

**INCIDENT AND COMPLAINT SUMMARIES  
FOR THE  
FIRST QUARTER 2009 \***

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“Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). These summaries will not appear in this report.”

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

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## Incidents Opened First Quarter 2009

### I - 8596 - Lost Sources - Wal-Mart- Various Locations in Texas

On January 13, 2009, the Agency was notified by the licensee that 1,558 tritium exit signs (TES) were lost from stores located throughout the State of Texas. This information was gathered during a nation wide inventory of TES located at Wal-Mart stores. The report included specific information for each TES reported as lost. The Agency continues to receive updates to the report from Wal-Mart and will consider violations pending the completion of their inventory.

File open.

### I - 8597 - Badge Overexposure - MEAH ASC Management LLC - Lake Jackson, Texas

On January 12, 2009, the Agency was contacted by the registrant and was informed that a doctor who performed fluoroscopy operations had a personnel dosimetry badge reading of 5,510 millirem for the year 2008. The badge had been worn outside of a thyroid shield at the neck. The registrant was allowed to correct the badge reading using the 0.3 Effective Dose Equivalent (EDE) provision in the Texas Administrative Code. The dose was corrected to 1,653 millirem EDE. The procedure for performing fluoroscopic examinations was changed to have the physician step away from the area when in use to minimize his dose. No violations were cited.

File closed.

### I - 8598 - Damaged Moisture/Density Gauge - Terra Testing Inc. - Lubbock, Texas

On January 15, 2009, the Agency was notified that a Troxler Model 3411 moisture density gauge containing one 8 millicurie Cesium (Cs) - 137 source, and one 40 millicurie Americium-Beryllium (AmBe) - 241 source was damaged when a ten pound hammer was dropped on the device. The hammer struck the operating rod of the Cesium source and bent it. The source remained in the shielded position. The gauge was returned to the storage area at the licensee's facility. The manufacturer was contacted for assistance and to arrange for the repair of the device. A leak test of the gauge was conducted and the results indicated that there was no leakage. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8599 - Radiation Detected At Scrap Yard - Private Individual - Houston, Texas

On January 20, 2009, the Agency was contacted by the Houston Hazmat Captain and informed that Houston Hazmat had responded to a local scrap yard that had detected radiation on a device offered to them for disposal. The Hazmat team was able to determine that the source of the activity was Radium (Ra) - 226 on what appeared to be the dial from an airplane gauge. The gauge was returned to the owner. No violations were cited.

File closed.

### I - 8600- Sources Discovered Abandoned and Recovered on Same Day, - Cardiac Medical Solutions - Pasadena, Texas

On January 21, 2009, an Agency Inspector attempted to perform a routine inspection at a nuclear cardiology office, but found the facility occupied by another business. The inspector notified the central office staff who investigated the situation to find that the licensee had declared bankruptcy the year before and had abandoned all equipment including a gamma camera and four calibration and reference sources. It was determined that the material was last used in July 2007, and the technologist affirmed that she had departed the facility in August 2007. Further investigation revealed that a properly licensed service company had purchased the four sources and other equipment that were left in the office at an auction in May 2008. An inventory and transfer document was provided to account for all of the sources. No violations were cited.

File closed.

### I - 8601 - Source Found At Recycling Facility - Newell Recycling of San Antonio - San Antonio, Texas

On January 20, 2009, the Agency was notified by a recycling company that it had found a source of radiation in a load of scrap steel. The company believed the material came from El Paso, Texas. An Agency Inspector went to the facility on January 21, 2009. The inspector was able to identify the radioisotope as Sodium (Na) - 22. The recycler stored the source in a remote location of its facility. The source was removed from the facility and disposed of by the Agency on March 25, 2009. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8602 - Stolen X-ray Fluorescence Analyzer - Allied Alloys - Houston, TX

On January 26, 2009, the Agency was informed that sometime between the night of Friday January 23, 2009 and the morning of Monday January 26, 2009 a Thermo NITON Analyzer X-Ray Fluorescence Device Model XL3p 800 was stolen. The device contains a 30mCi Am-241 source. A police report was filed, the manufacturer notified and a reward was offered. The source was not recovered. No violations were cited.

File closed.

### I - 8604 - Failure To Retract Source - METCO - Houston, Texas

On January 28, 2008, the Agency was notified by the licensee that a radiographer was working in one of their shooting bays when a 35.7 curie Iridium (Ir) - 192 source would not retract into the radiography camera. The radiographer used an installed video camera to look into the room and saw that the component he was working on had fallen and had crimped the guide tube attached to the camera. Two attempts to straighten the guide tube and retract the source failed. A source retrieval supervisor then entered the room and placed lead bags over the end of the source guide tube and placed a lead sheet over the lead bags. The supervisor unsuccessfully attempted to reshape the section of the guide tube that had been damaged using a hammer. Finally, the supervisor cut the damaged section of the guide tube out and the source was then retracted to the camera. The reported exposure for this event was 15 millirem. The radiographer received additional instruction on proper set up and operation of a radiography camera. No violations were cited.

File closed.

### I - 8605 - Plane Crash And Fire - Federal Express - Lubbock, Texas

On January 27, 2009, the Agency was notified that a Federal Express plane had crashed and caught fire in Lubbock, Texas. The plane was carrying seven packages of radiopharmaceuticals with varying activities. Initial indications were that the packages were not involved in the fire, but suffered small amounts of smoke and water damage. On January 29, 2009, an Agency Inspector inspected the packages and found that they were intact. Contamination surveys indicated that there had been no leakage of radioactive materials. The packages were placed in an overpack and shipped back to the supplier. An inspection by the supplier confirmed that the containers had not been damaged and that no contamination had leaked. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8606 - Radiation Alarm at Landfill - Allied Waste Industries - San Antonio, Texas

On January 30, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste contained sludge from the City of Kerrville's waste water treatment plant. The radionuclide was identified as Technetium (Tc) – 99m, a short lived radionuclide used in the medical field. In accordance with Agency rules, the landfill operator was allowed to dispose of the waste. No violations were cited.

File closed.

### I - 8607 - Radiation Alarm at Landfill - Allied Waste Industries - San Antonio, Texas

On February 3, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste had been picked up from multiple locations, including a local hospital. The radionuclide was identified as Technetium (Tc) – 99m, a short lived radionuclide used in the medical field. In accordance with Agency rules, the landfill operator was allowed to dispose of the waste. Nothing was found in the waste that explicitly indicated where the contaminated waste originated. However, the truck picked up waste from multiple locations, one of which was a hospital. Consequently, a phone call was made by the Agency to that hospital to inform them of the event. No violations were cited.

File closed.

### I - 8608 - Radiation Alarm at Landfill - Allied Waste Industries - San Antonio, Texas

On February 4, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste had been picked up at a location that had multiple tenants, some in the medical field. The radionuclide involved was identified as Technetium (Tc) – 99m, a short lived radionuclide used in the medical field. In accordance with Agency rules, the landfill operator was allowed to dispose of the waste. The office manager of the facility where the waste was collected agreed to send a notice to all their tenants concerning this event. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8609 - Radiation Alarm at Landfill - Allied Waste Industries - San Antonio, Texas

On February 5, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste had been picked up at a veteran's hospital. A call was made to the Nuclear Regulatory Commission (NRC) as they regulate the use of radioactive material at the veteran's hospital. The NRC agreed to contact the veteran's hospital and instruct them to retrieve the waste. No violations were cited.

File closed.

### I - 8610 - Radiation Alarm at Landfill - Allied Waste Industries - San Antonio, Texas

On February 5, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste had been picked up in a residential area. No licensees were on the pickup route. The radionuclide involved was identified as Technetium (Tc) – 99m, a short lived radionuclide used in the medical field. In accordance with Agency rules, the landfill operator was allowed to dispose of the wastes. No violations were cited.

File closed.

### I - 8611 - Radiation Alarm At Landfill - Allied Waste Industries - San Antonio, Texas

On February 6, 2009, the Agency received an e-mail from a landfill operator stating that a load of waste had alarmed their gate radiation monitor. The waste had been picked up on a route including a medical facility. The medical facility was contacted and stated that they believed it came from a new cancer center down the road. The radionuclide involved was identified as Technetium (Tc) – 99m, a short lived radionuclide used in the medical field. In accordance with Agency rules, the landfill operator was allowed to dispose of the waste. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8612 - Well Logging Sources Abandoned - Weatherford International, Inc. - Fort Worth, Texas

On November 7, 2008 a well logging tool with two sources became stuck in a gas well at greater than 12,000 feet. Over the next five weeks, several unsuccessful fishing attempts were made to retrieve the device. On December 12, 2008, the licensee prepared an abandonment plan, but due to the limited availability of rig equipment, the abandonment was not completed and the Agency was not notified until January 17, 2009. At that time, it was confirmed that the red dye cement plug had been poured, a 17 foot whip stock was placed on top as a deflection device, the permanent identification plaque was secured in place, and all proper notifications had been made. No violations were cited.

File closed.

### I - 8613 - Overexposure - Theda Oaks Gastroenterology And Endoscopy Center - San Antonio, Texas

On February 20, 2009, the Agency was notified by the registrant that one of their physicians, who performed fluoroscopy studies, had received 7,349 millirem deep dose equivalent for the year 2008, exceeding the annual limit. The doctor stated that he wore his thermoluminescent dosimeter on the outside of his lead apron on the left pocket. He stated that he did not know why his badge reading was so high. He stated that he has begun wearing his dosimeter at his collar outside the lead apron. The licensee received a notice of violation for the overexposure.

File closed.

### I - 8614 - Source Disconnect - Desert Industrial X-Ray - Abilene, Texas

On March 5, 2009, the Agency was notified by the licensee that a source disconnect had occurred. The source had been returned to the camera and was shielded. In this case, the connector, crimp fitted on the source pig tail, had separated from the source drive cable. The Radiation Safety Officer stated that neither worker who retrieved the source exceeded any exposure limits. The device was returned to the manufacturer located in the State of California. The Agency notified the State of California Radiological Health Branch of the event. The manufacturer inspected the devices and could not determine the cause for the failure. They also tested all of their connector assemblies they had in inventory and none of them failed. As the cause for the failure could not be identified, no corrective action could be taken. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

### I - 8615 - Therapy Event Using an Accelerator - Central Texas Center For Cancer Care - San Marcos, Texas

On March 6, 2009, the Agency was notified by the registrant of a therapy event. The event occurred when a therapist received a chart and proceeded to the reception area to call the patient. The wrong patient responded. The patient was taken to the accelerator room and was prepared for treatment. The picture in the patient's file was used to confirm the patient's identity. The appearance of the patient who responded was similar enough that the mistaken identity was not caught. Once the setup of the patient was completed, the therapist began the treatment. A second therapist remarked that she could not find her patient. The first therapist, upon hearing this remark, stopped the treatment she was giving. The two therapists then confirmed that the patient receiving the treatment was not the correct one. The first therapist stated that she had never met the patient before, and the customized mask and stabilization mouthpiece fit well enough that it did not raise a concern. A physicist review of the treatment determined that no clinical or psychological ill effects would be experienced by the patient, who received a maximum unintended dose of 40 centigray. The prescribing physician and patient were notified of the event. To prevent a reoccurrence of this event, the registrant has required additional interaction between the therapist and patient to assure the correct patient is treated. No violations were cited.

File closed.

### I - 8616 - Shannon Medical Center - San Angelo, Texas

**\*The Health and Safety Code Chapter 241.051 (d)**

File closed.

## Incidents Opened First Quarter 2009

### I - 8617 - Stolen Equipment - Radiology Associates of San Antonio PA - San Antonio, Texas

On March 11, 2009, the Agency was notified by the registrant that a GE MST 625 II x-ray device had been stolen. The company had relocated to a new building and left the device at the original location for storage. The device had not been used for over a year. The Radiation Safety Officer stated that they had determined a time frame when the device could have been removed, but not a specific date. No radioactive material had been left in the room with the device. The area where the device had been stored was being remodeled for a new tenant. Interviews with the workers did not provide any information about the disappearance of the device. Local law enforcement was notified of the event. The registrant has added a procedure to their radiation protection plan to provide guidance and controls for devices in storage. No violations were cited.

File closed.

### I - 8618 - Lost Americium Sources - Dr. Pepper Bottling Co. - Irving, TX

On February 20, 2009 during an internal audit/inspection, it was discovered that two Filtec Model FT 50 level detection devices each with 100 mCi of Am-241 were missing and had apparently been removed from the facility as scrap metal. The subsequent investigation has determined that the metal scrap, along with these devices, was subsequently shipped to a mill in India and most certainly has been melted. Specific details of the shipping, route taken, mode of transport, vendors, as well as actual location in India was gathered and provided to appropriate federal authorities for their disposition. The company was cited for failure to maintain control of license material.

File closed.

### I - 8619 - Sources Abandoned - Network Cancer Care - Corinth, Texas

On March 30, 2009, the Agency was notified that the property and assets of a medical business in had been seized by the property owner for overdue rent. The property seized included, among other equipment seized by the Drugs and Medical Devices unit, two nuclear medicine scanners with installed radioactive sources used for attenuation correction. Other assorted radiation sources typically found in a nuclear medicine clinic were discovered unsecured, so Agency staff impounded the sources with the permission of the agent/owner. Prior to the contents of the office being auctioned, staff assisted the property owner in seeing that the sources were removed from the devices by an authorized firm. The information was conveyed to the licensing branch of the Department of State Health Services so that the license could be properly terminated.

File closed.

## Incidents Opened First Quarter 2009

### I - 8620 - Inability to Close Nuclear Gauge Shutter - Union Carbide Corporation - Seadrift, Texas

On March 18, 2009, the Agency was notified that while attempting to close the shutter on a Ohmart/Vega SH-F1 level detection gauge, the handle shaft broke, separating it from the shutter closure device. The gauge contained a 10 millicurie Cesium (Cs) - 137 source. Dose rates were taken in the area and were found to be normal for a closed shutter. A technician from the manufacturer installed a shield over the shutter. The gauge was then moved to a storage area and packaged for return to the manufacturer. No violations were cited.

File closed.

### I - 8621 - Found Source - Digital Surveys Inc. - Alvin, Texas

On March 17, 2009, a DSHS regional inspector could not identify the current location of a three curie Americium (Am) - 241 source. The source was licensed to a company who had requested that their license be terminated, but had not provided any information on the disposal of the source. The Agency was able to locate a company who provided documents indicating that they had taken possession of the source on July 3, 2008. The new owner of the source is currently licensed to possess this source. No violations were cited.

File closed.

### I - 8622 - Overexposure - Weld Spec. Inc. - Beaumont, Texas

On March 25, 2009, the Agency was notified by the licensee that they had been notified by their dosimetry processor that one of their employee's thermoluminescent dosimeter badge read greater than 1,000 rad Deep Dose Equivalent, exceeding the annual limit. The licensee's Radiation Safety Officer (RSO) had contacted the individual and sent her to have complete blood count work done. The worker stated that she had only performed work nine days in the month of February, and all of that work was done in the dark room. She stated that she was in control of her badge at all times from the time she picked it up for the first time in her company mail box in mid February, until it was turned back in. The results of the blood work were normal. The licensee removed the recorded dose from the individual's dose history and assigned a dose of 416 millirem for the exposure period. The RSO conducted safety training with all of their technicians and informed them of the consequences of exposing an individual's dosimeter as a trick or to seek revenge. No violations were cited.

File closed.

## Incidents Opened First Quarter 2009

I - 8623 - The Methodist Hospital - Houston, Texas

\***The Health and Safety Code Chapter 241.051 (d)**

File closed.

I-8624 - Scott and White Hospital - Temple, Texas.

\***The Health and Safety Code Chapter 241.051 (d)**

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

### I- 8507 - Equipment - Damaged - Wal-Mart Stores - Cypress, Texas; Round Rock, Texas, Georgetown, Texas and Austin, Texas

On April 17, 2008, the Agency was notified by the licensee that they had conducted a physical inventory at one of their stores and found that an exit sign containing tubes of tritium (H-3) was missing some of the tubes. The licensee broadened their inventory to all of their stores containing Tritium Exit Signs (TES), which include more than 2,300 stores in Texas. A total of 73 signs were reported in Texas as either lost, or containing damaged or missing tubes of H - 3. All stores containing lost or damaged tubes were surveyed for contamination and released for unrestricted use. Wal-Mart is conducting an inventory to determine if any additional signs were shipped to Texas and are now missing. All TES were removed from their stores and returned to the manufacturer. The incident was closed in the Nuclear Material Events Database on March 4, 2009. No violations were cited.

File closed.

### I - 8562 - Medical Waste Found at Landfill - Allied Waste Industries - San Antonio, Texas

On September 22, 2008, the Agency was notified of a radiation monitor alarm that occurred at a waste landfill. Agency Inspectors arrived at the landfill later that day and were able to identify the radionuclide as Iodine (I) - 131, a radionuclide commonly used in the medical field. The inspectors were also able to identify other forms of medical waste. In accordance with Agency rule, the landfill operator was allowed to dispose of the waste. No violations were cited.

File closed.

### I - 8570 - Failed Shutter Mechanism - Flint Hills Resources LP - Odessa, Texas

On October 6, 2008, the Agency was notified that an Ohmart model SHLM-CR-2, Cs-137 level gauge source retractor failed to operate while being serviced by an Ohmart technician. It was determined that the source insertion well had become distorted due to the weight of the solidified polymer which had encased the insertion well, however, the gauge continued to work properly for level indication. On February 2, 2009, the polymer was removed from around the insertion well. The insertion well was removed from the vessel and the source was placed in a shielded container. Contamination surveys conducted on the source and insertion well were less than applicable limits. The source will be disposed of when the licensee has removed all the other remaining sources. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

### I - 8576 - Source Separation from Operator - Delek Refining LTD - Tyler, Texas

On October 28, 2008, the Agency received notification from the licensee that while trying to fix a failed level detection instrument, they discovered that the source used by the instrument had separated from its operating rod, and was now lying inside the gauge housing in an unshielded condition. The source is a 260 millicurie Cesium (Cs) - 137. The licensee also reported that since the workers repairing the gauge were unaware of the unshielded source, six of their workers had received exposures greater than the limit for members of the general public. The gauge manufacturer was contacted, removed the gauge and source from its installed location, and returned them both to their facility for investigation. It was determined that the silver solder used to connect the source holder to the operating rod had failed. The licensee has provided additional radiation protection training to their workers. The licensee is also purchasing a different style of gauge to prevent a reoccurrence. The licensee was cited for five violations.

File closed.

### I - 8582 - Stolen/Returned Moisture/Density Gauge -Giles Engineering Associates Incorporated - Dallas, Texas

On November 24, 2008, the Agency was notified by the licensee that a Troxler Moisture Density Gauge containing an eight millicurie Cesium (Cs) - 137 source, and a 40 millicurie Americium (Am) - 241 source was stolen. The gauge was stolen by cutting the chains and two locks that secured the gauge to the bed of a truck. The Dallas Police Department was notified and a report was filed. The gauge was recovered by the Dallas Police Department while conducting an investigation for stolen vehicles at a home. The gauge was returned to the licensee on December 2, 2008. The licensee amended their procedures to require that any gauge that is not in use is to be promptly returned to the storage room. The change also requires that any vehicle transporting a gauge be in the line of site of a technician at all times. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

### I - 8583 - Radiography Source Disconnect and Leaking Source - Desert Industrial X-ray, LP - Abilene, Texas

On November 25, 2008, the Agency was notified by the licensee that a source disconnect had occurred while using an INC IR - 100 radiography camera containing an 80 curie Iridium (Ir) - 192 source. While the licensee was collecting information on this event, they received a phone call informing them that this source had failed the latest leak test. A source recovery team was sent to the location and returned the source to the radiography camera. A second leak test was performed on November 26, 2008. The company performing the analysis of the leak test informed the licensee that both the first and the second test were within acceptable limits. The failure was determined to have been caused by a worn connection to the pigtail. The pigtail was sent to the manufacturer for evaluation. All exposures to individuals involved in this event were well below applicable limits. No violations were cited.

File closed.

### I - 8586 - Stuck Source - Southwest Regional Cancer Center - Austin, Texas

On December 11, 2008, the licensee notified the Agency that a service contractor had completed a successful source exchange on a Nordian GammaMedPlus Brachytherapy device on December 2, 2008. That same evening, the new source wire became jammed during the third position verification test procedure. The source was manually retracted to the shielded position by a service technician within a few minutes of the event. The source, cable, and associated equipment have been removed from the device and have been returned to the manufacturer in England for further examination. The manufacturer discovered that a compact black dust comprised of the same material as the source wire mixed with the lubricant used during the source exchange had built up in the guide tube and prevented the source from being fully retracted. The manufacturer has implemented new maintenance procedures to prevent a reoccurrence. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

### I - 8589 - Vehicle Accident During Delivery of Radiopharmaceutical - NuTech Inc. - Wichita Falls, Texas

On December 11, 2008, the Agency was informed by the licensee that one of their drivers was involved in a fatal accident. The truck he was driving veered off the road and struck a tree. The truck was carrying a single vial containing five millicuries of Technetium (Tc) – 99m for use at a hospital. A member of the Texas Department of Transportation took control of the material until a member of the pharmaceutical group arrived and returned it to the facility. The package and contents were inspected. The package had not been breached, and the container of Tc – 99m had not been damaged. Surveys indicated that the package was free of contamination. No violations were cited.

File closed.

### I - 8590 - The Methodist Hospital - Houston, Texas

#### **\*The Health and Safety Code Chapter 241.051 (d)**

File closed.

### I - 8593 - Landfill Radiation Monitor Alarm - Allied Waste Industries - Robstown, Texas

On December 19, 2008, an Agency Inspector was contacted by the landfill operator and was informed that a load of waste had alarmed their radiation monitor. The inspector went to the landfill and found radiation levels on the trailer as high as 257 microrem per hour. A survey conducted with a portable isotope identifier determined the radionuclide to be Iodine (I) - 131, a radioisotope commonly used in diagnostic medicine. In accordance with Agency rules, the landfill was allowed to dispose of the waste. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

### I - 8594 - Source Disconnect - Delek Refining - Tyler, Texas

On December 22, 2008, the Agency received a fax from the licensee stating that a Thermo Measure Tech Model 5191 level measurement gauge containing a 253.4 millicurie Cesium (Cs) - 137 source had separated from its operating rod. On January 16, 2009, the licensee provided documentation stating that a technician from the manufacturer had removed the source from the insertion well on December 8, 2008. The source was placed in a lead container and this container was then placed in a type "A" container, and returned to the manufacturer. The source separated from the operating rod due to failure of the silver solder connection. No exposures exceeded regulatory limits during this event. No violations were cited.

File closed.

### I - 8595 - Landfill Radiation Monitor Alarm - Allied Waste Industries - Robstown, Texas

On December 9, 2008, the Agency was notified by a landfill operator that a radiation monitor alarm had occurred on a load of material delivered to the landfill for disposal. An Agency Inspector performed an on-site inspection at the facility and found radiation levels on the load to be 27 microrem per hour. The inspector found cans containing a blue powder-like material manufactured by De Dietrich of Corpus Christi, Texas, in the containers. The inspector was not able to identify the radionuclide involved. The Agency requested a sample of the material from the manufacturer. The sample was analyzed by the Agency laboratory, and was identified as naturally occurring radioactive material also known as NORM. NORM is made up of radioactive elements such as thorium, uranium, and potassium, which occur naturally in nature. The manufacturer was notified of the results. In accordance with Agency rules, the landfill was allowed to dispose of the material. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2009

I - 8603 - Southwest General Hospital - San Antonio, Texas

\***The Health and Safety Code Chapter 241.051 (d)**

File closed.

## Complaints Opened First Quarter 2009

### C - 2172 - Unlicensed Source - Cummings Wireline - Kyote, Texas

On January 21, 2009, the Agency received a complaint alleging that an individual is using a well logging source without a license. The company's license was revoked in August, 2000. The Agency has not located a current address for the individual alleged to be using the source. A Regional Inspector has attempted to locate the individual to perform an inspection and was unable to find him. A search of the city of Kyote, Texas using radiation detection instrumentation has provided a possible address for the source. Addition surveys are planned to verify the radioisotope.

File open.

### C - 2173 - Hopkins County Memorial Hospital - Sulphur Springs, Texas

**\*The Health and Safety Code Chapter 241.051 (d)**

File closed.

### C - 2174 - Regulation Violation - Ashtead Technology - Pasadena, Texas

On February 3, 2009, the Agency received a complaint stating that the registrant was leasing radiation generating devices to individuals who are not registered to use them. A review of rental records obtained from the registrant by the Agency was conducted and indicated that each entity who had rented a device was correctly registered with this Agency. A review of records done during an on-site inspection by an Agency Inspector was not able to find any instances where the registrant had rented a device in violation of the Agency's code. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2009

### C - 2175 - Uncredentialed Technologists - Red Oak Cardiovascular Center P A - Houston, Texas

On February 3, 2009, the Agency received a complaint alleging that the registrant was laying off qualified technicians and hiring unqualified personnel to perform x-rays. An Agency Inspector performed an investigation at the facility on March 31, 2009. The inspector determined that only credentialed individuals were operating the x-ray equipment. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2176 - Laser Burns To Patient - Skin Deep Medispa - Rockwall, Texas

On February 13, 2009, the Agency received a complaint from an individual who alleged she had received second and third degree burns to her face and neck from a laser treatment. The individual stated that the event occurred on August 8, 2007. The individual stated that she expected the spa to pay for the medical bills received for treatment of her injuries, but the spa refused. The complainant provided a statement from her physician showing that she had made an office visit for the burns. A joint inspection with Drugs and Medical Devices Inspection Group was conducted on March 19, 2009 by the Agency. The co-owner of Skin Deep Medispa stated that they were aware of the event, but were not aware of the requirement to notify this Agency for this type of event. The complaint was substantiated. The company was cited for this violation and two additional violations.

File closed.

### C - 2177 - Wind Turbine Causing Adverse Health Effects - IBERDROLA Renewables - Jacksboro, Texas

On February 13, 2009, the Agency received a complaint from an individual alleging that he was suffering adverse health effects caused by a wind turbine farm located next to his property. An Agency Inspector performed a field inspection on March 5, 2009. He performed decibel readings in various locations at the wind turbine farm and near local residents' homes. The maximum reading taken at the wind turbine was about 80 decibels. Readings taken in front of the complainant's home were about 40 decibels. These measurements did not indicate any hazardous noise levels. The complaint could not be substantiated. No violations were cited.

File open.

## Complaints Opened First Quarter 2009

### C - 2178 - Failure To Provide Complete Records - Amarillo Family Physicians Clinic - Amarillo, Texas

On March 5, 2009, the Agency received a complaint from a registrant stating that records they were receiving by a local clinic were not always legible, the doctor was not always available to clarify the information, and that required information was not always provided. An investigation conducted by a Regional Inspector confirmed that the reports often contained cross outs and write over's, which made the records difficult to read. The inspector also determined that the name of the radiologist is not provided when the report is reviewed by someone other than the facility doctor. The complaint was substantiated. A notice of violation was cited for the violation.

File closed.

### C - 2179 - Failure To Provide Records - Advanced Radiology Associates - Edinburg, Texas

On March 10, 2009, the Agency received a complaint from a husband alleging that the registrant had refused to provide his wife's mammogram records as requested until the patient received additional testing. The husband stated that they had requested copies of a mammogram on February 19, 2009, and again on March 2, 2009. He stated that the doctor had stated that the patient needed a MRI done, and that they would not release his wife's records until the MRI was done. The husband had his local doctor fax a copy of the request to the mammogram facility on March 26, 2009. On March 27, 2009, the Agency contacted the registrant to confirm that they had not release the records. The Investigator was placed on hold for a few minutes. When the individual returned to the phone, they replied that they had not received a request for the records prior to this date, and that they were faxing the information as they spoke. The records were delivered to the requested location prior to 30 days as required. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2009

### C - 2180 - Unusual Feeling After X-ray - Lone Star Orthopedics - Houston, Texas

On March 3, 2009, the Agency received a complaint from an individual who stated that they had received chest x-rays from the registrant that made him feel as though "some one was walking through him". An Agency Inspector performed an on-site investigation on March 19, 2009. The inspector found that the registrant was aware of the event. On March 26, 2009, an Agency Investigator contacted the facility for additional information. The registrant was asked if they had any reason to suspect a device error for this event. The registrant stated that they checked the film of the individual involved for a possible overexposure and found that there was not. They also stated that after performing x-rays on the next patient, the patient was asked if they felt any unusual feeling during the x-ray. They stated that they did not. The complaint was not substantiated. The registrant did receive two unrelated violations.

File closed.

### C - 2181 - Uncredentialed Technologists Performing Exposures - Valley Ear, Nose, and Throat Specialists - McAllen, Texas

On March 12, 2009 an anonymous complaint was received that alleged personnel employed at a medical clinic were performing x-ray exposures of patients without being properly credentialed. The information was forwarded to the local Inspector who performed an unannounced investigation where the allegations of the complainant were substantiated. Four individuals without proper credentials were determined to have performed radiographic exposures. The complaint was substantiated. The registrant was cited for the violation.

File closed.

### C - 2182 - No Physician Supervision - Venus Day Spa - Austin, Texas

On March 11, 2009, the Agency received a letter from an anonymous source claiming that the facility was using lasers on humans for hair removal without physician supervision. On April 2, 2009, an Agency Investigator performed an unannounced investigation at the facility. The investigation determined that the laser device being used was registered. The operator provided numerous examples of patient's health information sheets being reviewed by a practitioner of the healing arts. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2009

### C - 2183 - Sources Not Properly Secured - Arlington Medical Imaging - Arlington, Texas

On March 18, 2009, the Agency received a complaint stating that the registrant had terminated its operation of a Positron Emission Tomography camera and that the sources used with it were not properly stored. An investigation conducted by an Agency Inspector found that the sources were secured in a closet located in a locked hallway. The sources were being stored inside of lead pigs. Dose rates on contact with the pigs ranged from four to six microrem and did not present an exposure risk to individuals. The sources were shipped from the facility on March 27, 2009. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2184 - Uncredentialed Technologists - Lone Star Pediatrics - Kaufman, Texas

On March 19, 2009, the Agency received a complaint alleging that the registrant has allowed Non Credentialed Technologist (NCT) to perform and supervise x-ray exposures. The complainant alleged that the physician is not at the facility on Fridays, and that the Nurse practitioner is required to perform unauthorized x-rays under the NCT. In a previous response to violations, the registrant had committed to send staff to training, but did not do so. An Agency Inspector performed an unannounced inspection at the facility on April 3, 2009. The Inspector found that on several occasions individuals had operated x-ray equipment they were not credentialed to operate. The physician stated that he had instructed all personnel that only properly credentialed individuals were to operate the device. The NCTs stated that they felt compelled to perform the operations due to time constraints and patient load. Disciplinary actions were taken by the facility for the individuals involved, the operating procedures for the facility have been updated, and the facility has hired a consultant to review their operations on a quarterly timeframe. The complaint was substantiated. Two violations were cited against the registrant.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2009

### C - 2170 - Uncredentialed Technicians - Health Texas Provider Network - Irving, Texas

On December 1, 2008, the Agency received a complaint stating that the registrant was requiring technicians without the proper credentials to take x-rays, and perform bone density tests. On January 8, 2009, an Agency Inspector performed an on-site investigation. The Inspector was able to determine that all individuals who had operated the facility's x-ray and bone density devices were properly credentialed. The complaint was not substantiated. No violations were cited.

File closed.