



INCIDENT AND COMPLAINT SUMMARIES FOR FOURTH QUARTER 2014*

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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.

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Incident and Complaint Summaries

4th Quarter 2014

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Incidents Opened Fourth Quarter 2014

I - 9240 - Radiography Source Disconnect - Fugro Consultants - Houston, Texas

On October 1, 2014, the Agency received notice that on September 30, 2014, a radiography source disconnect had occurred at a temporary field site in east Houston. The camera was a Sentinel 880D with 68.3 curies of selenium-75. The licensee reported that when the radiography crew attempted to crank the source out of the camera, the source could not exit the camera because the crew had failed to open the port cover. They could not retract the source back into the fully shielded position because they had also failed to connect the drive cable to the source assembly. An authorized person performed the source retrieval by opening the port cover and using another drive cable to push the source back into the fully shielded position. An investigation into this event is ongoing.

File open.

I - 9241 - Equipment Malfunction - Desert NDT, LLC - Odessa, Texas

On October 2, 2014, the Agency conducted a complaint investigation which confirmed that on August 1, 2014, one of the licensee's radiography crews had been unable to fully retract a 32 curie iridium-192 source into an INC model 100 exposure device (camera). The locking mechanism tripped while the ball stop was on the outside of the mechanism. The key was removed from the device and the radiographer was unable to unlock the camera when the key was re-inserted to fully retract the source. The dose rate at the front of the camera was 30 milliR/hr. The radiographer called the site radiation safety officer (SRSO), who provided instruction over the phone on how to manipulate the mechanism to allow the key to be turned to unlock the device and the source to be fully retracted. The SRSO did not consider the circumstances to be a source retrieval, but merely a mechanical issue. The licensee's corporate RSO (CRSO) was informed of the event and conducted an investigation. He did not think this was a reportable event. The radiographer trainee discovered the source was not fully retracted when he bent down to the camera to remove the guide tube and his alarming rate meter sounded. The radiographer trainer's self-reading pocket dosimeter indicated a dose of 50 millirem for the day and his dosimetry badge report indicated a dose of 87 millirem for the month. The radiographer trainee's pocket dosimeter indicated 5 millirem for the day and dosimetry report indicated 128 millirem for the month. Though not fully retracted, the source had remained (would not retract or move forward) inside the s-tube and was therefore shielded except at the front of the camera during the incident. The exposure device was inspected and it was found the locking mechanism had a buildup of dirt which prevented it from operating normally. It was cleaned and returned to service. The licensee addressed proper survey technique with its radiographers at its next safety meeting. Two violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9242 - * -Texas Health Harris Methodist Hospital Azle - Fort Worth, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9243 - Unable to Retract Radiography Source - QualSpec Services, LLC - Port Arthur, Texas

On October 15, 2014, the Agency was notified by the licensee that on October 14, 2014, one of its radiography crews was unable to retract a 38.7 curie iridium-192 source into a QSA Global 880D exposure device at a temporary field site. After the third shot at the site, the radiographers were unable to fully retract the source into the exposure device. The radiographers contacted their radiation safety officer (RSO) who was on-site. The RSO disconnected the crank mechanism at the handles, pulled the cable manually, and fully retracted the source. The RSO received 196 millirem during the retrieval according to his pocket dosimeter reading. The exposure device and guide tube were inspected and returned to service. The drive cable and crank out device were inspected and it was determined the take-up side of the drive cable shield had been placed on a pipe that had been inadvertently heated for treatment. This caused the plastic cable around the drive cable housing to melt and collapse to a point where the cable could not pass through it. This occurred about 24 inches from the end of the take-up housing. The licensee held stand down meetings with its staff to review the event. No violations were cited.

File closed.

I - 9244 - Stolen Devices - ELG Metals - Houston, Texas

On October 15, 2014, the Agency was notified by the licensee that a Thermo Niton model XLP-818 analyzer, containing 30 millicuries of americium-241, and a portable x-ray unit, Niton XL2980d, had been stolen. The devices were locked inside a cabinet on Friday October 10, 2014. The following week when the cabinet was unlocked and opened on October 13, 2014, they were both missing. The licensee and local police conducted investigations. The devices were not recovered. The licensee made several security and procedural changes to prevent future theft of equipment. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9245 - Source Retraction Failure - Desert NDT, LLC - Encinal, Texas

On October 20, 2014, the Agency received notice that on October 20, 2014, there had been a radiography source retraction failure at a temporary field site. A pipe had fallen from a stand onto the guide tube, causing a crimp. The source was retrieved by squeezing the crimp with pliers several times, allowing retraction. The camera was an IR-100 with a 46 curie iridium-192 source. No overexposures resulted from the event. One non-cited severity level IV violation was noted.

File closed.

I - 9246 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On October 21, 2014, the Agency was notified by the licensee that it had sent a customer the wrong form of technetium-99m for a cardiac study. The unit dose should have been in the form of tetrofosmin, but sestamibi was sent instead. The customer used the unit dose to complete the study with no untoward effects to the patient. The licensee counseled the employees involved in the event and changed its verification procedure for orders to prevent recurrence of this event. No violations were cited.

File closed.

I - 9247 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On October 21, 2014, the Agency was notified by the licensee that a labeling error had occurred on a pair of unit doses sent to a customer. The licensee had prepared two unit doses for the customer and the labels on the two doses were switched. The customer discovered the error prior to administering either unit dose. The licensee retrieved the unit doses and prepared and delivered correctly labeled unit doses to the customer. The licensee the unit doses were created at the same time and the labels were inadvertently placed on the wrong unit dose. To prevent recurrence of the event, the licensee changed its procedure to require orders for multiple unit doses be completed one dose at a time. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9248 - Nuclear Pharmacy Error - Triad Isotopes, Inc. - Houston, Texas

On October 14, 2014, the Agency was notified by the licensee that two customers had received the wrong form of technetium (Tc)-99m in unit doses and they had administered the doses to patients. The customers had requested Tc-99m mebrofenin and the unit doses were labeled that way. However, the pharmacy had produced and filled the unit doses with Tc-99m medronate. The licensee's radiation safety officer stated the unit dose for one facility contained 5 millicuries of Tc-99m and 6 millicuries at the other. No exposure limits were exceeded and the user did not report any adverse effects to the patient. The patients and their physicians were notified of the error. The licensee determined the root cause for the error was inadequate verification and confirmation of the product identity compared to the pharmacy computer dispensing system. The individuals involved received additional training in producing unit doses. The licensee is now using a bar code system to help control the process. No violations were cited.

File closed.

I - 9249 - Exposure to Member of the General Public - Sun Edison - Pasadena, Texas

On October 30, 2014, the Agency received notice that a member of the general public may have received a radiation exposure that exceeded regulatory limits on September 10, 2014, when a contract worker entered a tank without closing the source holder on two Ohmart Vega nuclear level/density gauges. The licensee's audit of its confined entry permits revealed the event. An abrasive blaster worker was lowered into a vessel and worked for 90 minutes. It was determined that his exposure exceeded the annual public dose limit. An additional contractor entered the tank for 10 minutes and his exposure exceeded the hourly limit for public exposure. The root cause of the overexposures was human error; specifically, procedures were not followed for tank entry including proper lockout and tagout of two nuclear gauges. Though the two workers' exposure exceeded public dose limits, neither received a dose that would pose a health risk. Two violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9250 - Unable to Retract Radiography Source - Team Industrial Services - Houston, Texas

On November 3, 2014, the Agency was notified by the licensee that one of its crews was unable to retract a 34.9 curie cobalt-60 source into a QSA Global 680A exposure device. The crew was performing radiography at a field site using a magnetic stand to support the guide tube and collimator. The stand fell on the guide tube and crimped it in two places about one inch apart. The radiographer attempted to retract the source, but it would not go past the crimped section of the guide tube. The radiographer returned the source to the collimator. One of the radiographers contacted the site radiation safety officer (SRSO). A recovery team was sent to the location to retrieve the source. The team slid a steel plate below the collimator. The guide tube was pulled to free the collimator from its holder causing it to drop onto the steel plate. The collimator was approached from the shielded side and using a pair of tongs, the collimator was rolled to face the outlet port towards the steel plate. Six bags of lead shot were placed on the collimator. The dose rate at the crimped section of the guide tube was then measured at 200 millirem per hour. Additional bags of lead shot were placed on the collimator. The licensee's first attempt to remove the crimps in the guide tube using channel locks was unsuccessful. The licensee then removed the outer coating on the guide tube in the areas the tube was crimped and then used channel locks to remove the crimps. This was successful and the source was returned to the fully shielded position. The highest exposure to any individual involved in the event was seven millirem. The licensee reported no exposures were received to members of the general public due to this event. The guide tube was taken out of service. The exposure device and crankout device were inspected and returned to service. The source was Leak tested and the results were below the applicable limit. The guide tube stand was modified to make it more stable. No violations were cited.

File closed.

I - 9251 - Industrial Radiography Camera Lost/Recovered - Phoenix Non Destructive Testing, Inc. - Channelview, Texas

On November 13, 2014, the Agency was notified by the licensee that on November 12, 2014, it was notified by local law enforcement (LLE) that one of its industrial radiography cameras had been found on the side of a road near a railroad crossing approximately 3 miles from the licensee's facility. Railroad operators had seen the camera and the radiation symbols on it and called LLE. The licensee retrieved the camera and there was no apparent damage to the device and a survey confirmed the source was still in the fully shielded position. The licensee determined that the SPEC 150 camera containing a 38 curie iridium-192 source had fallen from one of its trucks while in route to a temporary job site. The licensee estimated the camera was out of its possession approximately 2.5 hours. The camera was locked and the keys were not with it. The licensee reported the camera had been left on the tailgate and not secured inside the truck before it left the licensee's facility. There are no known exposures that resulted from this event. Three violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9252 Lost source - Weatherford International - Houston, Texas

On November 14, 2014, the agency was notified by the licensee that a 10 microcurie Americium-241 source was lost from its research and development facility. The source was previously inventoried in December 2013 and could not be found during the current inventory. The facility will continue to search for the source, but suspects it may have been thrown out with trash during regular cleanup operations. The licensee developed and implemented new procedures for source inventory and transfer. No violations were cited.

File closed.

I - 9253 - Radioactive Material Found - Frac Specialist, LLC - El Paso, Texas

On November 15, 2014, the Agency received a phone call from a Customs and Border Patrol (CBP) agent who stated a vehicle at the El Paso, Texas, entry point from Mexico had caused their radiation monitor to alarm. He stated they had found that a pair of red coveralls, two ceramic cups, and the liner of the vehicle's trunk were contaminated. The radionuclide was identified as scandium-46. The Agency instructed him to remove the material and to isolate it and the vehicle until the Agency could respond to the location. An Agency inspector arrived at the location the morning of November 17, 2014. The inspector could not find any readings above background in the vehicle or on the material removed from the vehicle. The vehicle's owner was also surveyed and no readings above background were found on him. The car was released, but the material removed by CBP was taken to the Agency's regional office for additional surveys. These surveys did not locate any radioactive material. On the evening of November 18, 2014, the Agency received a call from CBP stating the same individual was returning through a different border crossing from Mexico and had again set off the alarm. The Agency's inspector responded to the site and found a small particle in the floor of the vehicle's trunk that was reading greater than 600 microrem. The inspector removed the particle from the trunk using a tape press. The inspector surveyed the vehicle and no additional radioactivity was detected. The radionuclide was identified as scandium-46. The inspector took the particle to the Agency's regional office. The driver and all the material previously removed from the vehicle were released. The vehicle's owner stated he worked for a couple of weeks for a fracking company and had been at multiple well sites. The Agency attempted unsuccessfully to identify the source of the radioactive material. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2014

I - 9254 - Damaged Device Containing Radioactive Material - Arias and Associates, Inc. - Eagle Pass, Texas

On November 17, 2014, the Agency was notified by the licensee that a Troxler model 3430 moisture/density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source was damaged at a field site. The licensee's technician set up the gauge and began a compaction test with the cesium source extended into the soil. At the last minute he saw a road grader driving towards him so he quickly moved out of the way. When he looked back, he discovered that the grader had run over the gauge. The area was secured until the licensee's radiation safety officer responded to the site. The non-repairable gauge was returned to a service company for disposal. No contamination from the source was found and no one was exposed outside the normal range of operation. The licensee conducted training with its workers to make a better effort to ensure contractors are aware of gauges in operation at worksites. No violations were cited.

File closed.

I - 9255 - Equipment Malfunction - Desert NDT, LLC - Wichita Falls, Texas

On 21 November 2014, the Agency was contacted by the licensee to report an equipment malfunction when the source assembly, with a 42 curie iridium-192 source, could not be fully retracted into an INC IR-100 industrial radiography camera. A malfunctioning locking assembly prevented the source from being fully retracted. The source was temporarily put into a spare camera while parts of the locking mechanism were replaced. The source was returned to the original camera, and its use was resumed. No overexposures resulted from the event. No violations were cited.

File closed.

I - 9256 - Equipment Malfunction - Desert NDT, LLC - Hermleigh, Texas

On 25 November 2014, the licensee reported to the Agency that on November 24, 2015, one of its radiography crews had been unable to retract a source into a camera at a temporary job site. The crew was using an INC IR100 with a 51 curie iridium-192 source. A source retrieval was performed by an authorized person. An investigation into this event is ongoing.

File open.

I - 9257 - Badge Overexposure - Hi-Tech Testing Services, Longview, Texas

On December 5, 2014 the Agency was notified by a licensee's radiation safety officer (RSO) that an employee had lost his badge and it was returned to him by the company where the radiography work was being performed. The badge was sent for processing and the results caused the annual occupational exposure limit for the employee to be exceeded. The monthly dose was 2405 millirem. An investigation into this event is ongoing.

File open.

Incidents Opened Fourth Quarter 2014

I - 9258 - Badge Overexposure - QC Laboratories, Inc. - Houston, Texas

On December 8, 2014, the Agency received notification from the licensee that its dosimetry report for April 2014 had indicated one of its radiographers had received just over 5 rem for that month. The licensee stated it discovered during its annual audit in November 2014 that this had not been reported to the Agency. The licensee stated an interview with the radiographer revealed he had dropped his badge in the exposure bay and exposed it several times without realizing it. The licensee made the determination that the exposure was to the badge only. An investigation into this event is ongoing.

File open.

I - 9259 - * _____ - Providence Memorial Hospital - El Paso, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9260 - Annual Occupational Dose Limit Exceeded - Hi-Tech Testing Service, Inc. - Longview, Texas

On December 17, 2014 the Agency was notified by the licensee that its dosimetry report for November 2014 indicated one of its employees had a received an exposure that exceeded the 5 rem annual exposure limit. An investigation into this event is ongoing.

File open.

Incidents Opened Fourth Quarter 2014

I - 9261 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On December 17, 2014, the licensee notified the Agency that on December 2, 2014, it received a call from one of its customers who reported that one of two dosages of technetium-99m (Tc-99m) medronate was administered to a patient which had unexpected images showing free Tc-99m pertechnetate. The licensee's pharmacist contacted another customer who had also received two dosages from the same vial in the affected lot. The second customer had also administered one of its two dosages and had the same results as the first customer. The pharmacy replaced the two unused dosages for both customers. The licensee reported that the vial of Tc-99m medronate was prepared using standard procedures and the dispenser noticed there was a possibility of air introduced into the vial, which would have caused the oxidation of the drug following preparation. Initial quality control test of the affected lot showed greater than 95% radiochemical purity. The test after notification from the customer showed less than 90%. The licensee counseled all employees involved in preparation to avoid introducing air into the kits while still following standard procedures and the pharmacy manager has addressed the topic in a staff meeting. No violations were cited.

File closed.

I - 9262 - Possible NORM Contamination - Comanche Iron & Metal - Comanche, Texas

On December 22, 2014, the Agency received notice that a property involved in bankruptcy proceedings may be contaminated by naturally occurring radioactive material. An investigation into this event is ongoing.

File open.

I - 9263 - Radiography Source Disconnect - Texas Gamma Ray LLC - Houston, Texas

On December 23, 2014, the licensee notified the Agency that one of its radiography crews, who was performing radiographic operations at one of its licensed sites, had experienced a source disconnect. After completing an exposure, the radiographers cranked the 79 curie cobalt-60 source back into the SPEC300 exposure device. However, as they started to walk toward the end of the guide tube their survey meter and alarming rate meters indicated the source was still in the guide tube. They moved their boundaries back, secured the area, and called their supervisor. The licensee's radiation safety officer and two employees who are approved on the license for source retrieval responded to the site. They found that the source assembly (pigtail) cable had broken a couple of inches back from the source. The source was retrieved from the guide tube and placed back inside the exposure device. A survey confirmed the source was in the shielded position. The licensee is sending the exposure device and all associated equipment from this event to the manufacturer for evaluation. No member of the public received any exposure and there were no overexposures to any of the radiographers or source retrieval team. An investigation into this event is ongoing.

File open.

Incidents Opened Fourth Quarter 2014

I - 9264 - Stolen Radioactive Material - T S I Laboratories, Inc. - San Antonio, Texas

On December 30, 2014, the Agency was notified by the licensee that a Humboldt model 5001C gauge containing a 40 millicurie americium-241/beryllium source and a 10 millicurie cesium-137 source was stolen out of the back of a company pickup truck. The licensee stated the technician had parked the truck at a movie theater and entered the theater to be with family. The licensee stated the gauge was unattended for one hour and forty-five minutes. The licensee stated when the technician returned to the truck he found the chains securing the gauge to the truck were cut and the gauge and locks were missing. The investigation into this event is ongoing.

File open.

I - 9265 - Badge Overexposures - Chopra Imaging Center, LLC - Houston, Texas

On December 31, 2014, the registrant notified the Agency it had discovered that dosimetry badge reports indicated two of its employees had exceeded regulatory dose limits. For one employee the potential overexposure had occurred in 2013 and the other employee's potential overexposure occurred in August 2014. An investigation into these events is ongoing.

File open.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2014

I - 9185 - Possible Radiation Exposure To Member of General Public - Renegade Services - Andrews, Texas

On April 17, 2014, the licensee notified the Agency that it had received a dosimetry report from its processor that indicated the monitoring badge on one of its boundary fences had been exposed to 2,426 millirem for the first quarter of 2014. The Agency performed an on-site inspection at the facility on May 7, 2014. The inspection found that due to the distance between the licensee's property and the next occupied location and the remoteness of the location it was not likely that a member of the general public would have received an exposure above any regulatory limit. At the time of the inspection the licensee was installing additional shielding. The third quarters boundary dosimetry results showed a marked dose reduction. The third quarter results showed a maximum dose of 45 millirem at the fence for the quarter. No violations were cited.

File closed.

I - 9210 - Contamination of Individual - Protechnics - El Paso, Texas

On July 1, 2014, the U.S. Customs and Border Protection (CBP) contacted the Agency and reported that an individual crossing from Mexico at the border checkpoint in El Paso had set off its radiation monitors. The CBP had identified clothing in the trunk of the individual's car as being contaminated with scandium-46 and it reported readings of 173 microR/hr at one foot. It was determined that the individual was one of the licensee's technicians. Investigation by the licensee determined that six ceramic tracer beads containing scandium-46 were found to be on work overalls in the back of the individual's vehicle. No contamination was found at any other location visited by the individual since the previous job. The individual failed to conduct a proper post-work contamination survey. One violation was cited.

File closed.

I - 9215 - Retraction Failure - Fugro Consultants - Houston, Texas

On July 28, 2014, the Agency received notice that a radiography source retraction failure had occurred at a temporary job site on July 26, 2014. The camera being used was a Sentinel 880 Delta with a 40.7 curie selenium-75 source. The licensee reported the guide tube had separated at the crimp between the flexible portion and the fitting to the camera. The flexible portion had pushed out when the source was cranked out. This allowed the drive cable to be fed past the gearing of the crank mechanism, leaving the source unable to be cranked back in. The source was retrieved by manually pulling the drive cable back through the camera. The guide tube, which was removed from service and replaced, was returned to the manufacturer for inspection. It was determined that age and wear were the primary causes of the failure. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2014

I - 9223 - * - Lake Pointe Medical Center - Rowlett, Texas

*Health and Safety Code Chapter 241.051(d)

Two non-cited violations were identified.

File closed.

I - 9224 - * - Methodist Healthcare System of San Antonio - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 9225 - Badge Overexposure - US NDI, LLC - Abilene, Texas

On August 25, 2014, the Agency received notice that the licensee had received a dosimetry report that indicated one of its radiographer trainees had received an exposure of 8.6 rem for the period of July 5 to August 4, 2014. The licensee investigated and determined that overexposure had been to the badge only. The trainee had dropped his badge and it had been near the camera for several shots. The trainee had not told his trainer this had occurred. Based on the trainee's daily pocket dosimeter readings, the licensee assigned a dose of 301 millirem for the period. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2014

I - 9227 - Radioactive Material Found - CMC Steel Texas - Seguin, Texas

On September 2, 2014, a steel mill notified the Agency that it had discovered a dew point device in a load of scrap metal it had received from a scrap recycler in Killeen, Texas. The steel mill identified the isotope as radium-226 and the highest radiation measurement it detected was 4,500 microR/hr on contact. The steel mill properly disposed of the device. The dew point device is a General License device. The Agency's investigation identified the owner of the device as a heat treating services company in Round Rock, Texas. The company had unknowingly taken the device with other scrap metal to the recycler after it cleaned out some of its buildings. The company reported it does not have any other devices that contain radioactive material. The company paid for the device's disposal costs. No violations were cited.

File closed.

I – 9228 - Regulatory Violations - Acuren Inspection, Inc. - Nederland, Texas

On September 3, 2014, the Agency was notified by the licensee that it may have lost control of security related information. The licensee's corporate radiation safety officer (CRSO) stated a site radiation safety officer (SRSO) had received several new radiography cameras and became excited to see this office growing. The SRSO placed the new devices in the storage vault and took some pictures to show people their growth. The SRSO posted the pictures on social media. Another of the licensee's radiographers noticed the pictures and informed his management. The SRSO was contacted and all of the pictures were removed. The CRSO stated in an effort to prevent recurrence of the event, the licensee required all of its radiographers to review the licensee's social media policy. The licensee made changes to its security system to render any information in the pictures useless. The SRSO was removed as the SRSO and the licensee is monitoring the social media site. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2014

I - 9231 - Gauge Shutter Failure - Chevron Phillips Chemical Company LP - Pasadena,

On September 9, 2014, the licensee notified the Agency that on September 4, 2014, it attempted to close the shutters on two Ohmart Vega model SH-F2 level gauges, each containing 500 millicuries of cesium-137, and the shutters failed to operate. One shutter was initially resistant but then the shutter lever moved freely to the closed position. However, when the licensee tried to re-open it after completing vessel maintenance, the shutter would not open. An instrument mechanic placed two bolts in the open holes on the lever and the shutter lever was moved to the open position. After the radiation safety officer was informed of the problem, his investigation revealed the shutter was actually stuck in the open position and the bolts connecting the shutter lever had been sheared off. The other gauge's shutter would not close and was left in the open position. The gauges normally operate with the shutter in the open position. It was not required that either gauge shutter be closed for the vessel maintenance, they were just closing them as an extra precaution. The licensee contacted a service company who came on-site and restored the operation of the shutter lever on the second gauge by lubricating the shutter mechanism and parts were ordered for the first gauge. On October 27, 2014, repairs were completed on the first gauge. The cause of the failure was determined to be corrosion from water intrusion. The replacement shutter installed had an upgrade which includes a gasket at the seal location. The licensee has reported it will institute procedures for preventive maintenance to be performed during routine gauge inspections and will revise its radiation protection and standard operating procedures to include proper operation of radiation gauges, requirements for reporting any gauge malfunctions, and procedures to verify shutter closure. No individual received any exposure as a result of this event. One non-cited severity level IV violation was noted.

File closed.

I - 9232 - Equipment Malfunction - American X-ray & Inspection Services, Inc. - Midland, Texas

On September 11, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that a radiography crew reported it was unable to fully retract a 46 curie iridium-192 source into a SPEC 150 exposure device. After the licensee responded to the site, it was reported by the RSO that the drive cable broke at the crank handle. A person authorized to perform source retrieval arrived at the site and took apart the drive cable crank handle to find a broken cable. The cable was manually pulled and the source retracted into the shielded position. The cable was removed from service and replaced with a new drive cable and crank. Operations resumed without further actions. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2014

I - 9234 - Not Licensed for Radioactive Gauge - Pro-Stim Services, LLC - Hebronville, Texas

On September 16, 2014, the Agency was notified by U.S. Customs and Border Protection that a licensee had a radioactive gauge but no license or shipping papers. The Agency conducted an investigation and determined that the licensee had a General License Acknowledgment (GLA) with the Agency but the 200 microcurie cesium-137 gauge was not on the license. The gauge was purchased in April 2014. The licensee sent in an update to their GLA to add the gauge and update the contact person information. No violations were cited.

File closed.

I - 9236 - Nuclear Gauges Involved in Fire - Baker Hughes Oilfield Operations, Inc. - Dimmit County, Texas

On September 20, 2014, the Agency was notified by the licensee that four Thermo Fisher Scientific density gauges had been involved in a fire at an oil well site that involved multiple vehicles/equipment on which the gauges were mounted. Each of the gauges contained a 200 millicurie cesium-137 source. The gauges were secured then packaged and transported to the manufacturer for evaluation. Two model 5190 gauges that were directly in the fire were damaged beyond repair and had to be disposed. Two Model 5192 gauges that were not directly in the fire were repaired. There were no worker or public exposures due to this incident. No violations were cited.

File closed.

I - 9238 - Lost Moisture/Density Gauge - Integrated Testing & Engineering Company of DFW Metro, Inc. - Roanoke, Texas

On September 23, 2014, the licensee notified the Agency that one of its Troxler Model 3411 moisture/density gauges containing an 8 millicurie cesium-137 source and a 40 millicurie americium/beryllium source had been lost from the back of one of its trucks in Roanoke, Texas. The technician who was using the gauge stated it was 1730 hours and in his haste to leave the job site he failed to secure the gauge in the back of the pickup truck. While he was driving, he saw the tailgate fall down and the gauge fall out of his truck. He turned around and went back to the intersection, but he did not find the gauge. The technician notified his supervisor of the event. On September 24, 2014, the licensee was contacted by a contractor who stated that he/she saw the gauge fall out of the truck, picked it up, and took it to their facility. The licensee retrieved the gauge on September, 25, 2014. The licensee inspected the gauge and found the transport case was cracked, but the gauge was undamaged. The licensee reprimanded its technician and removed him from duties involving the use of a nuclear gauge until the gauge involved was returned to service. The licensee stated that in the future it was going to perform unannounced visits to the technicians' job sites to verify compliance with company rules. Two violations were cited.

File closed.

Complaints Opened Fourth Quarter 2014

C - 2598 - Regulatory Violations - Dr. Michael M. Heckman - San Antonio, Texas

On October 2, 2014, the Agency received a complaint alleging that the registrant may have allowed uncredentialed technologists to operate x-ray machines. Further, the complaint alleged that required notices were not posted and that personnel monitoring was not provided. The Agency performed an on-site investigation on October 29, 2014. The Agency's investigation did find the registrant had failed to post the "Notice to Employees". The registrant posted the notice during the investigation. The proper caution signs were in place. Interviews with the registrant's radiation safety officer and workers revealed one individual and the doctor are the only individuals who operate the x-ray device. The individual who normally operates the x-ray device does hold a current non-credentialed technician's certificate. The licensee was providing dosimetry for its employee operating the device, but during the investigation it was determined that the registrant had not and was not currently measuring the exposure to members of the general public. The complaint was partially substantiated. One violation was cited.

File closed.

C - 2599 - Regulatory Violations - Pioneer Wireline Services, LLC - San Angelo, Texas

On October 14, 2014, the Agency received an anonymous complaint referred by the Nuclear Regulatory Commission about various well logging regulatory violations. The alleged violations included improper boundaries, lack of remote handling tools, and not wearing dosimeters and were concerning the licensee's location in Kansas. However, the complainant alleged there may be similar problems in some of the licensee's Texas site locations. The complainant also stated that multiple personnel used the same visitor dosimeter badge at the San Angelo site office. On November 13, 2014, the Agency conducted a field investigation at a temporary job site. No violations were noted. On December 2, 2014, the Agency reviewed dosimetry records at the San Angelo office and determined that no method was used to track doses accumulated on visitor badges during three quarters in 2014. Multiple personnel used the same visitor badges and the doses on the badges were never assigned to an individual's record. The complaint was partially substantiated. One violation was cited.

File closed.

C - 2600 - * - University General Hospital - Houston, Texas

*Health and Safety Code Chapter 241.051(d)

An investigation into this complaint is ongoing.

File open.

Complaints Opened Fourth Quarter 2014

C - 2601 - Regulatory Violations - American Laser Med Spa - Amarillo, Texas

On October 24, 2014, the Agency received a complaint alleging the registrant was violating multiple laser hair removal regulations. An investigation into this complaint is ongoing.

File open.

C - 2602 - Unregistered Facility - Paradise Wellness Med Spa - San Antonio, Texas

On November 7, 2014, the Agency received a complaint regarding an unlicensed laser hair removal facility. The Agency contacted the facility to acquire information and provided guidance on registration. The facility is now in the process of completing an application for registration. Awaiting confirmation from license section that application was received.

File closed.

C - 2603 - * - Palestine Regional Medical Center - Palestine, Texas

*Health and Safety Code Chapter 241.051(d)

An investigation into this complaint is ongoing.

File open.

C - 2604 - Regulatory Violations - Baker Hughes Oilfield Operations - Perryton, Texas

On November 14, 2014, the Agency received an anonymous complaint reporting multiple regulatory violations related to inventory, shipment, and surveys of densometers containing radioactive sources. An investigation into the complaint is ongoing.

File open.

C - 2605 - Laser Injury - Amerejuve - The Woodlands, Texas

On November 12, 2014, the Agency received a complaint that alleged an individual was performing laser hair removal procedures and does not possess a certificate of registration to do so. The complaint also alleged that the individual had caused burns to a customer's face and underarms during a laser procedure. An investigation into this complaint is ongoing.

File open.

Complaints Opened Fourth Quarter 2014

C - 2606 – Unregistered Laser Hair Removal Facility – De Hita Skin Care Spa - Humble, Texas

On December 3, 2014, the Agency received an inquiry from an individual concerning whether a spa, which offers laser hair removal, was registered with the Agency. During an initial search of Agency records, no certificate of registration for the facility was located. The Agency contacted the facility owner and the owner stated that they were not currently performing laser hair removal but they were planning to offer such services in the future. The owner was advised as to what kind of registration with the state would be required. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2607 - Dose to Public - Customs and Border Patrol Rail Vacis System - El Paso, Texas

On December 4, 2014, the Agency received a complaint concerning radiation exposure to members of the public from a gamma imaging device used to scan rail cars at the United States border. The complainant had concerns of radiation exposure and harmful effects of the exposure. The Agency conducted an investigation and found that the cobalt-60 source used for scanning railcars was being used while railway workers were in the cars. The amount of exposure was calculated at less than the public dose limit. Information about regulatory limits for dose and exposure was provided to the complainant. In addition, the case was referred to Nuclear Regulatory Commission since this was an NRC licensed facility. No violations were cited.

File closed.

C - 2608 - Laser Injury - Rockwall Laser Center and Academy - Rockwall, Texas

On December 11, 2014, the Agency was notified that two individuals may have received burns during laser treatments that were not reported to this Agency as required. The investigation into this event is ongoing.

File open.

C - 2609 - Regulatory Violations - Team Industrial Services, Inc. - Pasadena, Texas

On December 16, 2014, the Agency received an anonymous complaint alleging multiple regulatory violations at a fixed radiography site. The alleged violations included radiographer trainees not being supervised, surveys not being performed, dosimetry not being worn, and a radiographer had walked up on an exposed source. An investigation into this complaint is ongoing.

File open.

C - 2610 - Unregistered Fluoroscopy Unit - Beltway Foot Clinic - Houston, Texas

On December 22, 2014, the Agency received a complaint that the entity may be operating a fluoroscopy unit and laser unit without proper registration. An investigation into this event is ongoing.

File open.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2014

C - 2553 - Laser Burns - Rain Beauty S and R, LLC - Harker Heights, Texas

On March 26, 2014, the Agency received a complaint alleging that several individuals had received injuries as a result of laser hair removal (LHR) procedures performed at a facility. The complaint also alleged that the facility did not have an LHR Professional Technician on staff at the facility and has not had one since December 2013. The Agency conducted an on-site investigation. The Agency did not find evidence to support the injury complaint. However, the investigation confirmed the facility was not properly registered with the Agency nor had it had an LHR Professional Technician since October/November 2013. The co-owner was performing LHR procedures but she had failed to renew her Senior LHR Technician registration and it was expired. The owners of the facility closed the business and the co-owner that had been a Senior LHR Technician works in a different industry and no longer performs LHR. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2568 - Unregistered Laser Equipment - Telos Fitness Center - Dallas, Texas

On May 29, 2014, the Agency received a letter alleging an individual was operating a class 3B laser at a facility and was not registered with this Agency. The Agency contacted the facility and a staff member stated they had four lasers at the facility and she believed they were class III B. The Agency attempted to contact the manufacturer of the device. After several attempts, the Agency was able to confirm the devices being used at the facility were class III B laser. The Agency contacted the facility's owner and they stated they were not aware they were required to be registered. On August 7, 2014, the Agency received the facility's registration documents and the required fees were received on August 22, 2014. The Agency's laser registration group confirmed it was processing the application. No violations were cited.

File closed.

C - 2576 - Unregistered Use of Dental X-ray Machines - WHC Clinic - Palestine, Texas

On July 1, 2014, the Agency received a complaint alleging that an unregistered facility may be operating dental x-ray units. Investigation revealed that the clinic had not yet begun dental operation and that the x-ray unit was not yet functional. The facility has submitted an application for registration. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2014

C - 2580 - Uncredentialed Technologists - Metroplex Occupational Health - Killeen, Texas

On July 4, 2014, the Agency received a complaint that the registrant may be allowing uncertified technologists to operate fluoroscopy equipment. An unannounced inspection was performed on July 27, 2014. The complaint could not be substantiated. Two unrelated violations were cited.

File closed.

C - 2584 - Regulatory Violations - Galaxy MRI and Diagnostic Center, Ltd. - Mesquite, Texas

On July 21, 2014, the Agency received an anonymous complaint alleging that the registrant's x-ray machine was defective, an orthopedic physician's assistant was performing fluoroscopy without the physician's oversight, and a non-certified technician had been performing pediatric core x-rays for many years. An unannounced inspection was conducted by the Agency on August 1, 2014. The registrant's x-ray machine and fluoroscopy machine had been tested by a service company and operated within specifications. The uncredentialed technician operating the x-ray machine and physician's assistant operating the fluoroscopy machine complaints were substantiated. Four violations were cited.

File closed.

C - 2585 - * - Seton Northwest Hospital - Austin, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2588 - Not Registered - Medical Imaging Solutions Group - Woodstock, Georgia

On August 28, 2014, the agency received a complaint stating a company had installed x-ray equipment at a facility and it did not hold a registration to do so. The complaint also alleged that the individuals who installed the equipment were not properly trained. The complainant was informed that similar allegations had been investigated under complaint the Agency had previously received. That investigation found the company was registered and the individuals stated in the previous complaint had received the training needed to provide the service. The complainant was requested to provide additional information regarding their complaint. The complainant agreed. However, attempts to contact the complainant to ask for the information requested were unanswered. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2014

C – 2590 - Regulatory Violation - Advanced Corrosion Technologies and Training, LLC - Angleton, TX

On May 29, 2014, the Agency received a complaint referred from the Nuclear Regulatory Commission alleging that radiographers from Louisiana had performed work in Texas under reciprocity without being properly documented as trustworthy and reliable. Investigation revealed that the radiographers that worked in Texas worked under a Texas license. The licensee was able to provide reciprocity identification and proof of its trustworthy and reliable investigation for radiographers working under the license. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2591 - Regulatory Violations - Desert NDT, LLC - Odessa, Texas

On September 12, 2014, the Agency was contacted by the Nuclear Regulatory Commission and informed it had received an allegation against the licensee. The complainant alleged that on or near the first of August 2014 one of the licensee's industrial radiography crews working near Odessa, Texas, had been unable to fully retract the source back into the exposure device (camera). Further, the complainant alleged the radiographers were told to remove their dosimetry badges and place them in their truck and they were then given instructions over the phone on how to retrieve the source by dismantling the locking device on the camera. Also, the complainant alleged that persons who brought up the event to management was told they would be fired if they told the State about it. The Agency's investigation confirmed that an event had occurred in which the source could not be fully retracted (see incident I-9241). Interviews and reviews of records did not produce any evidence to support that the radiographers were told to remove their dosimetry badges or that anyone was told they would be fired if they told the State about the event. These two complaint issues could not be substantiated. No violations were cited.

File closed.

C - 2592 - Unregistered Laser Equipment - Glow Laser Spa - Laredo, Texas

On September 17, 2014, the Agency received an allegation that a spa in Laredo, Texas was operating lasers without a valid registration certificate from this Agency. The facility was not registered and the facility manager has stated a registration application will be submitted. Awaiting confirmation from the licensing section that the application was received.

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2014

C - 2594 - Potential Exposure to Individual - LyondellBasell - La Porte, Texas

On September 9, 2014, the Agency received an anonymous complaint alleging workers were required to enter a vessel on April 13, 2014, prior to contamination surveys that were required due to the presence of naturally occurring radioactive material (NORM) were performed. The Agency contacted the licensee and determined that the required surveys were completed and levels of NORM contamination were approximately two times background, far below regulatory limits. The licensee stated it had investigated the complaint and debriefed the workers immediately after they had complained. The presence of NORM is expected during tank entry since one of the source materials used in production of propylene is from condensed gas from oil wells. The complaint was not substantiated. No violations were cited.

File closed