaccounted for since 1992. The Licensee conducted a thorough search of the facility and contacted the manufacturer to determine if the gauges had been returned for disposal. There was no indication that the gauges had been returned to the manufacturer. The gauges have not been located.

File Inactive.

I-7289 - Dose Irregularity - Providence Memorial Hospital/Sierra Medical Center/Syncor - El Paso, Texas

On March 30, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] each of [REDACTED] that occurred on March 21, 1998. Six patients from two different hospitals were [REDACTED] and showed [REDACTED] instead of just the [REDACTED]. The Licensee believes the explanation was inherent to the product since research shows that many different complexes form in a [REDACTED] kit. The patients and referring physicians were notified. The whole body doses were less than 5 rem and no organs received greater than 50 rad.

File Closed.

I-7290 - Dose Irregularity - St. Luke's Episcopal Hospital - Houston, Texas

On April 1, 1998, the Licensee notified the Agency of a dose irregularity involving 24 iridium-192 seeds, each having an activity of [REDACTED], that occurred on March 27, 1998. The out-of-state distributor switched the labels between the [REDACTED] and the [REDACTED] shipments. Since the labels could not be removed, the Licensee switched the [REDACTED] and the [REDACTED] to the appropriately labeled shipping container.

File Closed.

I-7291 - Radioactive Material Found in Scrap - Commercial Metals - Austin, Texas

On April 17, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on March 18, 1998. The scrap yard determined the radioactive material was a 0.56 millicurie radium-226 sealed source in a gas chromatograph. The scrap yard disposed of the source through a licensed disposal

company.

File Closed.

I-7292 - Radioactive Material Found in Scrap - Commercial Metals - Austin, Texas

On April 17, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on April 17, 1998. The scrap yard determined the radioactive material was a 7 microcurie radium-226 sealed source in a dew pointer. The scrap yard disposed of the source through a licensed disposal company.

File Closed.

I-7293 - Misadministration - MD Anderson Cancer Center - Houston, Texas

On March 27, 1998, the Licensee notified the Agency of a misadministration involving a [REDACTED] that occurred on March 27, 1998. The patient was scheduled for [REDACTED] in order to receive the dose. Due to [REDACTED] the patient would not stay in the bed for the treatment and received only [REDACTED]). The physician used an [REDACTED] to make up the remaining [REDACTED]. This resulted in the patient receiving the intended dose of approximately 3500 cGy (rads). The patient and referring physician were notified. To prevent a recurrence with [REDACTED] patients, high dose rate tandem and ovoid treatment techniques will be used.

File Closed.

I-7294 - Dose Irregularity - University Medical Center/Syncor - Lubbock, Texas

On March 13, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on March 2, 1998. A patient was [REDACTED] instead of the intended dose of [REDACTED]. The pharmacy reversed the labels on the two doses. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy counseled the pharmacist on comparing the printed prescriptions with telephone order before dispensing the prescription.

File Closed.

I-7295 - Dose Irregularity - Clinics of North Texas/North Texas
Isotopes - Wichita Falls, Texas

On April 9, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on March 10, 1998. A patient was [REDACTED] instead of the intended [REDACTED]. The pharmacist inadvertently grabbed the [REDACTED] kit and added it to the [REDACTED] prescription. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy color coded the kits for easier identification.

File Closed.

I-7296 - Radioactive Material Found - Haliburton Energy Services /Bush Intercontinental Airport - Houston, Texas

On April 27, 1998, the United States Nuclear Regulatory Commission (NRC) notified the Agency of an improperly labeled radioactive package that arrived on an international flight and caused the radiation detectors at the airport to alarm. An Agency investigation determined that the radioactivity was a 100 millicurie cesium-137 sealed source that was labeled as "empty." The shipping papers were correctly filled out. The incident was forwarded to the NRC for issuance of a citation for improper labeling of radioactive materials.

File Closed.

I-7297 - Dose Irregularity - Valley Nuclear Incorporated - Mission, Texas

On July 13, 1998, the Licensee notified the Agency of a dose irregularity involving 8 millicuries of technetium-99m sulfur colloid that occurred on June 16, 1998. The pharmacy performed quality control on the dose and it was below standards. The hospital was notified before the dose was administered. The pharmacy sent a replacement dose to the hospital.

File Closed.

I-7298 - Lost Radioactive Material - Litton Electro-Optical Systems - Garland, Texas

On March 30, 1998, the Licensee notified the Agency that 49 gaseous tritium light sealed sources containing a total of approximately 33 curies of tritium were lost between July 29, 1997 and March 6, 1998. Attempts by the Licensee to recover the sources were unsuccessful. The Licensee was cited for failure to maintain control of radioactive material and failure to conduct and record a physical inventory at intervals not greater than 6 months to account for all sealed sources received and possessed under the license. To prevent a recurrence, the Licensee locked all radioactive sources in a cabinet.

File Closed.

I-7299 - Radioactive Contamination - M.D. Anderson Hospital/ Mallinckrodt - Houston, Texas

On April 17, 1998, the Licensee notified the Agency of removable contamination of 380,000 disintegrations per minute per 100 square centimeters of thallium-201 on a radiopharmaceutical package that occurred on April 14, 1998. The package was being delivered from the pharmacy to the hospital when the contamination was discovered.

The package was decontaminated and no personnel were contaminated. To prevent a recurrence, the Licensee reviewed packaging requirements with all personnel and modified the package survey procedures.

File Closed.

I-7300 - Dose Irregularity - M.D. Anderson Hospital/Mallinckrodt - Houston, Texas

On April 20, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on April 13, 1998. The biodistribution was not as intended. The reason for the altered distribution was not discovered since all other images from this lot were as expected. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7301 - Badge Overexposure - Huntsville Memorial Hospital - Huntsville, Texas

On April 14, 1998, the Registrant notified the Agency of a 550 rem exposure to a fluoroscopic x-ray technician during the March 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and an assessment of 20 millirems, based on exposure history and co-worker exposure, was accepted.

File Closed.

I-7302 - Uranium Spill - Cogema Mining, Inc. - Bruni, Texas

On May 4, 1998, the Licensee notified the Agency of a uranium spill involving approximately 20,000 gallons of restoration flow solution containing 8.6 parts per million (5.7 microcuries per gram) uranium that occurred on May 2, 1998. The spill was caused by the failure of a saddle on the lateral line and was contained within the licensed area.

File Closed.

I-7303 - Source Abandoned Downhole - Schlumberger - Sugar Land, Texas

On May 1, 1998, the Licensee notified the Agency that a 1.7 curie cesium-137 source was abandoned downhole on May 1, 1998. Attempts to retrieve the source were unsuccessful. The source was abandoned at a depth of 8,996 feet. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25TAC289.253.

File Closed.

I-7304 - Dose Irregularity - Providence Memorial Hospital/Syncor - El Paso, Texas

On April 8, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] tagged with [REDACTED] that occurred on April 6, 1998. The image indicated [REDACTED] which indicated that some of the [REDACTED] were also tagged. The Licensee was unable to determine the cause of the abnormal biodistribution. The scan was not repeated since successful diagnostic results were obtained. The whole body dose was less than 5 rem and no organ received greater than 50 rad.

File Closed.

I-7305 - Dose Irregularity - Columbia Medical Center/Arlington Memorial/Charlton Methodist/Syncor - Arlington, Texas

On May 11, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on May 9, 1998. Three hospitals and a pharmacy were involved. The pharmacy intended to prepare [REDACTED] and [REDACTED] doses of [REDACTED] but the pharmacist switched the order and prepared [REDACTED] doses of [REDACTED] and [REDACTED] doses of [REDACTED] instead. All five patients were [REDACTED] with the wrong radiopharmaceutical. The patients and referring physicians were notified. The whole body doses were less than 5 rem and no organs received greater than 50 rad. To prevent a recurrence, the pharmacy conducted an inservice to train pharmacist on thoroughly checking kits before compounding and to only use one kit in the drawing station at a time.

File Closed.

I-7306 - Dose Irregularity - North Austin Medical Center/Syncor - Austin, Texas

On May 5, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on April 28, 1998. The patient was scheduled to receive [REDACTED] but received [REDACTED] instead. The pharmacy filled the [REDACTED] prescription with [REDACTED] and mislabeled the dose as [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy held an inservice for pharmacists to double check setups before drawing doses.

File Closed.

I-7307 - Radioactive Material Found in Scrap - Structural Metals -
Sequin, Texas

On May 5, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on March 13, 1998. The scrap yard determined the radioactive material to be a brass bushing containing 5.5 microcuries of radium-226. The scrap yard disposed of the material through a licensed disposal company.

File Closed.

I-7308 - Radioactive Material Found in Scrap - Commercial Metals -
Austin, Texas

On May 5, 1998, the scrap yard notified the Agency that radioactive material was found in a load of scrap metal on March 31, 1998. The scrap yard determined the radioactive material was military aircraft gauges containing 4.85 microcuries of radium-226. The scrap yard disposed of the material through a licensed disposal company.

File Closed.

I-7309 - Equipment Malfunction - Formosa Plastics - Point Comfort,
Texas

On May 20, 1998, the Licensee notified the Agency of an equipment malfunction involving a level gauge containing a 150 millicurie cesium-137 sealed source that occurred on May 20, 1998. The source became disconnected but remained in the source holder. The Licensee is awaiting support from the gauge manufacturer to retrieve the shielded source.

File Open.

I-7310 - Dose Irregularity - MD Anderson Cancer Center/
Mallinckrodt - Houston, Texas

On June 2, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on May 22, 1998. The dose was assayed by the hospital at [REDACTED] and was not used. Another dose was obtained to perform the treatment. The dose in question was disposed of before the pharmacy could retrieve the dose for evaluation.

File Closed.

I-7311 - Unauthorized Disposal of Radioactive Material - St.
David's Medical Center/BFI Landfill - Austin, Texas

On May 14, 1998 and May 15, 1998, a landfill notified the Agency of elevated radiation levels on two dumpsters received on May 14, 1998 and May 15, 1998. The medical center retrieved the waste on both occasions and determined the radioactive material was [REDACTED] from the same patient. An Agency investigation determined that the Licensee: created an exposure in an unrestricted area that exceeded regulatory limits and transferred radioactive material in a manner not authorized by regulation. The Licensee was cited for the violations. To prevent a recurrence, the Licensee modified their orders for post-indium patients.

File Closed.

I-7312 - Misadministration - University of Texas Health Science Center - San Antonio, Texas

On May 21, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] that occurred on May 19, 1998. The patient was administered a dosage [REDACTED] different from the intended dose of [REDACTED]. The technician failed to follow procedures consisting of identifying the patient and verifying the radiopharmaceutical. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee retrained the technician on policies and guidelines for dose administration.

File Closed.

I-7313 - Regulation Violations - Technical Welding - Pasadena, Texas

On May 21, 1998, United States Customs Agents reported that their radiation detectors alarmed while traveling on a highway on May 20, 1998. An Agency investigation determined that industrial radiography was being performed in the area. Field inspections of two radiography crews were conducted. The Licensee was cited for: failure to wear personnel monitoring devices; failure to perform surveys of the radiographic device to determine that the source returned to its shielded position; failure to keep area survey records; and recording lock-out and vehicle surveys prior to the survey being performed.

File Closed.

I-7314 - Badge Overexposure - Methodist Hospital - San Antonio, Texas

On May 26, 1998, the Registrant notified the Agency of a 23 rem exposure to a technologist during the April 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7315 - Stolen Moisture/Density Gauge - Paradigm Consultants, Inc. - Houston, Texas

On June 2, 1998, the Licensee notified the Agency of the theft of a moisture/density gauge containing a 10 millicurie cesium-137 source and a 50 millicurie americium-241 source that occurred on May 5, 1998. The gauge was stolen from a vehicle at an apartment complex. The Licensee notified the local police. The Licensee was

cited for not maintaining constant surveillance of radioactive material in an unrestricted area. The gauge has not been recovered.

File Inactive.

I-7316 - Radioactive Material Found - Air Force Radioisotope Committee - San Antonio, Texas

On May 26, 1998, the NRC notified the Agency that a Nuclear Regulatory Commission (NRC) Licensee had sent a load of scrap to a salvage yard that contained 34 helicopter transfer gear cases, each containing 40 microcuries of natural thorium, on May 1, 1998. The NRC Licensee took possession of the material and has arranged for proper disposal.

File Closed.

I-7317 - Dose Irregularity - John Peter Smith Hospital/Syncor - Fort Worth, Texas

On June 5, 1998, the Licensee notified the Agency of a dose irregularity involving [REDACTED] that occurred on May 21, 1998. The images revealed an unexpected biodistribution. This was a [REDACTED] with the same patient that occurred in January 1997. The unusual distribution was attributed to the patient's [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rads.

File Closed.

I-7318 - Possible Overexposure - BIX Testing Laboratories, Inc. - Baytown, Texas

On May 24, 1998, the Licensee notified the Agency that an industrial radiography crew received excessive radiation exposures on May 23, 1998. An Agency investigation determined that the radiography crew failed to perform a radiation survey of the entire circumference of the radiographic exposure device, source guide tube, and collimator after each radiographic exposure to determine that the sealed source had returned to the shielded position. This resulted in the pocket dosimeters going off-scale during radiographic operations. The radiographers were cited for the violation. The radiographers received exposures that did not exceed regulatory limits. To prevent a recurrence, the radiographers were counseled on proper survey procedures and were suspended from work for two weeks.

File Closed.

I-7319 - Unauthorized Use of Radioactive Material - Texas A&M University - College Station, Texas

On June 11, 1998, the Licensee notified the Agency of unauthorized possession of 20 picocuries of plutonium-242 that occurred on June 9, 1998 during a field experiment. A graduate student carried the radioactive material aboard a U.S. Coast Guard vessel off the coast of Alaska. The material was returned to the authorized storage area on June 17, 1998. The Licensee was cited for: allowing licensed radioactive material to be possessed at a location other than authorized, failure to conduct radiation safety training for the graduate student, unauthorized transportation of the material, failure of the user to obtain approval for conducting the field experiment. To prevent a recurrence, the Licensee terminated one permitted user, suspended a permitted user, increased security of licensed material, increased radiation survey performance intervals, and increased the frequency of internal inspections for this area of the university.

File Closed.

I-7320 - Radioactive Material Lost - Alpha Testing, Inc. - Dallas, Texas

On June 12, 1998, the Licensee notified the Agency of the loss of a moisture/density gauge containing an 8.2 millicurie cesium-137 source and a 40 millicurie americium-241 source that occurred between December 31, 1997 and May 31, 1998. The gauge was last used on December 31, 1997 and was unaccounted for during the May 31, 1998 inventory. The Licensee notified the local police. The Licensee was cited for the loss of control of radioactive material. The gauge has not been recovered. To prevent a recurrence, the Licensee adopted new procedures for gauge users.

File Inactive.

I-7321 - Equipment Damaged - Wheeler Coatings Asphalt, Inc. - Round Rock, Texas

On June 15, 1998, the Licensee notified the Agency of damage to a moisture/density gauge containing a 9 millicurie cesium-137 sealed source and a 44 millicurie americium-241 sealed source that occurred on June 15, 1998. The gauge was run over by a construction vehicle. The handle and case were damaged but there was no damage to the sources or the shielding. A leak test indicated no leakage. The gauge was returned to the manufacturer for repair.

File Closed.

I-7322 - Dose Irregularity - St. Luke's Episcopal Hospital - Houston, Texas

On June 2, 1998 the Licensee notified the Agency of a dose irregularity involving fifteen 3.38 millicurie gold-198 seeds that occurred on June 1, 1998. The courier delivered the seeds to the wrong hospital. The courier was notified and redelivered the seeds to the correct hospital.

File Closed.

I-7323 - Source Abandoned Downhole - Schlumberger - Sugar Land, Texas

On June 21, 1998, the Licensee notified the Agency that a 1.7 curie cesium-137 source and a 16 curie americium-241 source were abandoned downhole on June 21, 1998. Attempts to retrieve the source were unsuccessful. The sources were abandoned at depths of 9,320 feet and 9,293 feet respectively. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25TAC289.253.

File Closed.

I-7324 - Equipment Malfunction - Columbia Clear Lake Regional Medical Center - Webster, Texas

On June 11, 1998, the Licensee notified the Agency of an equipment malfunction involving a Nucletron Selectron Remote Afterloading Brachytherapy Unit, Model SEL 103, that occurred on June 11, 1998. After the applicator was inserted and connected to the selectron unit, the sources did not go all the way out and the unit was unable to retract them. This left [REDACTED] the patient. The patient was immediately [REDACTED] and the [REDACTED] rolled down the applicator into a lead pig. The patient was [REDACTED], but the malfunction of the selectron resulted in a dose of less than [REDACTED]. The patient and referring physician were notified. The malfunction was caused by operator error in that the wrong applicator was used for the procedure. The unit was repaired by a service company the following day.

File Closed.

I-7325 - Lost Radioactive Material - MD Anderson Cancer Center - Fort Worth, Texas

On June 18, 1998, the Licensee notified the Agency of the loss of a [REDACTED] that occurred on June 17, 1998. The Licensee's attempts to locate [REDACTED] were unsuccessful. The Licensee believes the manufacturer sent only [REDACTED] of the intended [REDACTED], or [REDACTED] were loaded incorrectly into the needles, or the [REDACTED] was misplaced during the procedure. The dose to the patient was approximately [REDACTED]. To prevent a recurrence, the Licensee will use radiographic films to count seeds after loading needles to obtain an accurate count.

File Closed.

I-7326 - Misadministration - Park Plaza Hospital - Houston, Texas

On June 15, 1998, the Licensee notified the Agency of a misadministration involving [REDACTED] that occurred on June 1, 1998. The dose was administered to the wrong patient resulting in a dose [REDACTED] difference from the intended dose [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee revised the procedures for transporting patients to the nuclear medicine department.

File Closed.

I-7327 - Badge Overexposure - Columbia Bellaire Medical Center - Houston, Texas

On June 23, 1998, the Registrant notified the Agency of a 10.48 rem exposure to an x-ray technologist during the May 5, 1998 through June 4, 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and a minimal assessment, based on exposure history, was accepted.

File Closed.

I-7328 - Badge Overexposure - Longview Inspection - Houston, Texas

On July 9, 1998, the Licensee notified the Agency of a 5.5 rem exposure to an industrial radiographer during the January 1998 through May 1998 reporting periods. An Agency investigation determined the exposure was only to the badge. A deletion was granted and an assessment of 350 millirems, based on exposure history and co-worker exposure, was accepted.

File Closed.

I-7329 - Equipment Malfunction - TN Technologies - Round Rock, Texas

On January 14, 1998, the NRC notified the Agency of an equipment failure involving a Texas Nuclear Model 5409 Pipe Gauge that occurred on October 29, 1997 in Long Beach, California. The shutter mechanism failed to close on the gauge resulting in a potential exposure in excess of regulatory limits. An Agency investigation determined that corrosion from nearby salt water caused the failure and the manufacturer concluded that the events surrounding the incident were not related to an equipment defect.

File Closed.

I-7330 - Lost Radioactive Material - Texas Department of Health - Austin, Texas

On June 23, 1998, the Licensee notified the Agency of a missing x-ray fluorescence gauge containing a 40 millicurie cobalt-57 sealed source that occurred on June 23, 1998. The gauge was found the following day in a vacant office.

File Closed.

I-7331 - Uranium Spill - Cogema Mining, Inc. - Bruni, Texas

On May 26, 1998, the Licensee notified the Agency of a uranium spill involving approximately 8,000 gallons of restoration flow solution containing 7.4 parts per million uranium that occurred on May 21, 1998. The spill was caused by a failure at a pipe connection and was contained within the licensed area.

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COMPLAINT SUMMARY FOR SECOND QUARTER 1998

C-1308 - Exposure to Public - Texas Regional Heart Centre - Plano, Texas

On June 26, 1997, the Agency received a complaint alleging that radiation from a Licensee, located downstairs from the complainant, was causing electrical interference on computer systems. An Agency investigation determined the Licensee was a diagnostic nuclear medicine facility and electrical interference from radiation was not possible from this facility.

File Closed.

C-1309 - Radioactive Material Contamination - Cherry Crushed Concrete - Pearland, Texas

On February 27, 1998, the Agency received an anonymous complaint alleging that radioactive materials were buried on a company's site during June or July 1997. The Agency performed a radiation survey of the company's grounds and interviewed employees. The Agency was unable to substantiate the allegations.

File Closed.

C-1310 - Uncredentialed Technologist - Columbia St. Davids South Hospital - Austin, Texas

On April 3, 1998, the Agency received a complaint alleging the Registrant allowed an uncredentialed technologist to perform mammography. An Agency investigation determined the technologist was credentialed.

File Closed.

C-1311 - Uncredentialed Technologist - South Texas Cancer Center - Brownsville, Texas

On February 24, 1998, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform medical radiography. An Agency investigation determined the technologist was credentialed.

File Closed.

C-1312 - Uncredentialed Technologist - Upper Valley Radiology Clinic - McAllen, Texas

On April 2, 1998, the Agency received an anonymous complaint alleging the Licensee allowed an uncredentialed technologist to perform nuclear medicine procedures. An Agency investigation determined the technologist was uncredentialed. The complaint was forwarded to the Professional Licensing and Certification Division.

File Closed.

C-1313 - Regulation Violation - Columbia St. David's Hospital - Austin, Texas

On April 16, 1998, the Agency received a complaint transferred from the United States Nuclear Regulatory Commission. The complaint alleged a nuclear medicine patient's room was not posted to indicate the presence of radioactive material and housekeeping staff entered and cleaned the unposted room. An Agency investigation determined a patient received 150 millicuries of iodine-131 on March 19, 1998. A nuclear medicine technologist was busy and could not immediately locate a radiation warning sign. The room was inadvertently unposted until the following day. Radiation levels from a patient in the room were 20 to 4.5 millirems per hour at 30 centimeters. The levels were such that an individual could receive a dose equivalent in excess of 5 millirems in 1 hour at 30 centimeters. The hospital estimated a housekeeper was in the room for ten to fifteen minutes and received minimal exposure. The Licensee was cited for failure to post a radiation area with a sign bearing the radiation symbol and the words "CAUTION, RADIATION AREA".

File Closed.

C-1314 - Regulation Violation - Jacinto MRI Center - Baytown, Texas

On May 19, 1998, the Agency received an anonymous complaint alleging the Registrant used outdated x-ray film and film cassettes to perform radiographs, resulting in blurred film images. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1315 - Uncredentialed Technologist - Brazos Orthopaedics - Houston, Texas

On May 21, 1998, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform medical radiography. An Agency investigation determined the Registrant allowed an uncredentialed technologist to perform medical radiography. The Registrant was cited for the violation.

File Closed.

C-1316 - Uncredentialed Technologist - Rice Medical Center - Eagle Lake, Texas

On May 28, 1998, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform a needle localization mammography procedure on May 28, 1998. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1317 - Regulation Violation - South Texas Orthopaedic & Fracture Clinic - San Antonio, Texas

On June 1, 1998, the Agency received an anonymous complaint alleging the Registrant radiographed a human for demonstration purposes. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1318 - NORM at Scrapyard - Bloch Metals Inc. - Tyler, Texas

On May 28, 1998, the Agency received an anonymous complaint alleging a scrapyard was storing radioactive material. An Agency investigation determined the material was scrap pipe containing naturally occurring radioactive material (NORM). The scrapyard was told that they could store the NORM under a general license until they disposed of it through a licensed NORM disposal company.

File Closed.

C-1319 - Regulation Violations - South Texas Medical Clinics - Wharton, Texas

On June 5, 1998, the Agency received an anonymous complaint alleging the Registrant: failed to perform quality assurance on mammography units, failed to properly evaluate phantom images,

failed to use masking while viewing films, and operated with processor problems. An Agency investigation determined the Registrant failed to cease performing mammograms when the phantom image was not of sufficient quality, failed to analyze quality control items, and failed to maintain quality assurance records for a one year period. The Registrant was cited for the violations. The Agency was unable to substantiate the other allegations.

File Closed.

C-1320 - Regulation Violations - South Texas Medical Clinics - Bay City, Texas

On June 5, 1998, the Agency received an anonymous complaint alleging the Registrant: failed to perform quality assurance on mammography units, failed to properly evaluate phantom images, failed to use masking while viewing films, and operated with processor problems. An Agency investigation determined the Registrant failed to ensure the collimation of the mammography unit was adequate. The Registrant was cited for the violation. The Agency was unable to substantiate the other allegations.

File Closed.

C-1321 - Unlicensed Radioactive Material - RT Technical Services - Burleson, Texas

On May 22, 1998, the Agency received a complaint alleging the Registrant possessed radioactive material without a license. An Agency investigation determined the Registrant did not possess radioactive material.

File Closed.

C-1322 - Uncredentialed Technologists - Wroten, Vanwyk, Benada - Fort Worth, Texas

On June 23, 1998, the Agency received an anonymous complaint alleging the Registrant allowed uncredentialed technologists to perform medical radiography. The Agency investigation determined the technician was uncredentialed. The Registrant was cited for the violation.

File Closed.

C-1323 - Unregistered Equipment - Gary C. Payne, DPM - Austin, Texas

On June 24, 1998, the agency received an anonymous complaint alleging a Registrant operated an x-ray machine and a laser at an unregistered subsite. An Agency investigation determined the subsite was unregistered. The Registrant was cited for the violation.

File Closed.

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INCIDENTS CLOSED SINCE FIRST QUARTER 1998

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

An Agency investigation determined that 11 dose irregularities occurred between November 20, 1997 and January 2, 1998. The irregularities involved diagnostic nuclear medicine doses which included xenon-133, technetium-99m, iodine-123, and gallium-67. The patients and referring physicians were notified. The whole body doses were less than 5 rem and no organs received greater than 50 rad. To prevent a recurrence, the pharmacy and hospital reviewed the discrepancies and the pharmacy agreed to change procedures which included the assaying of all doses before distribution. No irregularities have occurred since the two parties reviewed the irregularities.

File Closed.

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COMPLAINTS CLOSED SINCE FIRST QUARTER 1998

NO COMPLIANTS WERE CLOSED SINCE THE FIRST QUARTER OF 1998

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING SECOND QUARTER 1998

NO HOSPITAL OVEREXPOSURES REPORTED DURING SECOND QUARTER 1998

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING SECOND QUARTER 1998

NO RADIOGRAPHER OVEREXPOSURES REPORTED DURING SECOND QUARTER 1998

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APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 1998

Enforcement Conference: Coulter Imaging Center, L.L.P., Amarillo, Texas - Mammography

On May 5, 1998, an Enforcement Conference was held with representatives of Coulter Imaging Center, L.L.P. (CIC), holder of Certification of Mammography Systems Number M00348. The conference was conducted to discuss an inspection performed at the Registrant's facility. The Conference was held at the request of CIC. An inspection conducted April 20, 1998, resulted in the issuance of an Emergency Cease and Desist Order on April 20, 1998 and revealed what the Agency considered severe violations (three Severity Level I and one Severity Level II violations) which demonstrated what the Agency believed was a major deficiency in CIC's radiation safety program. In addition, a severity level IV violation of the Texas Regulations for Control of Radiation (TRCR) was noted. This Conference was also called as a prelude to a hearing requested by the Registrant on April 22, 1998 on the issuance of the Cease and Desist Order, in hopes of a resolution prior to the hearing, which was to be held on May 13, 1998. The violations included: failure to cease performing mammograms when the phantom image produced on dates from March 1997 through April 1998 were not of sufficient quality to visualize the four largest fibers, the three largest speck groups, and the three largest masses; failure of the supervising physician to provide oversight and direction for all aspects of the quality assurance program and ensure that technologists have adequate training in mammography and adequate continuing education; failure to have only qualified operators of mammographic equipment perform mammography; failure to document image quality evaluation with a phantom, a quality control item specific to mammographic imaging; and failure to provide documentation of qualifications for physicians who interpret mammograms. The Agency issued a Notice of Failure to this facility on April 30, 1998. The Registrant was required to post the notice of failure on the unit until all items of non compliance identified in the Notice of Violation letter have been resolved. After the conference, the Agency stressed concerns that the supervising physician was not providing oversight of the quality assurance program as required by the Texas Regulations for Control of Radiation. In addition, the Food and Drug Administration had put the facility on notice that their phantom image had failed at the last inspection on April 18, 1997. The Agency requested assurance that: there would be better communication between the technologist and the supervising physician; the supervising physician reviews the phantom images for failures and identify such failures; the Registrant have their quality control program (films and charts) reviewed, with the technologist, by the supervising physician on a monthly basis for a minimum of six months (The review must be

documented); the technologist attend a 16 hour mammography quality control course within four months from the date of the conference (documentation of attendance at this course must be submitted to the Agency upon completion). The Registrant must also notify all affected patients for the period of March 1997 through April 20, 1998, of the failure to use only qualified operators and all films interpreted by an unqualified interpreting physician must be read by a qualified interpreting physician and if discrepancies in the interpretation are noted, the patient(s) must be notified of the discrepancies and failure to use a qualified interpreting physician. The notification letter must be approved by the Agency prior to mailing. Notification must start 30 days after the Agency approves the notification letter and must be completed within 90 days after initiation. The Agency will also increase the number of unannounced inspections. The Registrant was informed by the Agency that their American College of Radiology accreditation expires April 6, 1998, and that they could not operate without an extension. In addition, the Registrant was informed that their Food and Drug Administration permit expires on May 6, 1998, and that they will need to apply for an extension. On May 11, 1998, the Agency received a formal written request to cancel the hearing on the Cease and Desist Order that is scheduled for May 13, 1998.

Enforcement Conference: Linden Municipal Hospital, Linden, Texas - Mammography

On May 26, 1998, an Enforcement Conference was held with a representative of Linden Municipal Hospital, holder of Certification of Mammography Systems Number M00118. The Conference was conducted as the result of an inspection performed on February 5, 1998, which revealed violations (three Severity Level I and one Severity Level III violations) of the Texas Regulations for Control of Radiation. The violations included: failure to perform quality control items; failure of the supervising physician to provide oversight and direction for all aspects of the quality assurance program and review the technologists' quality control test results quarterly and review the medical physicists' results annually; failure to document quality control items specific to mammographic imaging; failure to perform quality control items at correct time intervals; and failure to maintain test film records of the quality assurance monitoring program for a one year period. The Agency issued a Notice of Failure to this facility on April 17, 1998. The Registrant was required to post the Notice of Failure on the unit until all items of non compliance identified in the Notice of Violation letter have been resolved. After the enforcement conference, the Registrant was required to submit qualifications for all interpreting physicians to the Agency within 30 days, submit the mammography technologist's qualifications to the Agency immediately so they could be added to the Certification as a technologist. Linden Municipal Hospital was required to have the mammography quality control technologist complete an additional 16 hours of formal mammography quality control training within four months and submit documentation of successful completion to the Agency. The Registrant was required to ensure that the supervising physician review the technologists' quality control test results, including the quality control program, at intervals not to exceed 30 days, and sign a document indicating that the review has been completed and that everything was accurate. This must be done for a period of one year. The Registrant must also notify all affected patients for the period of March 11, 1997 through January 28, 1998, of the failure of the system during that time frame. The notification letter must be approved by the Agency prior to mailing. Notification must start 30 days after the Agency approves the notification letter and must be completed within 90 days after initiation. Linden Memorial Hospital was required to submit additional responses to the Notice of Violation within 30 days. The response is to include: a commitment that temperature tests will be performed daily; a commitment that the facility address corrective actions when phantoms are out of range and that mammograms will not be performed during that time; a commitment that equipment observation checks will be performed every 30 days as required. The Registrant must resubmit their ongoing mammography quality assurance program to the Agency and must be rewritten using Part 37 and the 1994 American College of Radiology Manual. The Agency required the Interim Administrator to sign and

commit to the Agency's requirements. The Agency will determine if any additional enforcement action is necessary based on follow-up inspections to be performed at decreased time intervals. This may include an additional Enforcement Conference with the Hospital Administrator and/or Supervising Physician.

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