



# **INCIDENT AND COMPLAINT SUMMARIES FOR FOURTH QUARTER 2013\***

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Regulatory Services Division  
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\* Any complaint and/or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & the Health and Safety Code Chapter 241.051(d). These summaries will not appear in this report.

Copies of this report are available on the internet at <http://www.dshs.state.tx.us/radiation/incident.shtm>

**Incident and Complaint Summaries**  
**4<sup>th</sup> Quarter 2013**

**Table of Contents**

Incidents Opened in Fourth Quarter 2013 .....	3
Incidents Opened in a Previous Quarter and Closed Fourth Quarter 2013 .....	14
Complaints Opened in Fourth Quarter 2013 .....	23
Complaints Opened in a Previous Quarter and Closed Fourth Quarter 2013 ...	32

## Incidents Opened Fourth Quarter 2013

I - 9121 - \*

- Christus Health - Nassau Bay, Texas

\*Health and Safety Code Chapter 241.051(d)

By policy, this severity level IV violation was not cited.

File closed.

I – 9122 – Dose Misadministration - Texas Oncology Cancer Center - Sugar Land, Texas

On October 8, 2013, the licensee notified the Agency that a medical event had occurred at its facility. The licensee reported that a diagnostic dose of 12.9 millicuries of fluorine-18, calculated dose to patient of 900 millirem, was administered to the wrong patient. The patient responded by name to the imaging technician. The technician failed to follow protocol when a second photo identification was not checked before injection of the dose. The patient and physician were made aware of the situation. No adverse health effects were expected. The technician was re-educated on proper protocols for at least two forms of identification. This event did not meet medical event reporting criteria. No violations were cited.

File closed.

I - 9123 - Lost Moisture/Density Gauge - Professional Service Industries, Inc. - Donna, Texas

On October 9, 2013, the Agency was notified by the licensee that a Troxler 3430 moisture/density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source had been lost by one of its technicians. The technician was working on the border wall near the Donna International Bridge near Donna, Texas. When the technician arrived at the job site, he took the gauge out of its transportation case and set it on the tailgate of the truck. The technician was informed by the construction supervisor the job had been delayed so he left the site. After driving 7.5 miles, the technician noticed the tailgate of his truck was down and the gauge was missing. The technician returned to the job site, searching for the gauge as he went, but he did not find the gauge. The technician notified their radiation safety officer of the event. The licensee searched for the gauge but it was not recovered. The licensee notified local law enforcement of the event. The licensee offered a reward to anyone returning the gauge. The licensee held a safety meeting with all of the site's gauge users to review company policies on gauge security. The licensee stated it did not believe anyone received any additional exposure from this event. One violation was cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9124 - Abandoned Well Logging Source Down Hole - ThruBit, LLC - Crane County, Texas

On October 4, 2013, the licensee notified the Agency it was abandoning a 1.6 curie cesium-137 source down hole in a well in Crain County, Texas. The source was in a logging tool that had become stuck in the well. During the retrieval process, the lower section separated from the tool and the cesium source dropped out of the tool. The source came to rest in the section of the well where the direction changed from vertical to horizontal. The bore hole was lined with steel casing that passed over the source, placing the source between the casing and the bore wall. A red dyed cement plug was placed between the casing and the bore hole to secure the source's position in the well. The well was logged to verify the position of the source. The well will not be produced near the location the source. A plaque will be placed at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. No violations were cited.

File closed.

### I - 9126 - Nuclear Pharmacy Error - Cardinal Health 414, Inc. - Corpus Christi, Texas

On October 3, 2013, the licensee notified the Agency that its customer had reported receiving unexpected imaging results following the use of a dose of technetium-99m mebrofenin. Based on the licensee's investigation, it is believed that the radiopharmaceutical oxidized post preparation after the initial quality assurance testing passed and the product was released. The licensee performed an extensive review of established procedures and pharmacy protocols to confirm no errors were made in the preparation of the drug product. The licensee notified its customers of the product breakdown and provided replacement doses. No adverse health effects were reported by physicians regarding any patients. The licensee counseled all personnel involved with the event to continue to follow standard preparation and dispensing procedures. No violations were cited.

File closed.

## **Incidents Opened Fourth Quarter 2013**

### I - 9127 - Badge Only Overexposure - Acuren Inspection, Inc. - Billings, Montana

On October 19, 2013, the Agency was notified by a licensee's radiation safety officer (RSO) that one of its employees had received a deep dose equivalent (DDE) reading of 17 rem for the September 2013 exposure period. The radiographer was working on a temporary job site in Billings, Montana. He lost his badge for several hours at the same time he was pulled off of a radiography job. At the end of the work day, the employee found it in a bucket used during radiography operations. He stated the tool bucket was sitting in close proximity to the source and guide tube (about 1.5 feet) on a scissor lift used to reach the shot location. The isotope was iridium-192 with an activity of 29 curies. Radiography operations were ongoing for 2 hours after the employee went to assist the other project. The dosimetry reading for the day of the incident was 6 millirem and the employee's film badge was in his checked luggage to and from Billings, Montana. The reported calculated dose rate for a distance of 1.5 feet is 76.04 R/hr, making the total dose equivalent for the 2 hour time period 158 rems. The employee did not show any signs or symptoms of a radiation exposure caused by a high dose, therefore, it was believed that employee did not receive the dose of 158 rems. The company corrective actions were to emphasize the importance to the employee and other workers aspects of radiation hazards and safety. Training was provided to all employees. There was a disciplinary action taken against the employee. No violations cited.

File closed.

### I - 9128 - Lost Equipment Containing Radioactive Material - W.W. Webber, LLC - Hillsboro, Texas

On October 17, 2013, the Agency was notified by one of its radioactive material inspectors that she had tried to perform an inspection at a licensee's location and found the facility had been closed. The inspector drove around the area and found a sign for the company in Waxahachie, Texas. The inspector entered the facility and inquired about the other location and the location of the moisture/density gauges. The inspector was met by the company's vice president and was told he did not know anything about the gauges, but provided the inspector with a phone number where information on the gauges might be obtained. She called the number and was connected to the company's contract administrator (CA). The CA told the inspector the radiation safety officer left the company two years ago and she thought their license had been terminated. The CA stated she thought the gauges had been returned to Troxler and she would locate the gauges and inform the Agency of their location. The CA later contacted the inspector and reported the gauges had been transferred to Troxler in December 2011 and June 2012 and provided documentation. The CA stated they no longer possessed any radioactive material. The licensee submitted a request to terminate its license on October 23, 2013. No violations were cited.

File closed.

## **Incidents Opened Fourth Quarter 2013**

### I - 9129 - Nuclear Pharmacy Error - Triad Isotopes, Inc. - Houston, Texas

On October 18, 2013, the Agency was notified via letter by the licensee that on September 2, 2013, they had found they had dispensed two bulk technetium-99m doses to two customers with incorrect expiration dates. The doses were sent to the customers with the expiration date of September 4, 2013, at 0530 hours instead of the correct date of September 3, 2013 at 0530 hours. The customers were notified of the error on September 3, 2013, during the licensee's night shift. The customers reported they had not used the bulk doses after the September 3rd date. The licensee stated its staff received additional training on product labeling and the nuclear pharmacy computer system. No violations were cited.

File closed.

### I - 9130 - Radiography Equipment Failure - Acuren Inspection, Inc. - Baytown, Texas

On October 23, 2013, the Agency was notified by the licensee that a radiography crew had been unable to retract a 77 curie iridium-192 source back into a QSA 880D exposure device at a temporary work site in Baytown, Texas. The radiation safety officer, the authorized source retriever, went to the site and determined that an equipment failure occurred with the drive cables. He disconnected the drive cable handle and was able to retrieve the source back into the camera. The radiation safety officer's total exposure was 800 millirem. The root cause of the event was a burn to the crank assembly sheathing by a nearby hot pipe that caused malformation of the inner plastic tubing which prevented movement of the drive cable. The sheathing was replaced. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9131 - Overexposure - Renegade Services - Anderson, Texas

On October 25, 2013, the Agency was notified by the licensee's corporate radiation safety officer (CRSO) that the licensee had received a call from its dosimetry processor informing it one of its employees had a badge reading of 7,077 millirem, which exceeded the annual occupational dose limit. On November 27, 2013, the licensee contacted the Agency and stated it was not able to dismiss the exposure. The Agency conducted an on-site investigation on December 5, 2013. During the interviews it was noted that the individual had worn the same OSL dosimeter from June 2012 through March 2013. It was also noted the individual's exposure for the second quarter 2013 was not recorded. The CRSO stated he would provide the second quarter exposure information for the individual to the Agency. The CRSO stated the exposure recorded on the March 2013 reading would be assigned to 2012 and 2013 based on the number of months the badge was worn in each year. This would lower the exposure for 2013 to below the limit. The CRSO stated the individual would have handled material containing iridium-192, scandium-46, and iodine-131 while performing his duties. The CRSO stated he would carry multiple vials of material containing less than 7 millicuries each, but he could have carried as much as 400 millicuries on his truck at a time. The licensee stated the individual was removed from all duties involving exposure to radiation for the remainder of the 2013 year. The CRSO stated he has issued self-reading dosimeters (SRD) to all the employees performing work with radioactive material. The CRSO stated he would review the weekly SRD readings for all employees. On February 19, 2014, the CRSO provided the exposure records for the individual which included the second quarter 2013 reading of 5,642 millirem and corrected dose for the first quarter 2013. The employee's total corrected DDE exposure was 10,011 millirem for 2013. The licensee was cited for three violations.

File closed.

### I - 9132 - Gauge Shutter Failure - GB Bioscience Corporation - Houston, Texas

On October 30, 2013, the Agency was notified by the licensee that while conducting routine maintenance checks on a Texas Nuclear model 5196 nuclear gauge containing a 20 millicurie cesium-137 source, the shutter was found stuck in the open position. The licensee lubricated the operating shaft and attempted to close and reopen the shutter. While attempting to reopen the shutter, the operating rod for the shutter broke. The licensee determined the gauge is in the open position, which is the normal operating position for the gauge. The company contacted the manufacturer for repair advice. The manufacturer responded with a non-repair statement due to the age of the device. The company requested an exemption to use the device within the next 8 months until repair parts could be manufactured or found. An exemption was granted by the Agency's licensing section. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9133 - Overexposure - Metrostat Diagnostic Services - Garland, Texas

On November 4, 2013, the Agency was notified by a registrant that it had received a multiple employer exposure report for an employee that it had hired in October 2013. The report indicated that the employee had received a total annual dose of 5,700 millirem at the end of the second quarter of 2013, which exceeds the regulatory annual dose limit. The Agency had not received a report of an overexposure from the registrant the employee had previously worked for. A review of the exposure report provided to the Agency revealed a second employee who had also exceeded the annual exposure limit. On November 22, 2013, the registrant's RSO where the overexposures had occurred contacted the Agency and stated he was unaware of the issue and would provide a report to the Agency. The registrant's investigation found that both employees had exceeded the annual limit. The RSO stated in the future he would review all exposure records, send copies of the reports to his employees, and have them acknowledge their exposure. The RSO contacted the dosimetry processor and had additional notification levels put in place to help prevent a recurrence. The RSO provided additional training for all of the registrant's badged employees. One violation was cited.

File closed.

### I - 9134 - Not Licensed for Radioactive Material - The Heart Clinic - Houston, Texas

On November 5, 2013, the Agency determined that the licensee had continued to order and use nuclear medicine despite the fact its license was revoked on October 6, 2010, for failure to pay for renewal of license. On October 10, 2010, the licensee sent in a payment and change of address for its license. After receiving payment, the Agency did not notify the licensee that it would have to apply for a new license. The licensee continued to order nuclear medicine for heart diagnostics since it assumed its license was still active and it was unaware that the license was revoked. The nuclear pharmacy that supplied the radiopharmaceuticals requested a copy of a new license on October 31, 2013, which was the expiration date on the last copy of the license. After the licensee contacted the Agency in early November 2014 to renew its license, it learned that its license was not active. The licensee immediately submitted a new application with fees. The licensee ceased ordering nuclear medicine on October 31, 2013. The licensee did use radioactive material for over 2 years without a license; however poor communication between the Agency and the licensee contributed to the incident. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9135 - Abandoned Well Logging Sources Down Hole - Schlumberger Technology Corporation - Kent County, Texas

On November 7, 2013, the Agency was informed by the licensee that a well logging tool containing a 1.7 curie cesium-137 source and a 16 curie americium-241/beryllium source was stuck down hole in a well in Kent County, Texas. The licensee reported that during a retrieval attempt, the tool separated and the section of the tool containing the cesium source was left down hole. When the upper section of the tool was returned to the well surface, the licensee found that the americium source was missing from its storage location in the tool. Radiological surveys conducted at the well site were normal. The licensee attempted to locate the americium source by logging the hole again, but the logging tool got stuck. The tool was retrieved and it was decided to place a whipstock above the last location of the tool at 6,847 feet and place a red dyed cement plug above that. The well owner intended to produce the well above the cement plug. While attempting to place the whipstock above the logging tool, the whipstock became stuck at 6,125 feet. The well owner decided to place a 100 foot red dyed cement plug above the whipstock. A second plug of 500 feet of cement would be placed from 4,300 feet up. A third plug would be set and the well side tracked at 3,900 feet. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

### I - 9136 - Radiography Source Disconnect - Texas Gamma Ray, LLC - Houston, Texas

On November 20, 2013, the licensee notified the Agency that on November 19, 2013, one of its radiography crews experienced a source disconnect at a temporary field site while using a SPEC 300 exposure device that contained a 91 curie cobalt-60 source. The disconnect occurred on the first exposure of the day. Authorized persons performed the source recovery and no overexposures occurred as a result of this event. The licensee's radiation safety officer reported that during an inspection of the equipment immediately following the event he and four other employees observed that the spring on the source connector was not operating properly and was not putting any pressure on the ball from the drive cable connector. The exposure device was sent to the manufacturer for an evaluation. The manufacturer was unable to duplicate the spring failure reported by the licensee. It did note that the source connector was worn and deformation had occurred; however, it could not replicate a disconnect. The manufacturer replaced the source connector. As corrective action, the licensee reported it will continue to send the exposure device to the manufacturer routinely for maintenance and evaluation, it will take photos on a monthly basis to share with the manufacturer on the size and wear of the new connector in order to create a record on the wear and tear of the connector when it is used in everyday conditions, and the licensee's radiography staff will continue to challenge the connection when attaching the drive cable to the source. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9137 - Equipment Malfunction - QualSpec Services, LLC - Corpus Christi, Texas

On November 22, 2013, the Agency was notified by the licensee that on November 20, 2013, one of its radiography crews was unable to retract a 55 curie iridium-192 source into a QSA 880D camera. The radiography crew was performing work on a job that required the use of an extension tube sold by the manufacturer for use with the guide tube. Following the fifth of five shots, when they attempted to retract the source it would not move. The radiographers contacted the licensee's radiation safety officer who responded to the location. The source was retracted and was returned to the fully shielded position. The RSO believes that over time the extension guide tube walls had weakened and collapsed to a point where the source drive cable could not pass through it. The RSO stated no one had exceeded any exposure limits. No other individuals received any exposure due to this event. The RSO submitted an amendment to the license and is aware of the notification timeframes for any future event reporting. The license was amended December 16, 2013, to add another authorized person for source retrieval. Two violations were cited.

File closed.

### I - 9138 - Transportation Event - Mistras Group, Inc. - Andrews, Texas

On November 22, 2013, the Agency was informed by the emergency management group in Odessa, Texas, that an accident involving an industrial radiography truck carrying two radiography cameras had occurred near Andrews, Texas. The Agency contacted the licensee and the licensee's radiation safety officer reported the driver had hit a patch of ice on the road and rolled over several times. Both of the QSA Model 880 cameras, each loaded with an 85 curie iridium-192 source, breached the storage location inside the truck's darkroom. Another of the licensee's radiographers was following the truck and provided aid until emergency response personnel arrived at the scene. The second radiographer then located the cameras near the dark room and performed radiation surveys of them. Dose rates were found to be normal. The radiographer maintained control of the cameras until licensee's staff came from its Midland, Texas, location and picked them up. There were no overexposures to any individual as a result of this event. The driver of the truck that turned over had been taken by ambulance to a local hospital's emergency department following the accident. The driver was examined and released after approximately 5 hours. The cameras were sent to the manufacturer for inspection. The manufacturer stated neither camera had been damaged during the event. The manufacturer performed leak tests on both cameras and the results were satisfactory. The cameras were released by the manufacturer for continued use. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9140 - Equipment Malfunction - Steris Isomedix Services - El Paso, Texas

On December 2, 2013, the Agency received information from the licensee that on November 29, 2013, the drive mechanism on a Nordion JS-8900 (continuous) pool-type irradiator had failed to completely lower one of the source racks into the fully safe position at the bottom of the pool. The source rack was completely lowered into the pool by venting the source hoist air cylinder. The licensee has reported that the root cause was debris in the air system which caused the solenoid to get stuck, thus preventing the source hoist piston from completely lowering the source rack. The solenoid valve spools were replaced, the source cycled several times, and normal operation continued. To prevent recurrence, the licensee installed an air filter on the pneumatic air line. No violations were cited.

File closed.

### I - 9141 - Stolen Radioactive Material - Associated Couriers - Rowlett, Texas

On December 9, 2013, the Agency was notified that a molybdenum-99 generator, containing 5.7 millicuries, was stolen from a general licensee common carrier's vehicle in Rowlett, Texas. On the morning of Saturday, December 7, 2013, the generator, along with nineteen others, was loaded from the carrier's warehouse in Dallas, Texas, onto one of the carrier's vehicles. The vehicle was attempting to meet another of the carrier's tractor trailers to transfer the shipment. The generators were being returned to the manufacturer in Missouri. The meeting had to be aborted due to extreme ice/snow conditions in the Dallas area. The driver could not return to the warehouse due to the weather and traffic gridlock. He took the vehicle to his residence in Rowlett, Texas. When he got back into the vehicle on Monday, December 9, 2013, at approximately 8:30 am, he found that the vehicle's door locks had been compromised with some sort of tool and personal items were stolen. The cargo area of the van was also breached in the same manner and one of the generators was missing. Local law enforcement (LLE) was notified as well as the company that had shipped the generator. The carrier has followed up and reported to LLE several leads associated with the use of the stolen company phone and driver's debit card. The generator has not been located as of January 8, 2014, nor has there been any new information. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I - 9142 - Exposure to Member of the Public - Wilco NDT - Seminole, Texas

On December 11, 2013, the Agency was notified by the owner of a manufacturing company that an incident occurred at its facility involving industrial radiography of a pressure vessel. The reporting individual stated that the site foreman was working with the industrial radiographer. The radiographer and foreman approached the pressure vessel to check and discuss film position. While he was walking away from the vessel and camera, the radiographer kicked the crank out mechanism and realized the source had not been retracted and was still in the collimator. The industrial radiography licensee's radiation safety officer (RSO) was contacted by the Agency the day of the incident report. The RSO reported the radiographer was using a 67 curie iridium-192 source in a SPEC-150 camera. The amount of exposure, which had been reduced by the collimator, was calculated and dose was assigned to the radiographer and member of the public (site foreman). The radiographer reported that he touched the collimator for approximately 10 seconds, which resulted in a calculated dose of 9.88 rem to his hand. The calculated whole body doses were 2.06 rem for the radiographer and 515 millirem for the foreman. The radiographer and the site foreman were evaluated and released by medical facilities. The radiographer was not following proper procedures or using personnel monitoring equipment or a survey meter. The licensee terminated the radiographer's employment and retrained all other personnel on policy and procedures. Four violations were cited.

File closed.

### I - 9143 -Abandoned Well Logging Sources Down Hole - Halliburton Energy Services - Webb County, Texas

On December 17, 2013, the Agency was notified by the licensee that a 15 curie americium-241 source, a 1.5 curie cesium-137 source, and two small check sources were to be abandoned down hole in a Webb County, Texas, well. The top of the logging tool is at a depth of 8,433 feet. A 400-foot red dyed cement plug was placed starting at the top of the tool and a whipstock was set above the cement plug. A permanent plaque has been ordered for placement at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2013

### I -9144 - Attempted Theft of Radioactive Material - Weldsonix, Inc. - Houston, Texas

On Dec 30, 2013, the Agency was contacted by the licensee who reported an attempted theft of radioactive material. The licensee stated it had been notified by its security company that the alarm at its facility had been activated. When the licensee arrived at the facility, it found the building where the storage area for its exposure devices was located had been breached. Inside the building it found one barrier had been breached but the lock on the final barrier to the exposure devices was still intact. Local law enforcement (LLE) and the Federal Bureau of Investigation (FBI) also conducted investigations. Two trucks and six truck hoods were stolen. The investigation by the company, LLE, and the FBI determined that the radioactive material was not targeted by the criminals. The company installed additional security devices. The incident did not involve radioactive material. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013

### I - 8876 - Radioactive Material Identified at Landfill - ProTechnics - Itasca, Texas

On July 27, 2011, the Agency was notified by a landfill in Itasca, Texas, that its radiation monitor had alarmed when a roll off container entered its gate. The landfill had used its portable radioisotope identification equipment and identified the material as iridium-192. According to the shipping manifest for the container, the contents were from a single source which was a well site in northern Texas. During the Agency's investigation it was learned that the licensee had performed tracer studies during well fracturing operations at the well site. The well operator failed to notify the licensee of a sandout/flowback event and the frac sand was taken to the landfill for disposal without being surveyed by the licensee. The frac sand containing the radioactive tracer was disposed at an authorized facility. No violations were cited.

File closed.

### I - 8877 - Radioactive Material Identified at Landfill - ProTechnics - Itasca, Texas

On August 6, 2011, the Agency was notified by a landfill in Itasca, Texas, that its radiation monitor had alarmed when a roll off container entered its gate. The landfill had used its portable radioisotope identification equipment and identified the material as iridium-192. The container was being brought from a gas/oil well in Johnson County. During the Agency's investigation it was learned that the licensee had performed tracer studies during well fracturing operations at the well site. The well operator failed to notify the licensee of a sandout/flowback event and the frac sand was taken to the landfill for disposal without being surveyed by the licensee. The frac sand containing the radioactive tracer was properly disposed. No violations were cited.

File closed.

### I - 8908 - Abandoned Radioactive Material - Lawrence Engineering - Dallas, Texas

On December 2, 2011, the Agency was notified by a facility owner that the licensee had abandoned what appeared to be Troxler Model 3430 moisture/density gauges in the building. Initial investigation revealed that the license had been revoked for non-payment. The Agency impounded 5 Troxler moisture/density gauges that were at the facility and conducted an on-site investigation. The investigation indicated that there was one more gauge that had not been accounted for. The Agency contacted the individual who had been the Radiation Safety Officer for the licensee. During the investigation he stated he made contact with several former employees and a former partner and they told him the gauges were all in the storage area to their knowledge. The Agency contacted the manufacturer and a gauge service company in the area. Neither had serviced the gauge recently and both agreed to mark their records to notify the Agency if the gauge came in for servicing. There was no information or evidence that the gauge had been legally sold or transferred. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 8962 - Radioactive Material Identified at Landfill - Spectrum Tracer Services LLC - San Angelo, Texas

On June 14, 2012, Agency investigators responded to a technical assistance request at The San Angelo municipal landfill. A trailer of trash from an oil well site had caused the radiation monitor to alarm on June 11, 2012, and the landfill was unable to identify the isotope. Agency investigators went to the site on June 14, 2012, and identified the material as iridium-192. The licensee recovered the portions of the trash that contained the radioactive material and returned it to its facility and then conducted an investigation to determine how it got to the landfill. The licensee reported that the contaminated trash consisted of used gloves and empty tracer material vials and flush gel containers whose contents had been used during a tracer injection at the well site by one of its technicians. During its investigation, the licensee found a second trailer of trash still at the well site with more of the same type of contaminated items. The licensee determined that the technician had failed to follow procedures for surveying items used during tracer operations and returning contaminated items to the licensee's facility for decay in storage. The licensee terminated the technician's employment and reviewed procedures for handling waste with its other technicians. One violation was cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 8988 - Lost Source of Radioactive Material - Halliburton Energy Services Inc. - Pecos, Texas

On September 11, 2012, the Agency was notified by the licensee that a 15 curie americium-241/beryllium source could not be located. The source had been used earlier that day at a well site near Pecos, Texas. The well logging crew left the Pecos site and went about 130 miles to a well site south of Odessa, Texas. When the crew attempted to remove the source, they discovered the source transport container lock and plug were not in place, and that the source was missing. A crew member returned to the well site near Pecos and searched for the source while the remaining crew members searched the logging truck for the source. They did not find the source. A search along the route traveled by the licensee's vehicle was conducted by this Agency and the 6 Civil Support Team (6CST) the week of September 13, 2012, using radiation detection instrumentation. The source was not recovered. On September 14, 2012, the Environmental Protection Agency's Airborne Spectralphotometric Environmental Collection Technology airplane flew over the route. The flight returned two possible locations that were searched by the Agency and 6CST. The source was not recovered. The licensee continued daily searches for the source using radiation detection instruments. On October 4, 2012, the source was found by a member of the general public. The individual contacted the licensee and the licensee recovered the source from the individual. The source was visually inspected and leak tested and the source was found not to be damaged. The individual was interviewed by this Agency on October 12, 2012. The individual stated that he found the source at a location eight miles from the well site where the licensee had been working but in the opposite direction from the path driven by the logging crew. Several scenarios were explored to determine how the source could have been left where it was found, but none proved feasible. It was determined that the individual who recovered the source had received 64 millirem whole body dose. It was also determined the individual had received more than 2 millirem in an hour and this exceeded the regulatory dose limit to a member of the public. On May 2, 2013, the Agency met with the licensee. The licensee addressed all the concerns the Agency had identified during the investigation of the event. Five violations were cited.

File closed.

### I - 9031 - NORM Waste at Landfill - Permian Enterprises, Inc. - Odessa, Texas

On January 4, 2013, the Agency was contacted by a landfill operator in Canyon, Texas, who reported that a container of waste had caused the radiation monitor at the facility to alarm. The Agency approved return transport of the container to the originator. The Agency conducted an on-site investigation at the originator's Odessa, Texas, location and determined the source of radiation to be naturally occurring radioactive material collected as a result of pipe reclamation/inspection services conducted by the originator. It was determined the originator was authorized by general license to possess the material. The originator contracted with a licensed company for the disposal of the material. The originator has increased radiation surveys and will dispose waste more frequently to ensure it maintains compliance with Agency regulations. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013

### I - 9070 - \* - Conroe Regional Medical Center - Conroe, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 9075 - Radioactive Material Found- Triple G X-ray and Testing Labs - Humble, Texas

On April 25, 2013, the Agency received a call from a member of the public who stated that he had inherited some property that may include radioactive sources. On May 1, 2013, the Agency conducted an on-site investigation at a storage facility in Humble, Texas. The uncle of the individual who contacted the Agency had stored 7 radiography cameras in a locked trailer at a storage facility after shutting down his radiography company. The license for the company had been revoked in August 2005. Six of the cameras contained decayed iridium-192 sources and depleted uranium shielding. The seventh camera was a large A/S Model 1 camera which contained a cobalt-60 source. Calculations estimated the source strength to be 2.3 curies. All cameras were impounded in place until the Agency used a state vehicle to transport the cameras to the DSHS down hole storage in Austin. No violations were cited

File closed.

### I - 9090 - Stolen X-ray Generating Device - W&M Environmental Group, Inc. - Houston, Texas

On June 13, 2013, the registrant notified the Agency that a Bruker Titan S1 hand-held, open beam x-ray fluorescence (XRF) analyzer had been stolen from its temporary work location in Houston, Texas. The analyzer was being stored inside office space the registrant was leasing at the site. The building was locked; however, a window had been broken to gain access and several laptops and the analyzer had been taken. The registrant reported the theft to the local law enforcement. The Agency notified the Texas Association of Pawnbrokers. The unit has not been located. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 9098 - Equipment Malfunction - Blanchard Refining Co. - Texas City, Texas

On July 19, 2013, the Agency was notified by the licensee that a 300 millicurie cesium-137 source in a Thermo Fischer Scientific (TFS) model 5221 fixed nuclear gauge fell to the bottom of its insertion tube inside a process vessel. The chain connecting to the source in the nuclear gauge broke. A radiation survey was conducted and radiation levels were determined to be normal. The manufacturer responded to the site and retrieved the source, repaired the device, and placed it back in service by July 22, 2013. No one involved in the event received an exposure that exceeded any regulatory limit. No member of the general public was exposed to any radiation due to this event. No violations were cited.

File closed.

### I - 9100 - Radiography Source Retraction Failure - Fugro Consultants - Houston, Texas

On July 30, 2013, the Agency received a call from the licensee regarding a source retraction failure on July 29, 2013. The 93 curie iridium-192 source could not be retracted into the INC model IR-100 exposure device due to a malfunction with the safety latch plate engaging before the source was retracted. The licensee's radiation safety officer (RSO), who was authorized to perform source retrievals, performed the operation to retract the source into the exposure device. The mechanism was flushed with solvent and returned to normal operation. It was thought that a piece of grit caused the failure. No overexposures resulted from this event. No violations were cited.

File closed.

### I - 9101 - Fire At Licensed Facility - Texas MPM Products, Inc. - Arlington, Texas

On August 1, 2013, the Agency was notified by one of its inspectors that she had seen a news report on television about a fire at a facility that possessed radioactive material. The Agency reviewed the report and found the fire department had stated that there were no abnormal radiation levels. The Agency contacted the licensee's radiation safety officer (RSO). Once the RSO was able to enter the facility, he reported it did not appear the sources had been damaged by the fire. The licensee leak tested the sources and the leak test results were satisfactory. The licensee sent the source devices to the manufacturer for inspection. On October 23, 2013, the RSO reported the manufacturer had completed the inspection and determined the devices were not damaged by the fire and did not require any repairs. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013

### I - 9102 - Abandoned Well Logging Sources Down Hole - Allied Wireline Services - Upton County, Texas

On August 5, 2013, the licensee contacted the Agency to report that it was abandoning two well logging sources down hole in a 10,600 foot well. The sources were an 11 millicurie californium-254 source at 10,527.5 feet and a 2 curie cesium-137 source at 10,537.5 feet. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A red-dyed cement plug was set with the top at 10,135 feet with an anchor installed on top to act as a deflection device. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. No violations were cited.

File closed.

### I - 9105 - \* - Hunt Regional Medical Center - Greenville, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 9106 - Damaged Device Containing Radioactive Material - Caribbean Inspection & NDT Services, Inc. - Victoria, Texas

On August 15, 2013, the licensee reported to the Agency that on August 14, 2013, the nipple to which the source guide tube attaches on one of its SPEC 150 exposure devices had broken off. The source was secure inside the camera at the time. There were no exposures as a result. The licensee contacted the manufacturer who provided a replacement part for the camera. The cause of the nipple breakage was not determined. The part was replaced and the camera tested. The camera operated properly. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 9110 - Equipment Malfunction - Fox NDE LLC - Big Spring, Texas

On September 5, 2013, the Agency was notified by the licensee that on September 4, 2013, a radiography crew was unable to retract a 65.4 curie iridium-192 source into a QSA 880 D exposure device. The licensee's radiation safety officer stated the guide tube was damaged when the camera fell from the pipe it was sitting on. When the camera struck the floor, the guide tube near the outlet nipple was crimped and the source could not pass back through it. The source was cranked out into the collimator and bags of concrete were placed over the source for additional shielding. The RSO stated he had to cut both the guide tube and the drive cable so that the guide tube connection to the camera could be broken and the connector removed. The drive cable was then threaded through the camera and the cable pulled by hand to return the source to the fully shielded and locked position. The camera was returned to the licensee's facility for further inspection. No one involved in the event received an exposure that exceeded any regulatory limit. No member of the general public was exposed to any radiation due to this event. The camera was not damaged. The RSO stated the company policy has been changed to address stability of radiography devices when conducting operations. No violations were cited.

File closed.

### I-9112 - Radiopharmaceutical Labeling Error- Cardinal Health - Houston, Texas

On September 13, 2013, the licensee notified the Agency of a dispensing error that involved mislabeling of a radiopharmaceutical dose. The labeling error had occurred on September 9, 2013. A dose of 10 millicuries of fluorine-18 Fludeoxyglucose (FDG) was ordered but the customer assayed the dosage and measured 50 millicuries at calibration. The customer did not wish to receive a replacement dosage, but opted to adjust the dosage prior to patient administration. The licensee's investigation determined that the pharmacy technician dispensing multiple F-18 dosages did not refresh the dosage fulfillment system prior to dispensing and labeling the customer's F-18 FDG unit dosage. The staff involved in the event have been counseled by the licensee to follow procedures for the proper use and for refreshing the dosage fulfillment system on a regular basis while dispensing. No patients were affected by the mislabeling. No violations were cited.

File closed.

### I - 9115 - Stuck Nuclear Gauge Shutter - Bayer Material Science - Baytown, Texas

On September 16, 2013, the Agency received notice that the shutter on one of the licensee's Ronan SA-1 nuclear gauges containing a 20 millicurie cesium-137 source had stuck in the open position. This had been discovered during the morning shutter check. The gauge normally operates with the shutter in the open position. The source did not represent a threat to the general public or workers. The licensee was able to repair the shutter later that day with assistance from the manufacturer. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 9117 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On September 23, 2013, the licensee notified the Agency that two of its customers had reported receiving unexpected imaging results following the use of doses of technetium-99m exametazime from the licensee on August 30, 2013. Based on the licensee's investigation, it is believed that the radiopharmaceutical oxidized post-preparation thus giving rise to Tc-99m sodium pertechnetate bio-distribution observed in the patients. The licensee performed an extensive review of established procedures and pharmacy protocols to confirm no errors were made in the preparation of the drug product. The licensee will focus on reducing the Tc-99m pertechnetate eluate age used in preparing Tc-99m exametazime, according to the manufacturer's recommendations. No adverse health effects to the patients were reported by the physicians. No violations were cited.

File closed.

### I - 9118 - Stolen Radioactive Material - Paradigm Consultants, Inc. - Houston, Texas

On September 25, 2013, the Agency was notified by the licensee that one of its Humboldt Model 5001EZ moisture/density gauges was missing and presumed stolen from its facility. The gauge contains a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The gauge could not be located on Friday, September 20, 2013, during a routine inventory. On Monday, September 23, 2013, after completing a search for the gauge, the licensee made the determination that the gauge was missing. The gauge had been secured inside a locked storage area inside the facility with several other gauges. No other gauges were missing. The licensee notified local law enforcement and a gauge sales/service company in Houston, Texas. The Agency notified the Texas Pawnbrokers Association. In an effort to prevent recurrence of this event, the licensee built a new storage area and storage bins in the storage area where the gauges could be locked in place independently. No violations were cited.

File closed.

### I - 9119 - Lost Lasers - Alcon Research LTD - Fort Worth, Texas

On September 26, 2013, the Agency was notified by the registrant's laser safety officer that two class 3B lasers were missing. The lasers were last accounted for during a 2012 annual inventory. The optic lasers were over 15 years old and no longer useful. After an employee who had kept the lasers in his work areas retired, new employees packed up older machines for surplus or disposal. A detailed search of the facility was conducted but the lasers were not located. They had no value and it is suspected that they were disposed of with other waste. Training was conducted on the security, inventory, and turnover of all lasers at the facility. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### I - 9125 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On September 20, 2013, the Agency received notice of a dispensing error by the licensee. One of its customers had ordered a 10 millicurie dose of fluorine-18 Fludeoxyglucose. Upon receipt, the customer assayed the dose and found it was 50 millicuries. The customer decided to adjust the dose prior to administration in lieu of a replacement dose. The licensee determined the error occurred due to failure by its pharmacy technician to refresh the dosage fulfillment system prior to dispensing and labeling the dose. The licensee counseled the technician on the proper procedure. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2505 - Regulatory Violations - Fox NDT, LLC - Abilene, Texas

On September 30, 2013, the Agency received a complaint alleging the licensee had 13 regulatory violations including trainees transporting cameras, trainees working without the supervision of a trainer and inadequate daily paperwork including increased controls documentation. On October 21, 2013, the Agency conducted an on-site investigation at the licensee's Abilene site office. A spot check of equipment maintenance, qualification of radiographers, survey records and the increased control program was completed. On October 22, 2013, a radiography spot check at a temporary field site was conducted. No violations were noted. An interview with the licensee's radiation safety officer was conducted to discuss the alleged violations. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2506 - Unlicensed NORM Decon Activity - Master Vac Industrial Services - Argyle, Texas

On October 1, 2013, the Agency received a complaint that a company was scheduled to perform work that included decontamination services involving naturally occurring radioactive material (NORM) without a license issued by this Agency. The Agency contacted the company alleged to be performing the work and was informed that the company had dissolved a relationship it had with one company and formed a new alliance with a new company. The company owner stated they had hired a radiation safety officer and would file for a license. They also stated no work with NORM would be conducted until the license was obtained. The company owner stated they had only hauled water for disposal up to this point. The application and payment for the license was recorded as received by the Agency on December 4, 2013. No violations were cited.

File closed.

### C 2507 - Laser Injury - Ageless Med Spa, LLC – Katy, Texas

On October 2, 2013, the Agency received a complaint regarding laser hair removal. The complainant received treatment at a spa in August 2012. The complainant received hair removal treatment from a technician at the spa. The technician performed photo facial treatment on about 40 freckles on the complainant's skin. The complainant reported that the spots are now white, a year later, and the complainant had been receiving medical attention from a physician. The complainant stated the spa's physician was aware of the injuries and had paid for the treatment; however, has stopped responding to calls from the complainant. To verify an injury had occurred, the Agency requested medical records from the complainant. The complainant then decided to withdraw the complaint and declined to provide any medical records to identify or substantiate any laser injuries or mistreatment from the registrant. The complaint will be logged as a reference but no further investigation will be conducted. The complaint was withdrawn. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2508 - Laser Injury - Wellsprings DermaSpa - Austin, Texas

On October 14, 2013, the Agency received an anonymous complaint in which the complainant alleged he/she had laser hair removal treatments from 2007 to 2008 which caused swelling of his/her arms and legs. The complainant stated the treatment was injurious in such a way that he/she still has adverse reactions from the hair removal treatment from five years ago. The Agency conducted an on-site investigation on October 25, 2013. The investigation was not able to determine any injuries occurring to patients. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2509 - Radioactive Material - J3 Metals - Vidor, Texas

On October 15, 2013, the Agency received an anonymous complaint from a citizen who was concerned about radioactive material stored at a scrap yard next to his residence. On November 11, 2013, the Agency conducted an on-site investigation. The facility had a stack of oil and gas pipe that contained Naturally Occurring Radioactive Material (NORM) that was being held until it could be properly disposed or sold. Radiation surveys were performed and measurements taken did not exceed any regulatory limit. The material does not pose a risk to the health and safety of the public. The facility has purchased a radiation monitor to check scrap metal for radiation prior to acceptance. The complaint was not substantiated. No violations were cited.

File closed

### C - 2510 - Uncredentialed Laser Hair Removal Technicians - Sleek Laser & Skin Center, Inc. - Spring, Texas

On October 16, 2013, the Agency received a complaint that the facility was not properly registered or staffed and that the technologists lacked proper credentials. The facility was able to provide copies of training logs and credentials for technicians, as well as a facility registration. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2511 - Inadequate Credentialing - Mid Cities Imaging - Desoto, Texas

On October 23, 2013, the Agency received a complaint alleging the licensee was allowing individuals to perform tasks outside their qualifications. On December 16, 2013, the Agency performed an on-site inspection at the facility. The inspector found that the operation of the device was limited to an individual who was qualified to operate it. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2512 - Unregistered Laser Facility - HMMC - Katy, Texas

On October 23, 2013, the Agency determined from information provided to it that the facility was performing procedures using an intense pulsed light (IPL) device and lasers, to include laser hair removal, and it was not properly registered with the Agency. A facility representative submitted the fee and application for registration to the Agency. A certificate of registration was issued to the facility. No violations were cited.

File closed.

### C - 2513 - Regulatory Violation - Tenaris Coiled Tubes - Houston, Texas

On October 28, 2013, the Agency received a complaint alleging a temporary employee was assigned to conduct x-ray radiography and was immediately put to work using radiography equipment without training or personnel monitoring. The Agency conducted an on-site investigation on November 13, 2013. The inspectors obtained documents signed by the complainant dated prior to the date she claimed to have operated the device indicating she had received training on operation of the equipment and safety related topics such as exposure to radiation. The inspectors could not confirm the complainant ever operated an x-ray device. On December 5, 2013, the Agency was contacted by the complainant. She provided the name of the individual she stated she was with when she operated an x-ray device. The individual was contacted by the Agency and stated they never allowed the complainant to operate the x-ray device as she was still in the observation phase of her training. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2514 - Regulatory Violations - Nisotopes, LLC – Houston, Texas

On October 29, 2013, the Agency was contacted by a competitor of a nuclear pharmacy licensee who filed a complaint for a regulatory violation. Specifically, the allegation stated the licensee was using a non-FDA approved kit with a generic form of Myoview (tetrofosmin) which is a violation of a license condition. The Agency contacted the licensee and determined that they typically use sestamibi kits for technetium-99 nuclear medicine tests. Additionally, the licensee provided proof that when it did purchase Myoview it was the FDA approved version from the original manufacturer. The complaint could not be substantiated. No violations were issued.

File closed.

## Complaints Opened Fourth Quarter 2013

### I - 2515 - Regulatory Violations - Arends Inspections LLC - Wheeler, Texas

On October 25, 2013, the Agency received a complaint from a radiographer from the State of Illinois alleging the licensee's workers working near Wheeler, Texas, were performing unsafe activities. The Agency attempted to find the radiographers working near Wheeler, Texas, on November 5, 2013, but did not. The Agency attempted to contact the complainant, but the complainant did not respond. A second attempt to locate the radiographers was conducted on December 3, 2013, but the inspector could not locate them. The licensee was contacted and the radiation safety officer stated they had ceased work in the area to resolve some issues that had come up with the company who had contracted them. A third attempt to observe the licensee's radiographers in the Wheeler area was conducted on April 14, 2014, but they were not located in the field or parked in the town they were reported to be staying in. The Agency will continue its attempts to observe the licensee's radiographers during the its industrial radiography temporary work site inspections throughout the state. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2516 - Uncredentialed Technologist - Gregorio Rodriguez - El Paso, Texas

On October 31, 2013, the Agency received a complaint that an individual was working as a nuclear medicine technologist in El Paso, Texas, without proper credentials to do so--specifically, a medical radiologic technologist certification. The complaint was originally received by the Agency's Professional Licensing and Certification Unit and it requested assistance with the investigation. An Agency radioactive material inspector conducted interviews with the individual, staff at two area radiopharmacies, and the individual's previous and current employer. No evidence or information was obtained that indicated the individual had performed any unlicensed activity. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2517 - Regulation Violations - Texas Health Presbyterian Hospital Kaufman - Kaufman, Texas

\*Health and Safety Code Chapter 241.051(d)

Three violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2518 - Response to Public Concern - College Station, Texas

On October 14, 2013, the Agency received a complaint from an individual who stated he had blood in his urine, difficulty sleeping, and sensitivity to radio devices. The individual suspected an upstairs neighbor was harassing him with ground penetrating radar, an x-ray device taken from their school, or using some other device. In addition, the individual suspected that recent changes to the city's fluoride in the water supply was combining with copper pipes to make him extra sensitive to microwave radiation. An Agency inspector contacted the individual and informed him the Federal Communication Commission has jurisdiction on non-ionizing radiation and that the levels on the detectors in the video the individual provided were below the regulatory limits for exposure to members of the general public. The inspector informed the individual that amount of fluoride in the their water supply was regulated by The Texas Commission on Environmental Quality and provided the individual with its contact information. The Agency attempted to contact the individual by phone and received a message that their phone does not accept incoming calls. The complaint could not be substantiated and was closed without further action by this Agency. No violations were cited.

File closed.

### C - 2519 - Unregistered Laser Hair Facility and Technicians - Rain Skin & Body - Harker Heights, Texas

On November 14, 2013, the Agency received a complaint alleging that a facility at which laser hair removal (LHR) procedures are performed does not have a LHR Professional on staff, that the technicians performing LHR are not registered with the Agency, and the facility may not be registered as a LHR facility. On November 19, 2013, the Agency contacted the facility and determined it did not have a laser hair removal facility registration. Additionally, the employee performing LHR was licensed as a LHR Professional; but her license expired on Sep 30, 2013. The Agency received a new LHR facility application and renewal for the LHR professional. The complaint was substantiated. No violations were cited.

File closed.

### C - 2520 - Radioactive Shipment - ACME Trucking - Fort Worth, Texas

On November 11, 2013, the Agency received a complaint from an individual who had seen a truck with a radioactive sign on it and the individual was concerned about the container spilling. The Agency contacted the trucking company and learned that the truck had been carrying a special form radioactive shipment with proper paperwork. The individual had likely seen the required hazmat shipping placards. The shipment consisted of radioactive sources used in the oil and gas industry. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2521 - Unregistered Use of Radiation Machines - Elite View Imaging, LLC - Mansfield, Texas

On November 19, 2013, the Agency received a complaint alleging that an imaging facility had been performing computed tomography scans and it was not registered to do so. The Agency's investigation found that the facility had submitted an application for registration within the required 30 days of beginning operation. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2522 - Regulatory Violations - University of North Texas - Denton, Texas

On November 21, 2013, the Agency received a complaint alleging the licensee had violated several license conditions due to its termination of employment of the assistant radiation safety officer. It was alleged that license conditions were in violation when the person was removed from employment. The Agency conducted an on-site investigation on December 3, 2013. There were violations cited for not completing personnel monitoring functions and ignoring the duties of radiation safety officer. The facility has assigned and hired new personnel to perform the duties of laser safety officer, radiation safety officer and environmental technologists to complete the functions in its radiation program. The facility updated records and submitted license amendments with new names and contact numbers. The complaint was substantiated. Three violations were cited.

File closed.

### C - 2523 - Naturally Occurring Radioactive Material - Lotus LLC - Andrews, Texas

On October 21, 2013, the Agency received a complaint alleging the licensee was in violation of several naturally occurring radioactive material (NORM) rules. The Agency conducted an on-site investigation on January 14, 2014. The inspectors performed radiation surveys of the area and did not find any areas of concern. The tour of the area did not find any pools of water or areas where runoff appeared to be occurring. A review of dosimetry records did not find any person had received 100 millirem for the year. The radiation safety officer stated the facility did not accept any pipes reading greater than 50 microrem per hour to insure it stays in compliance with the Agency's rules. Soil samples of the area were taken. Sample results indicated elevated levels of radium-228 near the descaling unit, but samples taken near the facility boundaries were found to be at background levels. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2524 - Possible Contamination - PSC Industrial Outsourcing - Deer Park, Texas

On November 21, 2013, the Agency received a complaint referred from the Texas Railroad Commission that the licensee was contaminating the environment surrounding its naturally occurring radioactive material (NORM) decontamination facility. On January 8, 2014, the Agency conducted an initial inspection of the facility and an investigation into the complaint. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2525 - Unregistered Laser Hair Removal Facility - Lookin Good Spa - Wichita Falls, Texas

On November 26, 2013, the Agency received a complaint that the entity was engaged in laser hair removal services without a registered facility or registered technicians. Upon investigation, it was found that the facility was not registered. The facility has submitted paperwork and fees to the Agency. The complaint was substantiated. No violations were cited.

File closed.

### C - 2526 - Unlicensed Possession of Radioactive Material - San Antonio Nuclear Cardiovascular Services - San Antonio, Texas

On December 9, 2013, the Agency was contacted by an employee of a former licensee. The facility's medical use license, which authorized diagnostic radiopharmaceuticals, had been revoked by the Agency on November 30, 2013, due to non-payment of fees. The employee was responding to the notice of revocation and notifying the Agency that the facility was in possession of radioactive material. The Agency's investigation revealed that at the time of the facility's last inspection it only had one cesium-137 calibration source. The former licensee contracted with a consultant who performed an inventory and confirmed there was only the one source. The consultant performed a close-out survey and the source was properly transferred to another license. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C -2527 - Regulatory Violation - Dexis - Granbury, Texas

On December 10, 2013, the Agency received an internal complaint from one of its x-ray inspection managers. The inspection group found a dental office conducting training and quality assurance/quality control (QA/QC) x-rays on other staff members. In this case, a service company, which installs a device to the x-ray machine to capture and process dental images, allegedly instructed the dental office personnel to test the equipment by x-raying each other for training and QA. The dental office co-operated with Agency inspections and provided names of the representatives who instructed the dental staff to complete these x-rays to demonstrate their equipment. The complaint has been substantiated that company representatives did instruct dental employees to complete prohibited practices and further need to be registered in the state of Texas for their equipment that supports or services x-ray machines. The device/equipment company has implemented new policies and corrective actions. Two violations were cited.

File closed.

### C - 2528 - Radiation Exposure to Member Of General Public - Ion Power – College Station, Texas

On December 20, 2013, the Agency received a complaint from an individual expressing a concern over an ion bracelet he/she had purchased at a local mall. After purchasing the bracelet, the individual took it home and surveyed it with a portable radiation survey instrument and observed measurements that were greater than background. The Agency performed an on-site investigation on February 19, 2014. The inspector found the vendor had sold the bracelets for a few weeks, but due to limited sales it sold the remaining stock to a person in Midland, Texas. The vendor did not have any of the bracelets but did have several sections of various styles of bracelets. These sections were surveyed and found to be emitting low levels of beta and alpha radiation. The dose rate on contact with the sections was five microrem per hour above background. The sections were sent to the Agency's laboratory for spectral analysis. The analysis of the bracelet pieces indicated the presence of decay products from radium-228 at levels below regulatory concerns. The Agency found the same allegation was being investigated by the United States Food and Drugs Administration and the Nuclear Regulatory Commission in various locations in this country. The Agency will track the progress of their investigations. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2013

### C - 2532 - Regulation Violations - Luxe Lasers, LLC - Austin, Texas

On December 30, 2013, the Agency received a complaint that a laser hair removal (LHR) facility in Austin, Texas, was not in compliance with the rule requiring an LHR Professional or licensed health professional to be present to provide supervision during the facility's operating hours and the machine's key was being removed but was being left in plain sight which did not prevent unauthorized access. The complainant alleged other issues that were not under the radiation rules and she was provided contact information at other agencies for those issues. The Agency's investigation found the facility was registered and the technician has a certificate of registration. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013

### C - 2295 - Inadequate Credentialing - Family Medicine Rural Health Clinic PA - Copperas Cove, Texas

On December 16, 2010, the Agency received an anonymous complaint alleging that the registrant was allowing two employees who were not properly credentialed to take x-rays. The Agency conducted an on-site investigation and inspection. Required certifications were current for technicians performing x-ray procedures. The complaint was not substantiated. Three violations, unrelated to the complaint, were cited.

File closed.

### C - 2357 - Regulation Violations - Eternal Wellness Med Spa - McAllen, Texas

On October 5, 2011, the Agency received a complaint that a spa facility in McAllen, Texas, was not following the state regulations with its laser hair machine in that the keys were left in the machines at all times, the facility might not be properly registered with the Agency, and the persons performing procedures with laser and intense pulsed light machines are not properly trained and registered with the Agency under the laser hair removal rules. The Agency's investigation revealed that the keys were being left in the machines out of the necessity to keep them ready, but the registrant stated access was limited. Procedures were changed by the registrant to keep the door to the room housing laser and intense pulsed light devices locked when the technician is not present to prevent any unauthorized access and use of the devices. The investigation also revealed that the facility was registered with the Agency under 25 TAC 289.301 for laser/laser services since 2008, but was not registered as required under 25 TAC 289.302 as a laser hair removal facility. Also, technicians at the facility who had been performing laser hair removal were not registered with the Agency as required. The facility and technicians took necessary actions to attain compliance. The complaint was substantiated. No violations were cited.

File closed.

### C - 2433 - Unregistered Laser Facility - Luxe Body Spa - Austin, Texas

On October 15, 2012, the Agency received a complaint alleging laser procedures were being conducted at a body spa that was not registered with this Agency. A search of the Agency's database was unable to find a registration for the entity, but a search of the internet did locate the entity. The Agency contacted the spa and it stated it was not aware of the registration requirements. The owner agreed to obtain the appropriate registrations. The spa received a registration from the Agency on December 5, 2013. The complaint was substantiated. No violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### C - 2437 - Laser Regulation Violations - Aqua Medical Spa, LLC - Dallas, Texas

On November 2, 2012, the Agency received a complaint alleging that the licensee was conducting business without a laser safety officer (LSO) and with non-registered technicians. Further, the complainant alleged that client forms were not documented correctly, as well as other health and safety concerns. The Agency's investigation revealed that facility was properly registered under the laser rules and was exempt from the laser hair removal rules. The registrant does have an LSO. The LSO was reminded to ensure that all activities required by regulations are completed and documented. The complainant was advised that the other health and safety concerns were not within the radiation regulations and was advised where they could be reported. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2444 - Laser Hair Removal Regulation Violations - Ideal Life Development Group dba Ideal Image - San Antonio, Texas

On December 6, 2012, the Agency received an anonymous complaint alleging that a laser hair removal facility in San Antonio, Texas, was not registered, customers had received injuries, the facility was operating without a laser safety officer, all of the technicians performing laser hair removal were not registered with the Agency, the physician was not reviewing or signing incident reports (adverse reactions, blistering), and the lasers were not being maintained like they should be. During the Agency's investigation, it was found that the facility was properly registered with the Agency and technicians were also registered. The facility has a laser safety officer as required. It has contracts with the equipment manufacturers and the equipment is maintained and serviced according to their recommendations. In response to the allegations concerning adverse events, the registrant reported it had not had an adverse event as defined in the Agency's regulations and no evidence could be provided to the contrary. The complaint could not be substantiated. No violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### C - 2484 - Unregistered Laser Hair Removal Facility and Technician - Be U Beautiful Center - El Paso, TX

On July 1, 2013, the Agency received a complaint that a technician performing laser hair removal at a facility was not registered with the Agency and the complainant had experienced reddening of the skin that lasted several days following a laser hair removal procedure. The Agency's investigation revealed that the complainant had no evidence he had sustained an injury. He stated to the investigator that his skin is back to normal. The owner of the facility reported hair removal and other procedures using an intense pulsed light device had been performed, but that another individual had been coming to the facility and bringing the device to perform the procedures. The owner of the facility provided assurance to the Agency that the facility would immediately cease offering any of these procedures and hair removal advertising was immediately removed from the facility's website. The complaint was partially substantiated. No violations were cited.

File closed.

### C - 2485 - Inadequate Shielding - Gulf Coast MRI & Diagnostic, Inc. - Pasadena, Texas

On June 8, 2013, the Agency received a complaint that the registrant may have been exposing workers and patients to unnecessary levels of radiation due to inadequate shielding. An inspection with additional attention to shielding was performed and no violations were found. The maximum dose over the six months worked by the complainant was concluded to be less than 6 millirem. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2487 - Regulatory Violations - Anderson Perforating, Ltd. - Albany, Texas

On July 12, 2013, the Agency received a complaint alleging that the licensee was not performing the required surveys and calibrations. During the Agency's investigation, which included an on-site visit, it was found that the calibrations were current on the radiation survey meters. However, the licensee had failed to perform required surveys. Other violations concerning personnel monitoring and dosimetry, record keeping, and posting were also discovered. The complaint was partially substantiated. Six violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### C - 2491 - Naturally Occurring Radioactive Material - Enviroklean Product Development, Inc. - Midland, Texas

On August 12, 2013, the Agency received an anonymous complaint that the licensee had kept a roll-off container of waste containing naturally occurring radioactive material (NORM) at a location in Midland, Texas, for over 30 days. The complainant was concerned about radiation exposure from the container. The Agency's investigation revealed that the licensee had moved a roll off container with soils/sludge containing NORM to its facility from a temporary work site. The NORM concentration in the material exceeded the regulatory exempt levels. The licensee was licensed to use radioactive material only at temporary work sites. The radiation exposure from the material did not exceed any regulatory limits. The complaint was partially substantiated. One violation was cited.

File closed.

### C - 2492 - X-ray of an Individual for Training Proposes - Dexis - Alpharetta, GA

On August 14, 2013, the Agency received an internal complaint that a dental service company in Texas was encouraging multiple facilities to take x-rays on employees for quality assurance testing and training. Additionally, the service company representative asked for volunteers to test a panoramic/cephalometric unit. An investigation of the complaint produced no credible evidence of prohibited x-ray practices. The complaint could not be substantiated. No violations were cited.

### C - 2495 - X-ray of Students for Training Purposes - Wheatland Dental Care - Dallas, Texas

On August 27, 2013, the Agency received a complaint that the registrant was x-raying students for the purpose of training. The Agency performed an on-site investigation and interviews. The complaint could not be substantiated. An unrelated non-cited severity level IV violation was found.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### C - 2497 - Regulatory Violations - Lone Star Orthodontics, PA - Austin, TX

On August 28, 2013, the Agency received a complaint alleging a dental office's new x-ray machine was installed without proper testing, no radiation signs were posted in the area of the machine, and that workers stood within 6 feet of the x-ray machine when operating the unit. The complainant was also concerned about shielding and pregnant women taking the x-rays. An Agency on-site inspection and investigation was conducted. No issues were found with shielding, distance, or testing. No pregnant women were taking x-rays and pregnant patients were provided shielding with a lead apron during the x-ray exam. The unit was properly installed but the paperwork was not completed and operating procedures were not updated. The signs were not posted as required. The complaint was partially substantiated. Three violations were cited.

File closed.

### C - 2498 - Laser Injury - Tres Jolie Laser - Houston, Texas

On September 11, 2013, the Agency received a complaint alleging that an individual had developed second degree burns following laser hair removal procedures at the registrant's facility. An on-site investigation was conducted by the Agency on November 14, 2013. The inspection found they were performing laser hair removal procedures, but did not possess a registration for laser hair removal. The inspection was unable to find any records of the complainant being treated by this facility. The inspector informed the laser safety officer (LSO) of the requirements under 25 TAC289.302 and gave her contact information for the laser registration group. Repeated contacts were made with the registrant in attempt to assist them in the registration process. On December 18, 2013, the LSO requested their registration under 25 TAC 289.301 be terminated. The LSO stated they would request a registration under 25 TAC 289.302 once a new office was opened. No violations were cited.

File closed.

### C - 2499 - Unregistered Laser Hair Facility/Technicians - Affinity Laser & Med Spa - Galveston, Texas

On September 17, 2013, the Agency received a complaint that a facility in Galveston, Texas, was performing laser hair removal and other laser procedures and neither persons performing the procedures nor the facility were properly registered with the Agency. The Agency contacted the facility and determined that the facility did not believe it was required to have its laser registered since it had a physician on site. The Agency informed the facility that having a physician on site does not exempt it from registering its laser. During the next month, the facility had an employee take a 40 hour laser safety officer course and it mailed in the proper registration application for its class 4 laser. No violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2013**

### C - 2500 - Abandoned Radioactive Material - The University of Texas Health Science Center at San Antonio - San Antonio, Texas

On September 17, 2013, the Agency received information that an individual was alleging that radioactive material in a nuclear powered artificial mechanical human heart had been buried in a time capsule between 1969-1972 at the licensee's location. Neither the Agency's nor the licensee's investigations into the allegations revealed any information or evidence that indicated this type of research had ever been conducted at the facility. The licensee performed radiation surveys in suspected areas but no measurement taken was above background radiation levels. Also, the licensee has never been licensed to possess plutonium, which research indicates was the radioisotope used in research attempts to power an artificial mechanical heart with nuclear material. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2502 - Uncredentialed X-Ray Technicians - Assurance Urgent Care - Houston, Texas

On September 27, 2013, the Agency received an anonymous complaint that the registrant was allowing uncredentialed individuals to perform x-ray procedures and alleged other "questionable practices". The Agency conducted an on-site investigation on October 22, 2013. During the investigation, the Agency found that the registrant failed to provide personal monitoring devices for one physician and one x-ray technician. The uncredentialed technologist allegation was unsubstantiated. Two violations were cited.

File closed.