



INCIDENT AND COMPLAINT SUMMARIES FOR THIRD QUARTER 2014*

Prepared by:
Art Tucker, Chris Moore, Karen Blanchard, Gentry Hearn, Irene Casares

Texas Department of State Health Services
Regulatory Services Division
Inspections Unit
Radiation Branch

* 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
3rd Quarter 2014

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Incidents Opened Third Quarter 2014

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. An investigation into this event is ongoing.

File open.

I - 9211 - Lost Moisture/Density Gauge - Ramming Paving Company, Ltd. - Austin, Texas

On July 3, 2014, the licensee notified the Agency that a Troxler model 4640 moisture/density gauge containing an 8 millicurie cesium-137 source had fallen from one of its trucks while in route from its facility in Austin to its facility in Buda, Texas. The licensee checked the travel route multiple times, notified local law enforcement and fire departments, and posted a reward. The licensee's investigation revealed that the technician had failed to secure the gauge and had left the tailgate down when he left the Austin facility. The licensee checked with local businesses and found one had video surveillance footage that showed the gauge falling from the truck in Austin and an individual, who could not be identified, picking it up from the side of the road. The gauge has not been recovered. The licensee checked all of its gauges for locks and ensured each had locking job boxes or chains/locks for transport. The licensee reviewed the incident and its causes with all of its employees that actively use the gauges. One violation was cited.

File closed.

I - 9212 - Monitoring Not Provided - Oak Hill Veterinary Clinic - Austin, Texas

On July 15, 2014, the registrant reported to the Agency that it had discovered it had failed to provide exposure monitoring for one of its employees for a period of one to two months. An on-site investigation was completed on August 5, 2014. By September 18, 2014 no records were provided to the Agency addressing issues during the on-site investigation. Violations were subsequently cited against the facility for not having operating and safety procedures, the radiation safety officer failed to assign or review occupational monitoring for employees, no public dose surveys had been completed, and equipment records were missing. Four violations were cited.

File closed.

Incidents Opened Third Quarter 2014

I - 9213 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On July 16, 2014, the Agency received a letter from the licensee stating one of its customers had reported dose irregularities. The customer had used technetium-99m (Tc-99m) macro aggregated albumin, but the results of two studies did not produce the expected images. The licensee's investigation determined the Tc-99m used in the preparation of the radiopharmaceutical disassociated in the dose syringe prior to administration to the patients. No other customer reported any issues with unit doses. No violations were cited.

File closed.

I - 9214 - Regulatory Violation - Texas Oncology, PA - Round Rock, Texas

On July 21, 2014, the licensee reported to the Agency that it had discovered it had failed to add one of its medical physicists to its license as an authorized medical physicist for high dose rate remote afterloader procedures. The medical physicist was properly trained, experienced, and was authorized on another license for a separate facility. The medical physicist had been present as the required medical physicist for 66 procedures between March 24 and June 27, 2014. The license was updated to add the individual as an authorized medical physicist. This was a non-cited severity level IV violation.

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 field site on July 26, 2014. 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. The source was retrieved by manually pulling the drive cable back through the camera. The guide tube was removed from service and replaced. The camera was a Sentinel 880 Delta with about 40 curies of selenium-75. An investigation into this event is ongoing.

File open.

Incidents Opened Third Quarter 2014

I - 9216 - Damaged Device Containing Radioactive Material - Kenneth E Tand and Associates – Houston, Texas

On July 29, 2014, the Agency was notified by the licensee that a Humboldt model 5001EZ moisture/density gauge containing an 11 millicurie cesium-137 source and a 44 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, on an area of a pad that compaction had been completed. He walked approximately 70 feet from the gauge to his vehicle. While his back was turned he heard a crunching noise and turned to discover that a compactor had advanced past its authorized stopping location and ran over the gauge. The area was secured until the licensee's radiation safety officer and a service company technician responded to the site. Radiation surveys were performed and no elevated readings were observed. The cesium source was returned to its shielded position. The non-repairable gauge was transported to the licensed service company's facility where it will be prepared, packaged, and returned to the manufacturer. As corrective action, the licensee has scheduled the technician for additional training. One violation was cited.

File closed.

I - 9217 - Therapy Event - Joe Arrington Cancer Research and Treatment Center - Lubbock, Texas

On July 30, 2014, the Agency was notified by the licensee that a patient had received a portion of a gamma knife treatment intended for a different patient. The incident was investigated at the facility and confirmed that a patient received a portion of a fractional treatment dose intended for another patient. The treatment time was for 2.68 minutes with a calculated total dose of 3.5 gray to the centerpoint maximum with 50% to the isodose lines at 1.75 gray to the wrong patient. The error occurred due to rescheduling patient one who had a much longer treatment time than patient two. The health physicist and radiation oncologist failed to communicate the schedule change to nursing staff and failed to identify the patient being treated until after the treatment was commenced. This communication error along with a lack of patient identification played a major role in the unintended treatment process. The facility completed a root cause analysis of the problem and self-reported the incident. Corrective actions have been implemented to include new policies and procedures incorporating better scheduling, patient identification practices to include "time outs" during the treatment process and limiting distractions during the treatment procedure. No violations were cited.

File closed.

Incidents Opened Third Quarter 2014

I - 9218 - Disabled Shutters - CMC Steel Texas - Seguin, Texas

On August 5, 2014, the Agency was notified by the licensee that it was unable to close the shutter on a Berthold model LB300ML fixed nuclear gauge that contained a 2.5 millicurie cobalt-60 source. The licensee stated some molten steel had spilled onto the shutter operating mechanism preventing the shutter from closing. On August 6, 2014, the licensee notified the Agency that it was unable to close the shutter on a second gauge of the same manufacturer, model, activity, and radionuclide. Both gauges were repaired by a service company and returned to service. The licensee reported no employee or member of the general public received any additional exposure resulting from this event. No violations were cited.

File closed.

I - 9219 - Radiography Source Disconnect - Mistras Group, Inc. - Houston, Texas

On August 14, 2014, the licensee notified the Agency that on August 13, 2014, a radiography crew using a 50-foot crank out device was unable retract a 54 curie iridium-192 source to the fully retracted and locked position in a QSA 880D exposure device. The licensee's radiation safety officer, who was authorized to perform source retrieval, responded. He disconnected the drive cable housing from the crank out device and found that the drive cable had broken in two at the crank out device. Using pliers, he was able to pull the drive cable and return the source to the fully shielded position. The manufacturer evaluated the equipment and reported that the crank's lack of maintenance and its overall quality contributed to the failure. No personnel exceeded exposure limits during the incident and source recovery. One violation was cited.

File closed.

I - 9220 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On August 15, 2014 the Agency was notified by the licensee that a dispensing error had occurred at its Dallas, Texas location. The investigation into the event is ongoing.

File open.

I - 9221 - * - Baylor All Saints Medical Center - Fort Worth, Texas

*Health and Safety Code Chapter 241.051(d).

Two violations were cited.

File closed.

Incidents Opened Third Quarter 2014

I - 9222 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On August 21, 2014, the Agency was notified by the licensee that its facility in Dallas, Texas, was notified by a customer that it had received the wrong activity for a unit dose of technetium-99m. The licensee reported the order was placed by the customer on their telephone answering system. The pharmacist who completed the order listened to the message and found the order did not include the activity needed. The pharmacist used the normal activity supplied to the customer to prepare the unit dose. The customer found the error when they counted the dose in their dose calibrator. The unit dose was not administered to a patient. The licensee counseled all persons involved in the event. Additional training will be provided to the licensee's pharmacist on how to properly take a customer's order. The licensee stated it will request that its customers use its web-ordering system for ordering doses to help prevent this kind of error. No violations were cited.

File closed.

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

*Health and Safety Code Chapter 241.051(d).

File open.

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.

Incidents Opened Third Quarter 2014

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

On August 25, 2014, the Agency received notice that a dosimetry badge for a radiographer trainee had come back with an exposure of 8.6 rem for the period of July 5 to August 4, 2014. It was determined by the licensee that the trainee had left his badge near the camera for several shots. The trainee stated that he did not tell his trainer he had dropped his badge. Based on the trainee's pocket dosimeter readings, a dose of 301 millirem was assigned for the period. An investigation into this event is ongoing.

File open.

I - 9226 - * - VHS San Antonio Partners, LLC - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

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 devices are General License devices. The Agency's investigation identified the owner of the device as a heat treating services company in Round Rock, Texas. The owner stated it had unknowingly taken the device with other scrap metal to the recycler after it cleaned out some of its buildings. The owner stated it does not have any other devices that contain radioactive material. The owner paid the device's disposal costs. No violations were cited.

File closed.

Incidents Opened Third Quarter 2014

I - 9228 - Regulatory Violation - 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.

I - 9229 - Source Damaged - Texas A & M University - College Station, Texas.

On September 5, 2014, the licensee notified the Agency that a reportable event had occurred at its facility; specifically, leakage from a sealed source. The licensee's radiation safety officer stated researchers were using a device which contained a 0.5 millicurie sealed americium-241 foil source and decided the device was not operating properly. The researchers removed the source from the device and cleaned the device with nitric acid. The researchers replaced the source and used the device. Later, the researchers noted the device was not operating properly and removed the source. A swab taken around the outside ring of the source was taken and counted for activity. The activity was determined to be 0.1 microcuries. The source was placed in storage. The manufacturer was contacted and the source will be returned to it as soon as possible. During the licensee's investigation, it determined that the source was actually an unsealed source and the activity on the swab would have been expected. A small amount of contamination was removed from the source holder, operating device, and surrounding floor. No violations were cited.

File closed.

I - 9230 - Transportation Event - Earth Engineering, Inc. - Houston, Texas

On September 9, 2014, the Agency was notified by the Woodlands Fire Department that it was at the scene of a traffic accident involving a vehicle transporting a gauge containing radioactive material. The source was undamaged. No overexposures resulted from the event. The investigation into this event is ongoing.

File open.

Incidents Opened Third Quarter 2014

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

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. 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 onsite and restored the operation of the shutter lever on the second gauge by lubricating the shutter mechanism. Parts have been received to repair the sheared bolts on the first gauge and the service has been scheduled. The gauges normally operate with the shutter in the open position. No individual received any exposure as a result of this event. 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. One violation was cited.

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 one of its radiography crews 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 and replaced with a new drive cable and crank. Operations resumed without further actions. No violations were cited.

File closed.

I - 9233 - * - VHS San Antonio Imaging Partners, LP- San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

One violation was cited.

File closed.

Incidents Opened Third 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 - 9235 - Overexposure - Midwest Inspection Services - Hillsboro, Texas

On September 18, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that two radiographers working at a field location may have received exposures in excess of the annual whole body exposure limit. One radiographer was working in the darkroom while the other, a trainer, was taking shots. The trainer cranked in the source but failed to fully retract it into the shielded position. The trainer then carried the camera to the tailgate and sat nearby for several minutes. The situation was discovered when the radiographer in the darkroom found all the film to be fully exposed and black. The radiographer in the darkroom was found to have received 1.58 rem via a properly worn dosimetry badge. The trainer outside was not wearing any safety or monitoring equipment save an off-scale pocket dosimeter. Reenactments with a health physics consultant concluded that the trainer received 4.74 rem to the body and 5.73 rem to the gonads. These calculations are pending a final blood work report. An investigation into this event is ongoing.

File open.

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 two Thermo Fisher Scientific Model 5190 density gauges, each containing a 200 millicurie cesium-137 source, had been in the middle of a large fire at an oil field temporary job site. The licensee's radiation safety officer (RSO) stated that the fire burned over twenty vehicles. There were no worker or public exposures due to this incident. It was determined that one of the gauges' shielding had been compromised. The gauges were secured then packaged and transported to the manufacturer for evaluation. The investigation into the incident is ongoing.

File open.

Incidents Opened Third Quarter 2014

I - 9237 - Source Retraction Failure - Desert NDT - Abilene, Texas

On September 24, 2014, the Agency received notice that on September 22, 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, allowing retraction. An investigation into this event is ongoing.

File open.

I - 9238 - Stolen 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 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. The technician stated 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 the gauge was gone. He looked for the gauge, but did not find it. The technician notified his supervisor of the event. On September 24, 2014, the licensee was contacted by a contractor and informed they had seen the gauge fall out of the truck and picked the gauge 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 a nuclear gauge. The licensee stated in the future it was going to perform unannounced visits to the technicians' job sites to verify compliance with company rules. The investigation into this event is ongoing.

File open.

I - 9239 - Medical Event - Physician Reliance Network, LLC - Round Rock, Texas

On September 29, 2014, the Agency was notified by the registrant that a medical event occurred on September 25 and 26, 2014. The registrant reported that a patient who was being treated with electron beam therapy was inadvertently treated on the wrong site (similar lesion on the same limb) for two fractions of the treatment. The patient received a total of 360 centigray. The patient's physician was not present at the treatment. The radiation safety officer stated that the patient and the patient's physician were notified as soon as the error was discovered. To prevent recurrence of this type of event, the licensee made changes to its operating procedures and training program for physicists, radiation therapists, and physicians. The attending physician will have an additional qualified person verify the clinical setup. If the patient's physician is not present, the pictures taken at time of consult will be used to ensure the proper area is treated. No violations were cited.

File closed.

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

I - 9109 - Radioactive Waste - Effective Environmental - Mesquite, Texas

On July 26, 2013, the licensee reported to the Agency that it received four drums of waste that contained iridium -192 tracer material. The Agency conducted an on-site investigation of the barrels on July 26, 2013. Iridium-192 was identified in two of four barrels of waste; however, the radiation levels were only 30 microR/hr. On September 24, 2013, the licensee's customer hired a contractor to take soil samples from all four barrels. On November 21, 2013, the results indicated trace amounts of iridium-192 and scandium-46. One barrel exceeded regulatory limits for scandium-46 and required Agency approval for disposal in a Type 1 solid waste site. The licensee properly disposed of the barrels at a licensed facility in July 2014. No violations were cited.

File closed.

I - 9139 - NORM Soil Contamination - BRM Metals Group, LLC - Burleson, Texas

On June 6, 2013, the Agency received a request from the Texas Department of Public Safety to inspect an empty lot for radiological contamination. The lot was used by a recycling company that cut up pipe and tanks resulting in potential radium-226 contamination of the soil. On June 11, 2013, the Agency conducted an on-site investigation and took multiple soil samples and radiation measurements. The highest radiation measurement was 300 microR/hr and the highest soil concentration was 206 picocuries/gram of radium-226. Soil samples from four sampling locations exceeded regulatory limits. The company made one site remediation attempt; however, it was inadequate and regulatory compliance was not achieved. After the company resisted cleaning up the leased site for over 9 months, the Agency sent an order to clean up the site. Two violations were cited.

File closed.

I - 9160 - Potential Overexposure - Thermo Process Instruments, LP - Sugarland, Texas

On February 6, 2014, the Agency received a report from the licensee stating one worker had exceeded the annual deep dose equivalent (DDE) exposure limit for the year 2013. The individual was initially reported to have received 5,035 millirem. However, the licensee's subsequent re-evaluation of the employee's exposure for the year revealed a large overestimate for a particular exposure. After an adjustment of quality factor for that exposure by the dosimetry provider, the total DDE for the year was reduced below the regulatory limit to 3,897 millirem. No violations were cited.

File closed.

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

I - 9165 - Stuck Shutter - OEXA Chemical - Bishop, Texas

On March 11, 2014, the Agency received notice that an Ohmart Vega SH-F1A nuclear gauge containing 12 millicuries of cesium-137 failed to close during testing. The gauge was left open and operational until repairs could be completed on March 21, 2014. It was found that some rust and other debris was the cause. The gauge was cleaned, repainted, and returned to service. No violations were cited.

File closed.

I - 9170 - * - Methodist Healthcare System of San Antonio - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

I - 9172 - Stolen Radioactive Material - C N A Metals, Ltd. - Stafford, Texas

On March 28, 2014, the Agency received a letter from the licensee stating it had determined a Thermo Niton model XLP-818Q analyzer, containing 30 millicuries of americium-241, had been taken by one of its employees. The licensee stated that after several weeks of no contact with the employee, it began trying to locate him. Its attempts were unsuccessful. The licensee contacted local and federal law enforcement. The licensee's radiation safety officer stated he did not believe any individual would receive any exposure due to this event. The licensee reported that neither the employee nor the device has been located. The licensee will continue to search for the device. No violations were cited.

File closed.

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

I - 9174 - Radiography Source Disconnect - Big State X-Ray - Odessa, Texas

On March 26, 2014, the Agency received information during a complaint investigation (C-2550) that a radiography source disconnect had occurred at a temporary job site on November 12, 2013. The Agency contacted the licensee. The licensee reported that the radiography crew had been using a QSA model 880D exposure device that contained a 66.7 curie iridium-192 source. The licensee's radiation safety officer reported he had inspected the equipment following the disconnect and subsequent source retrieval. He found that the equipment showed abnormal wear and he could connect the controls without making a complete pigtail connection. He determined the pigtail had not been properly connected. The source was retrieved without any overexposures and the drive cable was replaced. The licensee failed to report the incident to the Agency. Two violations were cited in connection with this incident and complaint C-2550.

File closed.

I - 9175 - Stuck Shutters - International Paper Company - Queen City, Texas

On April 2, 2014, the licensee notified the Agency that while it was doing lockouts on fixed nuclear gauges in preparation for the annual shutdown of its facility, the handles on two shutters broke. The handles sheared the roll pins. Both gauges were manufactured by KayRay. One gauge, model 7063, contained 1.5 curies of cesium-137 and the other gauge, model 7063P, contained 1 curie of cesium-137. The two gauges were mounted on digesters and used for level control. The licensee was able to close one of the shutters but the other shutter remained stuck in the open position. There was no exposure risk to any person. The licensee contacted a service company and made arrangements for the company to come on-site and make repairs. Age and corrosion were found to be the cause. The gauges were replaced and the old sources sent to the manufacturer for disposal. No violations were cited.

File closed.

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

I - 9178 - Radiography Source Disconnect - Midwest Inspection Services - Abilene, Texas

On April 4, 2014, the Agency was notified by the licensee's corporate radiation safety officer (CRSO) that one of its radiography crews had experienced a source disconnect while using an INC IR-100 exposure device. The device contained a 70 curie iridium-192 source. The CRSO stated the radiographers had completed a shot and noted the dose rates on the camera had not returned to normal after the source was retracted. The radiographers increased the barricaded area around the exposure device and contacted their supervisor for assistance. The CRSO stated the source was recovered a short time later by an authorized individual. No individual received an exposure which exceeded any regulatory limits. No member of the general public received any exposure. The licensee's investigation into the disconnect determined the connector on the source pigtail had expanded, which caused the locking pin to stick in the open position. This allowed the ball on the drive cable to pop out of the connector. The licensee provided additional training to its employees on performing checks on the equipment prior to use and the proper response to a source disconnect event. No violations were cited.

File closed.

I - 9180 - Radiography Source Disconnect - Hi-Tech Testing - Carrizo Springs, Texas

On April 9, 2014, the Agency received notice from the licensee that a radiography source disconnect had occurred at a temporary field site in Carrizo Springs, Texas. The camera was a SPEC 150 and contained a 28 curie iridium-192 source. The source was retrieved. The licensee found the drive cable had broken near the connection with the source. The licensee sent the drive cable to the manufacturer for evaluation and the manufacturer concluded that wear and corrosion were the cause of the failure. The cable was replaced and the licensee provided additional instruction to its employees regarding equipment inspection and maintenance. No violations were cited.

File closed.

I - 9190 - Source Retraction Failure - METCO - Houston, Texas

On May 7, 2014, the Agency received notice that an industrial radiography source retraction failure had occurred on May 6, 2014. The camera was a QSA Global 880D with a 46 curie iridium-192 source. The licensee reported the guide tube had fallen off of the guide tube stand and crimped. The licensee made a small cut in the guide tube, pried open the crimp, and was able to retract the source. The guide tube was removed from service. No overexposures resulted from this event. To prevent future occurrence of this type of event, the licensee replaced some of its guide tube stands and conducted additional training. No violations were cited.

File closed.

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

I - 9191 - Stolen Moisture/Density Gauge - The Murillo Company - Houston, Texas

On May 9, 2014, the licensee notified the Agency that one of its Humboldt model 5001EZ moisture/density gauges had been stolen from the back of one of its trucks in Houston, Texas. The licensee's technician had stopped at a fast food establishment on the way to the work site. After he arrived at the work site, he found that the truck's tailgate was down, one of the locks on one of the chains securing the gauge was missing, and the gauge was missing. Within a few hours, the licensee notified the Agency that the gauge had been recovered. A member of the public had found the gauge by the side of the road. The gauge's source rod handle was still locked and the gauge was inside its transportation case. The licensee's investigation determined the gauge had not been properly secured and someone was able to remove the gauge by removing one padlock. To prevent recurrence, the licensee reviewed its policies and procedures and each of its inspectors have demonstrated how their gauge is secured in their truck. Additional procedures have been implemented and chains, padlocks, and handles on the cases have been replaced where necessary. The licensee conducted an additional nuclear gauge training class for all of its inspectors to review the policies and procedures for handling and securing portable gauges. One violation was cited.

File closed.

I - 9195 - * - Methodist Healthcare System of San Antonio, Ltd., LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

One non-cited severity level IV violation was noted.

File closed.

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

I - 9200 - Equipment Malfunction - Westlake Longview Corporation - Longview, Texas

On June 6, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that after retracting a 148 millicurie cobalt 60 source into a Vega model SHLM-CR gauge the source separated from the cable. The RSO reported the gauge shutter closed and locked in the closed position. The RSO stated the manufacturer had been contacted and would be at the facility on the morning of June 6, 2014. On July 1, 2014, the manufacturer contacted the Agency and stated the reason for the separation was the wrong crimping tool had been used when the gauge was manufactured. The manufacturer also found its facility had been going through some design changes and the individual who was to test the connection believed the pull test device was not available and did not test the connection. The manufacturer has implemented changes to its process and retrained its personnel on the testing requirements for all gauges. No violations were cited.

File closed.

I - 9202 - * - Methodist Healthcare System of San Antonio. Ltd., LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

One violation was cited.

File closed.

I - 9203 - Operator Error - Hi Tech Testing - Longview, Texas

On June 13, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that the licensee had received a report from its dosimetry processor that indicated two of its radiographers had received higher than expected exposures. During the licensee's investigation the radiographers stated that in mid-May 2014 they were performing radiography on a pipe in a ditch when the side of the ditch caved in and the camera fell in. They cranked the source back to the camera, but failed to crank it all the way to the locked and shielded position. Their survey meter had failed the battery test so they did not use it. As they approached the camera, their alarming rate meters alarmed. The radiographer saw the guide tube was bent at a sharp angle so he picked up the camera and straightened the guide tube. He then retracted the source to the fully shielded position. The radiographer saw that his self-reading dosimeter was off scale, but he decided to complete the last shot for the day. They did not report the incident to anyone and the licensee did not discover the incident until it received the dosimetry processor's report. The licensee and the radiographer were cited for multiple violations.

File closed.

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

I - 9204 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On June 16, 2014, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on two Ohmart Vega model SHD gauges, each containing a 250 millicurie cesium-137 source, failed to shut during an operational check. Additionally, a third gauge appeared to cycle shut but there was no change in the radiation level. The gauges normally operate with the shutter in the open position. No licensee employee received any exposure as a result of this event. The gauges failed due to aging and environmental conditions. The company contacted the manufacturer for repair advice. The manufacturer responded with a non-repair statement due to the age of the devices. The licensee has contacted a vendor to design a better shutter for the environment and replace all three shutters. The company requested an exemption to use the devices until replacement shutters are installed. On July 31, 2014, an exemption was granted by the Agency's licensing section. No violations were cited.

File closed.

I - 9205 - Lost Moisture Density Gauge - Raba-Kistner Consultants, Inc. - Austin, Texas

On June 20, 2014, the licensee notified the Agency that one of its Humboldt model 5001EZ moisture/density gauges had been lost from the back of one of its trucks in Austin, Texas on June 19, 2014. The licensee's technician had rushed off the job site due to a family emergency and did not secure the gauge and he left the pickup tailgate down. The device had been in the back of the truck towards the front of the bed but fell out between the worksite and his home. It was in the stored locked position inside the storage case with two outside locks on the case. The area was searched in an attempt to recover the device. On Saturday, June 28, 2014, the licensee reported via email the gauge had been found and was sent to be checked for damage and to have a leak test performed. It was reported that the gauge was not damaged and passed the leak test. Company employees have been counseled and retrained on proper use, storage, and transportation of the gauges to prevent a recurrence. Two violations were cited.

File closed.

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

I - 9206 - Radioactive Material Found - USA Environment, LP - Houston, Texas

On June 20, 2013, a landfill notified the Agency that a load of dirt from an excavation site in Houston, Texas, caused its radiation monitor to alarm as it entered the facility. The Agency's investigation revealed that one of its licensee's was performing non-radiological remediation of the excavation site. The Agency conducted an on-site investigation with the licensee at the excavation site and at the landfill. The licensee reported that the site had been filled in the 1930's to 1940's with waste, that included waste it had found that was obviously from a medical facility, and incinerator ash. The licensee performed a radiation survey of the site and began monitoring subsequent loads of soil leaving the site. The excavated soil was returned from the landfill to the site and the licensee performed remediation under the conditions of its license. The licensee located the source of radiation, determined it was radium-226, and that it appeared to be a radium needle. Soil sampling results confirmed no radium had leaked from the source. The source was secured and transferred to another licensee for disposal under the U.S. Department of Energy's Orphan Source Program. No individual received any overexposure from this event. No other sources of radiation were found during the excavation. No violations were cited.

File closed.

I - 9207 - Shipping Documentation Error - NSSI, Inc. - Houston, Texas

On June 27, 2014, the Agency received information of a source shipped to a facility in Texas from North Carolina. The shipping paperwork did not match the source found in the shipping container. The licensee receiving the shipment reported the shipping error to the Agency. Thorough investigation from shipping source to final delivery was completed by the licensee in North Carolina. The shipping documents were incorrect. The source which was shipped was in a proper package (type A) and there was no issue with dose to public or transporter. The documentation for the source has been corrected and final shipping destination licensee has the correct license to accept the source. No violations were issued by the State of Texas.

File closed.

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

I - 9208 - * - Methodist Healthcare System of San Antonio, Ltd., LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d).

One severity level IV violation was not cited.

File closed.

Complaints Opened Third Quarter 2014

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. An investigation into this complaint is ongoing.

File open.

C - 2577 – Laser Hair Removal Registration - Allure Laser Studio - Houston, Texas

On May 27, 2014, the Agency received a complaint on a facility that provided services to a patient. The patient/complainant was not satisfied with the level of service from the facility and wanted a refund. On July 2, 2014, the complaint was forwarded to the radiation control program to determine the facility registration. The facility was registered as a laser hair removal facility. No violations were cited.

File closed.

C - 2578 - * Memorial Medical Center of East Texas - Lufkin, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2579 - Regulatory Violations - Orthopedic & Spine Institute, Inc. - San Antonio, Texas

On July 3, 2014, the Agency received a complaint from one of the registrant's former employees who stated after she left the registered facility in late May 2014 her dosimeter was being worn by a new employee in June 2014 to conduct fluoroscopy. The complainant stated that the badge was in her desk during April and May 2014 and that she did not conduct any x-rays or fluoroscopy. An investigation by the Agency determined that the badge had been properly transferred to the new employee. The registrant had a letter from the licensed dosimetry company authorizing the transfer of the dosimeter and all of the dose for the second quarter was assigned to the new employee. Since the complainant stated she did not use the dosimeter for occupational exposure, all dose on the badge was assigned to the correct employee. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third 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 investigation into this complaint is ongoing.

File open.

C - 2581 - Laser Regulatory Violations - Eternal Eden Afterhours - Dallas, Texas

On July 14, 2014, the Agency received an anonymous complaint from a technician who works in the laser entertainment business. The complainant alleged that, based on a friend's personal account and pictures posted on the internet, Class 3B or 4 lasers were being pointed into the public's faces and eyes at an entertainment establishment. An investigation into the complaint is ongoing.

File open.

C - 2582 - No Personnel Monitoring or Shielding - Northstar Urgent Care - Spring, Texas

On July 15, 2014, the Agency received a complaint that a facility was performing x-rays on adults and children without using protection devices (lead aprons), that exposure monitoring devices were not being used (dosimetry badges), and there was no certificate of registration displayed showing the facility was permitted to perform x-rays. An on-site investigation was completed to find personnel monitoring records, lead aprons, and a copy of the registration. The registrant will be placed on the inspection schedule for an x-ray inspector to re-inspect the facility in the next few months. The complaint was not substantiated. No violations were cited.

File closed.

C - 2583 - Required Documentation Not Available - Medical Associates of Brownsville, PA - Brownsville, Texas

On July 21, 2014, the Agency received a complaint alleging that the registrant did not have required quality control documentation for its mammography unit for 2014. An Agency inspector performed an inspection at the registrant's facility on July 30, 2014. The inspector found that some digital mammography quality control tests were not performed or were not performed at the correct interval. The inspector also found the lead interpreting physician did not perform various required duties. The complaint was substantiated. Three violations were cited.

File closed.

Complaints Opened Third Quarter 2014

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)

File open.

C - 2586 - Possible Overexposure - First Choice Emergency Room - Plano, Texas

On August 1, 2014, the Agency received a complaint in which the complainant stated he had experienced adverse symptoms following a computerized tomography (CT) exam and he was concerned that the CT machine had not been certified recently and had given him an overdose of radiation. The Agency's investigation found that an imaging compliance and safety evaluation, which is required to be performed annually, had been completed on the CT machine just two days after the complainant's exam. The machine was found to be in compliance. Also, periodic maintenance had been performed on the machine one week prior to the complainant's exam and there had not been any issues. The complainant's dose was estimated using information on his CT exam record and the estimated dose was far below accepted reference levels. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2014

C - 2587 - False Records and Credentials - The Medical Surgical Clinic of Irving, PA - Irving, Texas

On August 29, 2014, the Agency was notified by a complainant that the radiology manager recreated some or all of the mammography quality control records in the days preceding the annual inspection conducted on April 18, 2014. In addition, it was stated that the manager had hung certificates showing completion of special training to operate the bone density machine, for all the MRTs, in the bone density machine room, but none of them had taken the training. An on-site investigation was completed on September 8, 2014, which produced no violations of the facility. The facility provided training documents and certification records for the employees. Quality control records were reviewed and appeared appropriate, a violation for the compression thickness indicator chart had been cited in the annual mammography inspection from April 2014. A few suggestions on better practices were discussed with the manager and new policies/procedures will be implemented at the facility. 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 a 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.

C - 2589 - Regulatory Violations - TechCorr USA, LLC - Port Neches, Texas

On September 2, 2014, the Agency received a complaint alleging the licensee had violated multiple Agency rules which included security concerns. On September 16, 2014, an Agency investigator observed the licensee's site office vault was properly secured. On September 17, 2014, the investigator visited two radiography crews at a temporary job site. The alarm on one truck failed to work when tested. The radiographer trainee on each crew did not have a trainee status card on their person as required. The second crew's camera had insufficient transport container labels. The complaint issues were not substantiated. Three unrelated violations were cited.

File closed.

Complaints Opened Third Quarter 2014

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

On May 29, 2014, the Agency received a complaint referred by the Nuclear Regulatory Commission alleging that radiographers on reciprocity from Louisiana had performed work in Texas without being properly documented as trustworthy and reliable. An investigation into this complaint is ongoing.

File open.

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). The complainant also alleged that 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. The investigation into this complaint is ongoing.

File open.

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 investigation into this complaint is ongoing.

File open.

I - 2593 - Inadequate Credentialing - Advanced Corrosion Technologies & Training - Lake Jackson, Texas

On September 9, 2014, the Agency was notified by the Nuclear Regulatory Commission of an allegation. The Agency sent a request via email to the complainant requesting additional information. The complainant contacted the Agency on September 19, 2014, and stated the registrant was allowing individuals to operate x-ray radiography devices without proper training or dosimetry. The investigation into this complaint is ongoing.

File open.

Complaints Opened Third Quarter 2014

C - 2594 - Potential Exposure to Individual – Lyondell Basell - 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.

C - 2596 - Uncredentialed X-ray Technologist - St. Elizabeth Family Care, LLC - Dickinson, Texas

On September 26, 2014, the Agency received a complaint that a facility was using a medical assistant to take x-rays when the regular x-ray technologist was not at work. The complaint also expressed concern that the regular technologist may also not be properly credentialed as there was no certificate displayed in a visible location showing she was certified. An investigation into this complaint is ongoing.

File open.

C - 2597 - Regulatory Violations - General Inspection Services - Hempstead, Texas

On September 30, 2014, the Agency received a complaint that the licensee was allowing trainees to conduct radiography alone, that various required equipment was broken, missing, or unused, and that various other violations were occurring regularly. An investigation into this complaint is ongoing.

File open.

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

C - 2534 - Potential Exposure to Public - TECHCORR USA, LLC - Houston, Texas

On January 16, 2014, the Agency received a complaint referred from the Nuclear Regulatory Commission that a licensee may be exposing members of the public to radiation. Specifically, a worker at a facility, company-A, measured elevated levels of radiation from industrial radiography that was being performed at an adjacent facility, company-B, during extended operations at night. The worker was using his own rate meter. The worker alleged his illness over the last six months was due to the radiation he was receiving. The Agency conducted an on-site investigation over multiple visits. An optically stimulated luminescence (OSL) dosimeter was placed at company-A on the outside wall of the building closest to the fence boundary between the companies. Radiography was being conducted at company-B inside a building close to the fence line. The Agency and a radiation consultant hired by company-A measured radiation levels over a two month time period. Radiation levels were higher than expected but did not exceed any regulatory limits. The industrial radiography licensee performing radiography at company-B reported it had moved the radiography for about 6 months from a bay with concrete walls to the building with thin metal walls. The licensee moved the radiography back to the bay and radiation levels measured on company-A's property were reduced significantly. The complaint was not substantiated. No violations were cited.

File closed.

C - 2542 - Uncredentialed Technicians - Unidentified Facility - Austin, Texas

On March 3, 2014, a complainant left a voice message on an Agency telephone. The complainant stated he was concerned about an outpatient facility in Austin, Texas, that he alleged was allowing unlicensed persons such as scrub techs and nurses to operate x-ray equipment. The complainant left his phone number. Multiple attempts were made to contact the complainant and messages were left on the voicemail of the number he provided that contained the Agency investigator's contact information. The Agency did not receive a response. Without further information, specifically the name of the facility, the investigation could not move forward and was closed.

File closed.

C - 2550 - Regulation Violations - Big State X-ray - Odessa, Texas

On March 17, 2014, the Agency received a complaint alleging an industrial radiography licensee was not complying with a number of the Agency's rules, which included radiographers not using survey meters, radiographers not wearing personnel dosimetry devices, and equipment and training issues. The complainant also provided information about a source disconnect incident and alleged that during that incident, and at other times, radiographer trainees are allowed to without the proper, required supervision. An on-site investigation was conducted at the licensee's facility on March 26, 2014, and a spot inspection of one of the licensee's radiographer crews was conducted at a temporary field site on April 7, 2014. While none of the other allegations could be substantiated, the licensee did confirm that a source disconnect had occurred on November 12, 2013, and that radiographer trainee was not properly supervised at the time (see incident I-9174). The complaint was partially substantiated. Two violations were cited in connection with this complaint and incident I-9174.

File closed.

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

C - 2556 - Regulatory Violations - Spain-Short, LLC - Tyler, Texas

On April 10, 2014, the Agency received a complaint alleging that an individual with a Non-Certified Technician (NCT) certificate had taken x-rays of the complainant and had failed to collimate the beam to the clinical area of interest as required. The complainant questioned whether or not an NCT could perform the particular exams that she did and was concerned about her lack of knowledge for positioning the complainant for the exams. The Agency conducted an on-site investigation and found some of the complainant's images had no collimation. The NCT was credentialed to perform the exams. Information obtained concerning the NCT's training was referred to the appropriate Agency authority. The complaint was substantiated. One violation was cited.

File closed.

C - 2562 - Not Registered To Provide Services - Medical Imaging Solutions, Inc. - Austin, Texas

On April 30, 2014, the Agency received a complaint alleging a company had provided services on x-ray equipment in the State of Texas and did not hold a registration to do so. The complaint also stated two of the individuals who provided services at the registrants facility did not possess the appropriate training. The Agency's investigation found that the company did have a current registration. The Agency requested training documents for the individuals who had provided the services. A review of the training documents found the individuals had received the appropriate training to provide the services rendered. The complaint could not be substantiated. No violation was cited.

File closed.

C – 2564 - Regulatory Violations - Element Materials Technology - Houston, Texas

On May 15, 2015, the Agency received a complaint alleging multiple industrial radiography violations including a potential overexposure, no oversight of radiography trainees by trainers, and surveys not being performed to verify radiation area boundaries. An on-site investigation was conducted on June, 10, 2014. The complaint was partially substantiated when the crew did not perform an area survey during the first radiographic exposure to confirm the boundaries. On August 12, 2014, phone interviews were conducted about the potential overexposure. The Agency and licensee calculations, along with information from personnel monitoring reports, indicated that no exposure limits were exceeded. The crew did violate several regulations including the failure to conduct a post-exposure survey. The complaint was substantiated. Four violations were cited.

File closed.

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

C - 2565 - Unauthorized Radioactive Waste Burial - CMC Recycling - Vinton, Texas

On May 16, 2014, the Agency received a complaint alleging that a scrap metal recycling facility was dumping scrap metal that had caused its radiation monitors to alarm into a pit at the back of its facility. The Agency conducted an on-site investigation and found no evidence of such a pit or improper disposal. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2567 - Laser Injury and Unregistered Facility - Bliss Laser Spa - San Antonio, Texas

On June 20, 2014, the Agency received a call regarding burns received during laser hair removal treatment by a technician at an unregistered facility. More information was required to complete an investigation. Attempts to contact the complainant were unsuccessful and the file has been closed.

File closed.

C - 2570 - Failure to Provide Exposure Record - IDEV Technologies, Inc. - Webster, Texas

On June 3, 2014, the Agency received a complaint that a former employee had not received his radiation exposure record from the registrant as requested. The Agency's investigation found that the record had not been sent by the registrant. The record was subsequently sent by certified mail and received by the former employee. The complaint was substantiated. One non-cited severity level IV violation was noted.

File closed.

C - 2571 - Dose to Public and Safety Concerns - AGD Inspection Services - Houston, Texas

On June 3, 2014, the Agency received information from the U.S. Customs and Border Protection (CBP) that some of its officers had detected radiation while driving near the port area of Houston, Texas, and the officers were concerned that a radiography source may have been used with improper safety controls. CBP had identified one licensee working within the area of concern. The Agency conducted an investigation which included an on-site investigation. The investigation revealed that there were several facilities in that area where industrial radiography licensees were routinely performing radiographic operations. The Agency identified and contacted 5 licensees, including the one identified by CBP. The Agency asked the licensees to reinforce with all of their radiographers the importance of performing required surveys to ensure compliance with exposure limits. The complaint was not substantiated. No violations were cited.

File closed.

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

C - 2572 - Regulatory Violations - University of Texas M. D. Anderson Cancer Center - Nassau Bay, Texas

On June 18, 2014, the Agency received a complaint that the staff in the radiation therapy area (linear accelerators) at the facility were not wearing individual exposure monitoring devices (dosimetry badges). In response to the patient complaint, the site radiation safety officer (SRSO) made an unannounced visit to the site on June 25, 2014. The SRSO noted that all pertinent staff were wearing dosimetry badges and occupational dose records for the nursing and radiation therapy staff showed that there were no exposures exceeding regulatory limits. The SRSO completed a public dose assessment during patient treatments and observed that therapy staff followed appropriate radiation safety protocols. The results of the public dose assessment verified that it would not be possible for a member of the public to exceed the general public annual dose limit of 100 millirem/yr. The complaint was not substantiated. No violations were cited.

File closed.

C - 2574 - * - Parkview Regional Hospital - Mexia, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2575 - Uncredentialed Radiographer Trainee - Weld Spec - Lumberton, Texas

On June 23, 2014, the Agency received a complaint alleging the licensee was not properly credentialing its industrial radiographer trainees. It was also alleged that the forty hour safety training was not provided by an entity approved by the Agency for industrial radiography safety training. Investigation revealed that the trainee in question had attended an approved class. The trainee had left the original employment prior to receiving the physical trainee card, which had since arrived at the original employer's office. The complaint could not be substantiated. No violations were cited.

File closed.