

REDACTED - 8/2003

SUMMARY OF INCIDENTS FOR THIRD QUARTER 1998

I-7332 - Dose Irregularity - MD Anderson Cancer Center/  
Mallinckrodt - Houston, Texas

On June 3, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on May 26, 1998. The facility ordered [REDACTED] but the pharmacy dispensed [REDACTED]. The patient was not injected and the dose was returned to the pharmacy. The pharmacy was cited for failure to report the irregularity to the Agency within 30 days. To prevent a recurrence, the Licensee counseled pharmacists on the importance of separating doses and reading each unit dose as it is brought to the dispensing hood.

File Closed.

I-7333 - Ruptured Source - Radiographic Specialists, Inc. -  
Houston, Texas

On June 19, 1998, the Licensee notified the Agency that a 43 curie iridium-192 sealed source ruptured while performing industrial radiography on June 19, 1998. An Agency investigation determined the source ruptured when an energized welding lead arced. The high temperature melted the radiography cable and the metal encapsulating the source. The source was disconnected and breached resulting in contamination. Decontamination efforts were conducted by an authorized Licensee and consisted of decontamination of five radiography employees, ten temporary job site employees, and the temporary job site facility. The five radiographers performed source retrieval and decontamination of the exposure device were sent for bioassays and whole body counts. There was no evidence of inhalation or ingestion of the iridium-192. The ten temporary job site employees had minor contamination on the clothing and shoes. The contamination was tracked through a large portion of the temporary job site facility and was decontaminated in three days. The exposure device was sent to the manufacturer. The Licensee was cited for unauthorized retrieval of a disconnected source.

File Closed.

I-7334 - Lost Radioactive Material - Mainland Eye Clinic - Texas  
City, Texas

On June 26, 1998, the Licensee notified the Agency that a 100 millicurie strontium-90 eye applicator had been missing since May 1998. The Licensee was unable to determine the location of the source until receiving a letter from El Salvador thanking the

Licensee for donating the applicator to help the poor people of Santa Ana, El Salvador. The Licensee was cited for loss of control of radioactive material and for failure to notify the Agency within 24 hours.

File Closed.

I-7335 - Dose Irregularity - Arlington Memorial Hospital -  
Arlington, Texas

On July 1, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] and [REDACTED] occurred on May 29, 1998. The [REDACTED] was intended to be given [REDACTED] and the [REDACTED] was intended to be given [REDACTED]. The technologist accidentally administered the unlabeled [REDACTED]. After discovering the error, the [REDACTED] and the study proved to be useful. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled technologists to label syringes and read labels prior to administration.

File Closed.

I-7336 - Misadministration - Park Plaza Hospital - Houston, Texas

On June 24, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on June 13, 1998. The procedure for the patient was [REDACTED] and [REDACTED], the technologist failed to notice the procedure was canceled. The patient was [REDACTED] with a [REDACTED] when he was not intended to receive any [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 counseled all technologists on reading the charts immediately prior to procedures.

File Closed.

I-7337 - Leaking Source - Lockheed Martin - Fort Worth, Texas

On July 15, 1998, the Registrant notified the Agency that a leak test on June 17, 1998, indicated a 5.0 microcurie strontium-90 betascope source (generally licensed) was leaking. The source was immediately retrieved from storage and double bagged. The manufacturer was notified and agreed to accept the source. A survey of the work area and the storage location did not reveal any contamination.

File Closed.

I-7338 - Badge Overexposure - Bonded Inspections, Inc. - Garland, Texas

On June 19, 1998, the Licensee notified the Agency of a 7.36 rem exposure to an industrial radiographer during the May 1998 monitoring period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and an assessment of 270 millirems, based on past exposure history, was accepted.

File Closed.

I-7339 - Stolen Radioactive Material - Longview Inspection - LaPorte, Texas

On July 8, 1998, the Licensee notified the Agency that an industrial radiography exposure device containing a 50 curie iridium-192 sealed source was stolen on July 8, 1998. A radiographer intentionally stole the exposure device and discarded the device along an interstate highway. The exposure device was recovered the same day by the Department of Public Safety in cooperation with the radiographer. The device was returned to the authorized storage location. No personnel were exposed to radiation since the source remained in the fully shielded position throughout the event. The employment of the radiographer was immediately terminated and the radiographer's card was revoked. To prevent a recurrence, the Licensee issued a corporate directive which increased the security of vehicle keys for industrial radiography crews.

File Closed.

I-7340 - Dose Irregularity - West Texas Nuclear Pharmacy/Odessa Regional Hospital/Medical Center Hospital/Diabetes Center of the Southwest/Associates of Midland Cardiovascular/Westwood Medical Center/Golder X-Ray - Midland/Odessa, Texas

On June 23, 1998, the Licensee notified the Agency that dose irregularities involving six hospitals and a pharmacy occurred on June 23, 1998. [REDACTED]

[REDACTED] were prepared by the pharmacy. All [REDACTED] were administered and [REDACTED] of the patients were rescheduled due to [REDACTED]. The doses did not maintain radiochemical integrity. The quality of the tagging broke down between preparation and injection times resulting in the poor images. [REDACTED] should be used within six hours of preparation. The patients and referring physicians were notified. The whole body doses were less than 5 rem and no organs received greater than 50 rad. One Licensee was cited for failure to notify the Agency within 30 days of the irregularity. To prevent a recurrence, the pharmacy will conduct quality control much closer to injection time to insure an adequately tagged product.

File Closed.

I-7341 - Badge Overexposure - BIX Testing Laboratories, Inc. - Baytown, Texas

On June 25, 1998, the Licensee notified the Agency that a greater than 1000 rem exposure to an industrial radiographer occurred during the May 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and an assessment of 416 millirems, based on exposure

history, was accepted.

File Closed.

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

On July 8, 1998, the Licensee notified the Agency that a disconnect involving a 120 curie iridium-192 source occurred during radiography of an auditorium ceiling on June 24, 1998. The source pigtail became disconnected from the drive cable and the source remained in the collimator during attempts to crank the source into the radiography device. The Licensee successfully retrieved the source. A consultant calculated exposures and determined members of the public present in the auditorium received doses that exceeded regulatory limits. Badge reports and dosimeter readings for the radiation workers did not indicate excessive exposures. The Licensee inspected the pigtail-drive cable connection and observed a loose connection. It was determined the source pigtail and the drive cable were incompatible. The manufacturer had apparently shipped a source to the Licensee based on a source code indicated on an outdated copy of the Licensee's license. Source codes were not indicated on the copy of the new license. The Licensee called the manufacturer and received a source with the appropriate pigtail that matched the connector on the drive cable. The source manufacturer and the manufacturer's state regulatory agency were notified.

File Closed.

I-7343 - Dose Irregularity - Lake Granbury Medical Center - Granbury, Texas

On July 8, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on July 8, 1998. A patient was scheduled for [REDACTED] and received [REDACTED] by mistake. A technologist removed the wrong syringe from storage and [REDACTED] the patient. The syringe and the lead storage container were both labeled correctly. 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 to require a second technologist to verify the correctness of doses prior to administration.

File Closed.

I-7344 - Possible Radioactive Material Contamination - Federal Express/DFW Airport - Irving, Texas

On July 8, 1998, a shipping company notified the Agency of possible radioactive material contamination. A package containing strontium-90 was dropped and broken open on July 8, 1998. An Agency investigation determined the integrity of the strontium-90 was not compromised and a survey confirmed no radioactive contamination was present.

File Closed.

I-7345 - Damaged Moisture/Density Gauge - Texas Department of Transportation - Austin, Texas

On July 1, 1998, the Licensee notified the Agency that a moisture/density gauge containing a 9.0 millicurie cesium-137 sealed source and a 44.0 millicurie americium-241 sealed source was damaged on July 1, 1998. The gauge was run over by a dump truck. The sources were not damaged and remained in the fully shielded position during the event. Leak tests were performed and analysis revealed no leakage. Damage to the gauge was limited to the control panel. To prevent a recurrence, the RSO reviewed emergency and notification procedures with project personnel.

File Closed.

I-7346 - Dose Irregularity - MD Anderson Cancer Center/Syncor - Houston, Texas

On July 10, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on June 16, 1998. The intended dose was supposed to be [REDACTED]. The out-of-state research reactor that produced the radiopharmaceutical sent one half of the intended dose to the

pharmacy. The hospital agreed to accept the dose but did not administer it to the patient. To prevent a recurrence, the research reactor has changed its protocol on preparing [REDACTED].

File Closed.

I-7347 - Radioactive Material Found - Texas City Police Department  
- Texas City, Texas

On July 31, 1998, a police department notified the Agency that two lead nuclear pharmacy shields were found in a ditch on July 31, 1998. Bottles inside the shields were labeled "Caution Radioactive Material". Each bottle contained 15 millicuries of iodine-131 with assay dates of October 1989. The containers were surveyed and no radioactivity above background was detected. The labels were removed and the bottles were disposed of as normal waste. The police department was told to keep the lead shields or dispose of them as hazardous waste.

File Closed.

I-7348 - Misadministration - Good Shepherd Medical Center - Longview, Texas

On July 22, 1998, the Licensee notified the Agency that a misadministration involving a [REDACTED] during a [REDACTED] procedure occurred on July 15, 1998. The patient removed the [REDACTED] and requested dismissal from the hospital during the [REDACTED] procedure. The patient received [REDACTED] instead of the intended [REDACTED]. An Agency investigation determined exposures to the nurse and nuclear medicine technician were minimal during source recovery. The patient and referring physician were notified. The Licensee failed to notify the Agency within 24 hours of discovering the therapy misadministration. The Licensee was cited for the violation.

File Closed.

I-7349 - Misadministration - Denton Regional Medical Center - Denton, Texas

On July 24, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on July 9, 1998. The wrong patient was [REDACTED] with the dose. The technician failed to properly identify the patient. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled the technician on following policies and procedures.

File Closed.

I-7350 - Found Moisture/Density Gauge - Texas Department of Transportation - Houston, Texas

On July 20, 1998, a member of the public notified the Agency that a moisture/density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source was found along an interstate highway on July 19, 1998. The member of the public took the gauge home and notified the local authorities. The local hazardous materials team responded and verified no radioactive contamination existed in the home or on the individual. The source was never removed from its fully shielded position. The Licensee was identified by the markings on the gauge. The gauge was lost while moving materials from one construction site to another on July 17, 1998. The Licensee took possession of the gauge and returned it to an authorized storage location. The Licensee was cited for failure to maintain control of licensed radioactive material and failure to submit a written report to the Agency within 30 days. To prevent a recurrence, the Licensee counseled gauge users on temporary storage site procedures.

File Closed.

I-7351 - Misadministration - The Methodist Hospital - Houston, Texas

On July 22, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on July 10, 1998. The dose was administered to the wrong patient. The patient was scheduled for a [REDACTED] study with the [REDACTED] department and a scheduling error and incomplete patient verification resulted in the incorrect injection. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee conducted an employee inservice on verification of physician orders and presentation of charts to the nuclear medicine physician.

File Closed.

I-7352 - Misadministration - The University of Texas Southwestern Medical Center - Dallas, Texas

On July 15, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on July 15, 1998. The dose was administered to the wrong patient. The patient was not properly identified by the technician. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled the technician on following patient identification procedures.

File Closed.

I-7353 - Possible Exposure to Member of the Public - Reinhart & Associates, Inc. - Austin, Texas

On August 17, 1998, the Licensee notified the Agency of a possible exposure to members of the public that occurred on August 11, 1998. Industrial radiographers were performing radiography on 27 floors of a building. Radiography of floors 2 through 27 were performed without incident. After performing radiography on the first floor, it was realized workers were sleeping on the second floor. The second floor was visually checked before performing radiography. No individuals were observed and the area appeared to be an unoccupied jobsite. Calculations by the Licensee indicated the maximum exposure for individuals on the second floor was less than 3.0 millirem which is well within regulatory limits.

File Closed.

I-7354 - Dose Irregularity - Memorial Hospital Northwest/Syncor - Houston, Texas

On August 14, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on August 14, 1998. The hospital ordered a [REDACTED] dose from the pharmacy but received the [REDACTED] dose and a [REDACTED] dose, which was intended for another hospital. The technician injected the patient with the [REDACTED] instead of the [REDACTED]. The technician did not follow the procedure of using the dose calibrator before injecting the patient. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy counseled delivery personnel on delivery procedures and the hospital counseled the technician on using the dose calibrator before injecting patients.

File Closed.

I-7355 - Misadministration - Trinity Valley Medical Center - Palestine, Texas

On August 17, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on July 7, 1998. The dose was administered to the wrong patient. The patient was not properly identified by the technician. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The Licensee was cited for not reporting the incident within 30 days. To prevent a recurrence, the Licensee counseled the technician on following patient identification procedures.

File Closed.

I-7356 - Radioactive Material Abandoned - St. Luke's Episcopal Hospital - Houston, Texas

On August 6, 1998, the Licensee notified the Agency that a [REDACTED] was abandoned on August 10, 1990. The hospital was told by the patient's family the patient was alive and well up to January 1998. An investigation by a hospital attorney revealed the patient died in August 1990. No attempts have or will be made to retrieve the source.

File Closed.

I-7357 - Dose Irregularity - Park Plaza Hospital/Syncor - Houston, Texas

On August 5, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on August 3, 1998. The patient was supposed to receive [REDACTED]. The hospital ordered [REDACTED] from the pharmacy, but the pharmacy sent a dose of [REDACTED] and a [REDACTED] instead. The technician [REDACTED] the patient with the [REDACTED] instead of the intended [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 and the hospital counseled technicians on checking orders against doses.

File Closed.

I-7358 - Misadministration - The Methodist Hospital - Houston, Texas

On August 13, 1998, the Licensee notified the Agency that a misadministration involving [REDACTED] occurred on August 11, 1998. The dose was administered to the wrong patient. The patient was scheduled for a [REDACTED] study and a scheduling error and incomplete patient verification resulted in the incorrect injection. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee conducted an inservice to review orders and procedures and emphasized the verification of patient identities.

File Closed.

I-7359 - Dose Irregularity - Providence Memorial Hospital/Sierra Medical Center/Syncor - El Paso

On August 26, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on August 24, 1998. The distribution was not as expected during the [REDACTED] study. Quality control of the product was reaccomplished at the pharmacy and showed product degradation in the syringe. 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-7360 - Equipment Malfunction - Syncor - San Antonio, Texas

On July 29, 1998, the Licensee notified the Agency that an equipment malfunction involving a main fume hood occurred on July 27, 1998. The fume hood was inoperable for approximately 30 hours before the repair was performed. The cause of the failure was a broken axle on the motor. The available inventory in the pharmacy was 600 millicuries of xenon-133 and 400 millicuries of iodine-131. Bioassays were performed and no abnormally high results were identified. Air monitoring and calculations revealed derived air concentrations and effluent releases were within regulatory limits.

File Closed.

I-7361 - Unauthorized Disposal of Radioactive Material - South Austin Hospital/BFI Landfill - Austin, Texas

On July 2, 1998, a landfill notified the Agency of elevated radiation levels on a dumpster received on July 2, 1998. The hospital retrieved the waste and determined the radioactive material was iodine-131. An Agency investigation determined the Licensee: created an exposure in an unrestricted area that exceeded regulatory limits, failed to perform required surveys, failed to store radioactive material for decay to background levels, and transferred radioactive material other than authorized by regulation. The Licensee was cited for the violations. To prevent a recurrence, the Licensee modified their iodine therapy procedures.

File Closed.

I-7362 - Dose Irregularity - MD Anderson Cancer Center/Mallinckrodt  
- Houston, Texas

On September 30, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on September 21, 1998. The hospital ordered [REDACTED] but received straight [REDACTED] instead. Confusion during the ordering process was the cause of the problem. The cause of the confusion was not resolved. The dose was not administered to the patient. The correct dose was ordered and administered.

File Closed.

I-7363 - Dose Irregularity - North Austin Medical Center - Austin,  
Texas

On September 1, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on September 1, 1998. The patient was injected with the [REDACTED] instead of the intended [REDACTED]. Since the [REDACTED] also concentrates in the [REDACTED], the [REDACTED] was accomplished using the [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 counseled the technician on verifying doses before injecting patients.

File Closed.

I-7364 - Dose Irregularity - MD Anderson Cancer Center/  
Mallinckrodt - Houston, Texas

On August 31, 1998, the Licensee notified the Agency that a dose irregularity involving 33.5 millicuries of technetium-99m occurred on August 21, 1998. The hospital ordered 20 millicuries of technetium-99m but when the material arrived it assayed at 33.5 millicuries. The dose was not administered and was returned to the pharmacy. The pharmacist mistakenly prepared a 30 millicurie dose instead of the requested 20 millicuries. To prevent a recurrence, the pharmacist was counseled on following procedures.

File Closed.

I-7365 - Stolen Moisture/Density Gauge - ATSER - Houston, Texas

On September 9, 1998, the Licensee notified the Agency that a moisture/density gauge containing an 11 millicurie cesium-137 sealed source and a 44 millicurie americium-241 sealed source was stolen on September 9, 1998. An employee failed to return the vehicle which contained the gauge after a field assignment. The gauge and vehicle were returned the following day. To prevent a

recurrence, the employee was fired and all other employees were counseled on gauge use and storage.

File Closed.

I-7366 - Dose Irregularity - Abilene Regional Medical Center/  
National Central Pharmacy - Abilene, Texas

On September 1, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on August 31, 1998. The pharmacy prepared and delivered the [REDACTED] dose instead of the ordered [REDACTED] dose. The patient was [REDACTED]. The patient and referring physician were notified. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the pharmacy instituted new procedures on isolating radiopharmaceuticals in different areas of the preparation area.

File Closed.

I-7367 - Radioactive Material Found at Landfill - BFI Landfill -  
San Antonio, Texas

On July 24, 1998, a landfill notified the Agency of elevated radiation levels on a residential trash truck on July 24, 1998. An Agency investigation determined the trash was iodine-131 from a nuclear medicine patient. The landfill was allowed to dispose of the trash.

File Closed.

I-7368 - Overexposure - Wilson Inspection X-Ray Services, Inc. -  
Corpus Christi, Texas

On September 8, 1998, the Licensee notified the Agency that a 5.167 rem exposure to an industrial radiographer occurred during the June through August 1998 reporting periods. An Agency investigation determined the employee may have received the exposure. No deletion was requested and the radiographer was laid off until the start of the next calendar year. The Licensee was cited for allowing an industrial radiographer to receive radiation exposures greater than the annual limits specified.

File Closed.

I-7369 - Source Disconnect - Midwest Inspection Services -  
Perryton, Texas

On September 2, 1998, the Licensee notified the Agency that a source disconnect involving an 80 curie iridium-192 sealed source occurred during industrial radiography on August 24, 1998. The radiographer trainee failed to ensure a positive connection while connecting the control assembly. The radiography was being performed in a hole seven feet below ground level. After the first exposure, it was discovered the source did not return to the shielded position. The source was retrieved by an authorized Licensee. No exposures exceeding regulatory limits were received by the radiographers, the authorized retrieval consultant, or members of the public. An investigation by the Licensee determined the control cable connector was not a compliance connector and was unauthorized for use. The Licensee immediately ordered a new control cable from the manufacturer. The Licensee was cited for using equipment that did not comply with regulatory requirements and for allowing a radiographer trainee to connect source/drive cable assemblies without the personal supervision of a radiographer trainer.

File Closed.

I-7370 - Dose Irregularity - St. Luke's Episcopal Hospital - Houston, Texas

On September 10, 1998, the Licensee notified the Agency that a dose irregularity involving 10 millicuries of technetium-99m MAG3 occurred on September 10, 1998. The hospital ordered ten doses of Cardiolite but received nine doses of Cardiolite and one dose of MAG3 instead. The pharmacy accidentally put the MAG3 which was intended for another hospital in the wrong package. No patients were injected and the pharmacy reshipped the correct doses. To prevent a recurrence, the pharmacy counseled delivery staff on checking doses against prescriptions.

File Closed.

I-7371 - Badge Overexposure - Desert Industrial X-Ray, Inc. - Odessa, Texas

On September 18, 1998, the Licensee notified the Agency that a 5.459 rem exposure to an industrial radiographer occurred during the July 15, 1998 through August 14, 1998 reporting period. An Agency investigation determined the exposure was only to the badge. A deletion was granted and an assessment of 140 millirem, based on co-worker exposure, was accepted.

File Closed.

I-7372 - Leaking Source - TN Technologies - Round Rock, Texas

On September 17, 1998, the Licensee notified the Agency that a 20 microcurie cadmium-109 sealed source and a 3.3 millicurie iron-55 sealed source were determined to be leaking on September 9, 1998. The alloy analyzer had been returned to the Licensee for routine disposal when the leaking sources were discovered. The removable contamination which exceeding regulatory limits consisted of 0.138 microcuries of iron-55. The analyzer and contaminated materials were placed in a waste drum for disposal. No contamination was detected on the external surfaces of the analyzer. No personnel exposures or further contamination were encountered. The customer in South Carolina was notified and was told some of the source material may have been lost at their site. Their reporting obligations were explained to them by the Licensee. To prevent a recurrence, the Licensee issued letters to customers reminding them to return units for source replacement in a timely manner.

File Closed.

I-7373 - Stolen Moisture/Density Gauge - Giles Engineering - Dallas, Texas

On September 23, 1998, the Licensee notified the Agency that a moisture/density gauge containing a 10 millicurie cesium-137 source and a 50 millicurie americium-241 source was stolen on September 19, 1998. The gauge was stolen from the bed of a pickup truck in the rear of the Licensee's building. The local police were notified. The gauge has not been recovered. The Licensee was cited for loss of control of licensed radioactive material.

File Inactive.

I-7374 - Dose Irregularity - MD Anderson Cancer Center - Houston, Texas

On September 15, 1998, the Licensee notified the Agency that a dose irregularity involving [REDACTED] occurred on September 2, 1998. The Licensee ordered [REDACTED] from an out-of-state research reactor and only received [REDACTED]. The study was accomplished with the reduced activity level. 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 and the sponsor of the study discussed the situation with the out-of-state research reactor.

File Closed.

COMPLAINT SUMMARY FOR THIRD QUARTER 1998

C-1324 - Regulation Violations - Serv-Corp - Weslaco, Texas

On June 25, 1998, the Agency received an anonymous complaint alleging students were being taught limited x-ray techniques without personnel dosimetry. An Agency investigation determined the school was teaching x-ray procedures to students without the presence of any x-ray machines. Students are issued personnel dosimetry before beginning x-ray clinic rotations. The Agency was unable to substantiate the allegation.

File Closed.

C-1325 - Regulation Violations - Raytheon Engineers and Constructors - Houston, Texas

On June 28, 1998, the Agency received a complaint alleging an industrial radiography crew worked without barricades, roping, or warning signs on June 27, 1998. The complainant alleged their personnel, who were also industrial radiographers, were exposed to radiation. Three pocket dosimeters went off scale and the film badges were sent for emergency processing. An Agency investigation determined nobody received any excessive exposures and was not able to substantiate the allegation.

File Closed.

C-1326 - Regulation Violations - TN Technologies - Round Rock, Texas

On June 26, 1998, the Agency received a complaint alleging the Licensee improperly transferred devices containing byproduct material and improperly rented out generally licensed devices. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1327 - Regulation Violations - Wilson Inspection X-ray Service -  
Corpus Christi, Texas

On July 9, 1998, the Agency received an anonymous complaint alleging the Licensee stored radioactive material improperly. An Agency investigation determined the radioactive material was stored in an authorized location and was properly posted.

File Closed.

C-1328 - Laser Injury - Elysium Spa/RKS Spa/Urban Retreat -  
Arlington/Houston/Houston/, Texas

On July 29, 1998, the Agency received complaints alleging unauthorized persons at health spa facilities used lasers for hair removal and the treatments resulted in burns and permanent scarring. One woman had hair removed from her legs and another from her chin. According to the federal Food and Drug Administration, hair removal lasers are prescription medical devices and require that licensed practitioners authorize their use for an individual. The lasers inspected by the Agency were not affixed with the required legend indicating the device is prescriptive. Joint investigations conducted by the Agency and Bureau of Food and Drug Safety (FDS) found three facilities operating without the supervision of a licensed practitioner or a registration as required. FDS issued orders to detain and prevent operation of the lasers at the three facilities. The Agency issued notices of regulation violations. The Agency is pursuing escalated enforcement actions against two facilities where burns allegedly occurred. A press release was issued by the Agency to alert consumers and create an awareness of the unauthorized use of lasers and the possibility of injury to the skin or to the eye.

File Closed.

C-1329 - Possible Overexposure - Columbia North Hills Hospital - North Richland Hills, Texas

On July 21, 1998, the Agency received an anonymous complaint alleging the Registrant failed to properly operate x-ray flouroscope equipment resulting in a possible overexposure to an extremity on July 1, 1998. An Agency investigation determined the anonymous complainant decided to not pursue the complaint.

File Closed.

C-1330 - Regulation Violations - Tek-Rap, Inc. - Houston, Texas

On June 23, 1998, the Agency received a complaint alleging the Licensee failed to provide radiation safety training for employees and failed to display "Caution Radioactive Material" labels on their fixed nuclear thickness gauges. An Agency investigation determined the Licensee failed to inform the Agency within 30 days of the change in contact person on the license and determined the Licensee exceeded the 36 month leak test interval. The Licensee was cited for the violations. The Agency was unable to substantiate the other allegations.

File Closed.

C-1331 - Unregistered Laser - Laser Hair Removal Center - Austin, Texas

On July 31, 1998, an advertisement in a local newspaper indicated a company was performing laser hair removal. An Agency investigation determined the facility was operating a Class IV laser without registering the laser with the Agency. The company was cited for failure to register the laser. The company was given an application form to register the laser.

File Closed.

C-1332 - Regulation Violations - Mercy Regional Medical Center - Zapata, Texas

On July 18, 1998, the Agency received a complaint alleging the Registrant operated an unsafe x-ray machine and allowed uncredentialed technicians to perform medical radiography during April 1996 and January 1998. An Agency investigation determined the x-ray unit was in compliance except for the manual collimation which exceeded two percent of the source to image distance. The Registrant was cited for the violation. The Agency was unable to substantiate the uncredentialed technician allegation.

File Closed.

C-1333 - Unauthorized Disposal of Radioactive Waste - NSSI - Houston, Texas

On July 27, 1998, the Agency received a complaint alleging the Licensee was disposing of radioactive and mixed waste in an unauthorized manner. The complaint is being investigated.

File Open.

C-1334 - Unregistered X-Ray Equipment - 3304 FM 1960 - Houston, Texas

On August 12, 1998, the Agency received an anonymous complaint alleging the use of unregistered x-ray equipment. An Agency investigation determined the x-ray equipment was unregistered. The Registrant was cited for not submitting an application for registration to the Agency within 30 days of commencement of operation of a radiation machine.

File Closed.

C-1335 - Regulation Violations - X-ray Xpress Corporation - Houston, Texas

On August 4, 1998, the Agency received an anonymous complaint alleging the Registrant: allowed uncredentialed technologists to perform medical radiography; failed to perform calibration or maintenance on x-ray equipment; and failed to have lead aprons available. An Agency investigation, which included a full inspection, was unable to substantiate the allegations.

File Closed.

C-1336 - Regulation Violations - K Clinic, P.A. - Irving, Texas

On August 10, 1998, the Agency received a complaint alleging the Registrant failed to notify the Agency, in writing, within 30 days of the change of radiation safety officer. An Agency investigation substantiated the allegation. The Registrant provided the Agency with a change of radiation safety officer.

File Closed.

C-1337 - Laser Injury - Aziz Salon Day Spa - Austin, Texas

On August 17, 1998, the Agency received a complaint alleging a laser caused an injury to an individual during hair removal in January 1998. An Agency investigation determined the equipment in the facility was not governed by Agency regulations. The facility used a prescription medical device which is governed by the Bureau of Food and Drug Safety. The complaint was forwarded to them. The Agency was unable to substantiate the allegation of the laser injury.

File Closed.

C-1338 - Laser Injury - Aesthetics Permanent Cosmetics - Houston, Texas

On August 20, 1998, the Agency received an anonymous complaint alleging a laser caused an injury to an individual during tattoo removal. An Agency investigation determined the facility failed to register a Class IV laser within thirty days of the commencement of use. The facility was cited for the violation and was provided materials needed to register the laser. The injury complaint was forwarded to the Bureau of Food and Drug Safety.

File Closed.

C-1339 - Unauthorized Disposal - Vastar Resources - Houston, Texas

On July 20, 1998, the Agency received complaints alleging a company was planning an unauthorized NORM disposal site near Fashing, Texas. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1340 - Failure to Provide Mammograms - Radiology Clinics of Laredo - Laredo, Texas

On August 25, 1998, the Agency received an anonymous complaint alleging the Registrant failed to provide mammograms to a patient. An Agency investigation was unable to substantiate the allegation.

File Closed.

C-1341 - Laser Injury - Smooth Solutions - San Antonio, Texas

On September 2, 1998, the Agency received a complaint alleging a patient's arm was [REDACTED] after a laser treatment. The complainant alleged the arm healed but the skin became [REDACTED]. The patient is [REDACTED] and believes the treatment administered was inappropriate for [REDACTED]. An Agency investigation determined the facility had documented the injury and an onsite dermatologist had checked and treated the injury. The facility was registered to use the hair removal lasers. No violations of regulations were cited.

File Closed.

C-1342 - Regulation Violations - Pin Oak Medical and Surgical Associates - Katy, Texas

On September 14, 1998, the Agency received an anonymous complaint alleging the Registrant had multiple regulation violations. An Agency investigation determined the x-ray machine was not being used, therefore no violations were occurring.

File Closed.

C-1343 - Regulation Violations - Central Texas Oral Surgeons - Austin, Texas

On September 11, 1998, the Agency received a complaint alleging the Registrant was using x-ray equipment in October 1996 that did not comply with regulatory requirements. An Agency investigation was unable to substantiate the allegations.

File Closed.

C-1344 - Regulation Violations - Phoenix Non-Destructive Testing Company, Inc. - Channelview, Texas

On September 21, 1998, the Agency received an anonymous complaint alleging an individual worked as a radiographer trainee without completing a 40 hour safety course or possessing a trainee status card. An Agency investigation determined the individual worked as part of a two man crew on at least three occasions. The Licensee was cited for the violation.

File Closed.

C-1345 - Unregistered Equipment - William Haskett, MD - Waco, Texas

On September 16, 1998, the agency received a complaint alleging the Registrant was using an unregistered bone densitometer. An Agency investigation determined the bone densitometer was not registered and registration forms were left for the Registrant to fill out. The Registrant was cited for not submitting an application for registration to the Agency within 30 days of commencement of operation.

File Closed.

C-1346 - Regulation Violations - Zoran Cupic, MD - Houston, Texas

On September 20, 1998, the Agency received an anonymous complaint alleging the Registrant failed to use protective devices on patients while performing medical radiography. An Agency investigation was unable to substantiate the allegation.

File Closed.

INCIDENTS CLOSED SINCE SECOND QUARTER 1998

NO INCIDENTS WERE CLOSED SINCE SECOND QUARTER 1998.

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COMPLAINTS CLOSED SINCE SECOND QUARTER 1998

NO COMPLAINTS WERE CLOSED SINCE SECOND QUARTER 1998.

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES  
REPORTED FOR THIRD QUARTER 1998

NO HOSPITAL OVEREXPOSURES WERE REPORTED FOR THIRD QUARTER 1998

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES  
REPORTED FOR THIRD QUARTER 1998

Corpus Christi, Texas

Wilson Inspection X-ray Services, Inc.

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## APPENDIX C

### ENFORCEMENT ACTIONS FOR THIRD QUARTER 1998

#### Enforcement Conference: Memorial Mother Frances Hospital - Palestine, Texas - Mammography

On July 15, 1998, an Enforcement Conference was held with representatives of Memorial Mother Frances Hospital, holder of Certification of Mammography Systems Number M00110. The conference was held at the request of the Bureau and was conducted to discuss the violations found during the inspection performed at the Registrants' facility on May 7, 1998. The violations included: failure to analyze quality control items, specifically, the results of tests; acceptability limits were not evaluated daily; image quality evaluations with a phantom were not documented monthly; and temperature measurements specific to mammographic imaging were not performed daily. These violations demonstrated what the Agency believed to be a deficiency in the supervision and quality control of the mammography department, and showed a need for improvements in Memorial Mother Frances Hospital's radiation safety program. A review of the Registrants' responses to these violations during the Conference determined two additional violations of 25 Texas Administrative Code existed, and a Notice of Violation was issued on July 20, 1998. These violations included: performing mammography when the results of the mammography phantom imaging tests were outside established limits; and failure to notify the Agency of changes that would render the Certification of Mammography Systems inaccurate in that changes in authorized personnel were not submitted to the Agency within 30 days of the date of the change. The Registrant must respond to this Notice within 30 days of receipt. As a result of the conference, the Registrant was placed on an elevated inspection interval. These inspections will be unannounced, and the results of these inspections will determine if additional enforcement actions are necessary. The Registrant must institute the use of an outside monitor for the mammography program for the period of one year. If the Agency determines this requirement can be withdrawn before the end of one year, the Registrant will be notified in writing. The Supervising Physician must sign and date a statement that the quality control records were reviewed after each review, and must also submit a written commitment to the Agency by July 31, 1998, attesting the review will be performed in this manner.

#### Enforcement Conference: Petroleum Industry Inspectors - Houston, Texas - Radiography

On July 23, 1998, an Enforcement Conference was held with representatives of Petroleum Industry Inspectors, holders of Radioactive Material License Number L04081. The conference was held at the request of the Bureau and was conducted to discuss the violations found during inspections performed on May 11, 1998 and

May 20, 1998. The violations for the May 11, 1998 inspection included: failure of the Licensee to return TLD's to the supplier for processing; exceeding six-month leak test interval for sealed sources; and failure to include on the utilization log the dates each source of radiation was returned to storage. The violations for the May 20, 1998 inspection included: Licensee transported radioactive material on public roadways without the required shipping papers; personnel were conducting industrial radiographic operations even though the required Agency issued identification cards were not present at the job site; an operable and calibrated survey instrument was not present in the radiography work area during exposure of a 51 Ci. iridium-192 source; industrial radiographic operations were performed by a radiographic trainee who did not have a personnel monitoring device, a direct-reading pocket dosimeter, and an alarming rate meter on his person; a radiographer trainer was not physically present to provide personal supervision when a radiographic trainee manipulated the controls of a radiographic exposure device; a radiographer was not physically present to protect against unauthorized entry into a radiation area; and a physical radiation survey was not performed when a radiographic exposure was terminated to verify the sealed source had returned to its fully-shielded position. A review of the Licensees' responses to the violations during the conference determined the Agency needs an additional response regarding Compliance Number L980545 to violations 1 and 3, by August 10, 1998. The Agency will look at what action(s) need to be taken against Mr. Edgar Baird and the unannounced inspection interval for Petroleum Industry Inspectors will be decreased for a period of two years. A satisfactory response was received by the Agency on June 25, 1998 for Compliance Number L980545 to Violations 1 and 3. Upon further review of violations involving Mr. Edgar Baird, the Agency filed a Complaint to Suspend Mr. Baird's license, at which time Mr. Baird requested a hearing. The date and time of the requested hearing is currently pending.

Enforcement Conference: El Paso Inspection - El Paso, Texas - Radiography

On September 9, 1998, an Enforcement Conference was held with representatives of El Paso Inspection, holder of Radioactive Material License Number L04599. The conference was held as a result of a facility inspection conducted on July 28, 1998, in which it was determined a violation existed regarding radiographic operations conducted from an unauthorized storage location. The violation was of particular concern to the Agency due to the failure of the Licensee to submit a request to amend the license adding the Laredo, Texas location to the license prior to conducting radiographic operations from that location. As a result of the conference, the Licensee will submit, within 30 days of the date of the conference: copies of use records for November 1997, and for the time period from January, 1998 to the present; copies

of leak test records for the sealed sources received and used; and copies of receipt records for all Ir-192 sealed sources for the Laredo location. Pertaining to the use location amendment request, El Paso Inspection will submit a more thorough description of the area surrounding the proposed authorized site location, and specific information regarding storage location, posting, and security for the location.

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