



INCIDENT AND COMPLAINT SUMMARIES FOR FIRST QUARTER 2012*

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

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

**Incident and Complaint Summaries
1st Quarter 2012**

Table of Contents

Incidents Opened in First Quarter 2012 3

Incidents Opened in a Previous Quarter and Closed First Quarter 201213

Complaints Opened in First Quarter 201216

Complaints Opened in a Previous Quarter and Closed First Quarter 201220

Incidents Opened First Quarter 2012

I - 8915 - Gauge Shutter Failure - Coilplus Texas, Inc. - San Antonio, Texas

On January 4, 2012, the licensee reported to the Agency that a gauge shutter had failed in the closed position during a routine shutter test on an Xact Ray, Model 5310, which houses a 1,000 millicurie americium-241 source. The gauge is on a machine that is not in service and the shutter is kept closed. The licensee has locked the equipment to prevent attempted operation of the shutter. The licensee plans to have the gauge removed as it does not intend to use the equipment in the future. The licensee is in the process of locating and contracting with a licensed company for the removal. Upon removal, the gauge will be examined to determine the cause of the failure. An investigation into this event is ongoing.

File open.

I - 8916 - Regulatory Violation - Desert Industrial X-Ray LP

On January 5, 2012, while driving to investigate a complaint in Godley, Texas, two Agency investigators noted two radiography trucks parked at a gas well site near Cleburne, Texas. One of the trucks appeared to have a radiography camera sitting on the tail gate and no one appeared to have it under surveillance. After completing the complaint investigation, the investigators returned to the location where they had seen the trucks. Only one truck remained and a radiography camera was sitting on the truck's tailgate. The investigators observed that the radiographers were sitting inside the cab of the truck and could not maintain surveillance of the camera. The investigators pulled behind the radiography truck and observed the truck and camera for several minutes. They exited their vehicle and began taking pictures of the truck and camera and inspected the camera. After several minutes, an investigator went to the passengers window and knocked. The radiographers were asked to place the radiography camera in its transportation container inside the dark room. The radiographers were informed that the camera had been left in a position where they could not prevent unauthorized access or removal of the camera by an unauthorized individual. The radiographers and the licensee were cited for the violation.

File closed.

I - 8917 Gauge Shutter Failure - Huntsman Petrochemical LLC - Port Neches, Texas

On January 6, 2012, the Agency was notified by the licensee that while conducting a routine maintenance check, the shutter on an Ohmart /Vega model SH-F2 was found stuck in the open position. The gauge contained 375 millicuries of cesium-137. The gauge normally operates with the shutter in the open position. The gauge did not pose an increased exposure hazard to the general public or to the workers. On February 3, 2012, the manufacturer representative attempted to close the shutter on the gauge but was unsuccessful. The licensee decided that the gauge and source were no longer needed and on April 5, 2012, the gauge and source were returned to the manufacturer. No violations cited.

File closed.

Incidents Opened First Quarter 2012

I - 8918 - Stolen Moisture/Density Gauge - Terracon Consultants, Inc. - McKinney, Texas

On January 12, 2012, the Agency was notified by the licensee that a Troxler Model 3430 moisture/density gauge containing 40 millicuries of americium-241 and 8 millicuries of cesium-137 had been stolen from one of its vehicles at a convenience store in McKinney, Texas. The licensee reported that the gauge was secured in the bed of the pickup truck with two independent chains as required. While the licensee's technician was inside the store, both chains were cut and the gauge removed. The licensee notified local law enforcement as well as the manufacturer and a nuclear gauge service company in the area. The Agency notified The Texas Pawnbrokers Association. The licensee will notify the Agency if new information is received or the gauge is located. No violations were cited.

File closed.

I - 8919 - Radiography Source Disconnect - Texas Gamma Ray LLC. - Katy, Texas.

On January 13, 2012, the Agency was notified by the licensee that a source disconnect had occurred on January 10, 2012, at one of their job sites. The radiographer was using a SPEC Model 300 radiography camera containing a 116 curie cobalt-60 source. After the twentieth exposure, the radiographers approached the radiography camera and noted that their dose rate instrument was indicating that the source was not shielded. The radiographers returned to the end of the crank out device to make sure that he had retracted the source. The radiographer found that while the drive cable was completely retracted the lock was not operating and the source was still exposed. The radiographer contacted the company's Radiation Safety Officer (RSO). The radiographer set new boundaries at two millirem per hour and waited for the RSO. The RSO arrived at the location and determined that the source was located in the collimator. The RSO retrieved the source without incident. An inspection of the connector on the source pig tail indicated that it had spread allowing it to disconnect. The licensee sent the source to the manufacturer for inspection. The manufacture determined that the connector was worn in a manner which allowed for the disconnect. The manufacturer stated that the wear was caused by normal use of the source. The source connector was repaired by the manufacturer. No exposure limits were exceeded during this event. No violations were cited.

File closed.

I - 8920 - Radioactive Material Found - Bed Bath & Beyond - Various Locations

On January 9, 2012, the Agency was notified that tissue box covers contaminated with cobalt-60 had been shipped to store locations that belong to a major chain of domestic merchandise retail stores in the United States. Four stores in the State of Texas were identified as having received a shipment of these boxes. Surveys of the tissue boxes at each location were conducted by the Agency. Radiation readings greater than background were found at each location on at least one of the boxes. The retail stores' corporate office coordinated the collection of the items with the Nuclear Regulatory Commission and regulators in states where the items were received. The boxes were removed from the shelves and the company made arrangements to dispose of the boxes. On March 20, 2012, the Agency confirmed that all of the tissue boxes that were located in Texas had been delivered to a smelter in Oak Ridge, Tennessee, for destruction. No violations were cited.

File closed.

Incidents Opened First Quarter 2012

I - 8921 - Medical Event - Cardinal Health - Houston, Texas

On January 14, 2012, the Agency was notified by a hospital that a patient was injected with 4.7 millicuries of thallium-201 instead of 8 millicuries of gallium-67 which was ordered from the licensee, a nuclear pharmacy. Using a dose calibrator, an assay of the dose prior to injection measured within 10% of the prescribed dose. The 4.7 millicuries of thallium resulted in a whole body dose of 6.2 rem to the patient. The error occurred because the nuclear pharmacist inadvertently dispensed thallium-201 in a vial labeled gallium-67. The pharmacy conducted training and counseled employees involved in the incident on the proper procedures of product selection and product review. No violations were cited.

File closed.

I - 8922 - Radiography Source Disconnect - NDE Solutions LLC - College Station, Texas

On January 17, 2012, the Agency was notified by the licensee of a source disconnect event that occurred on January 14, 2012. The licensee's radiography crew was using a QSA 880D radiography camera containing 54.9 curies of iridium-192. The disconnect was caused by the drive cable, also QSA, breaking approximately four inches from the source connector. Source retrieval was conducted by the licensee's authorized employees. No individual received any exposure that exceeded regulatory limits as a result of the event. The drive cable and guide tube were sent to the manufacturer for evaluation. The manufacturer reported there was no clear indication of the exact cause of the stress seen by the drive cable, but that the force known to be required to cause this type of unwinding failure indicates that the cable experienced an excessive force that was directly responsible for the teleflex weakening and further unwinding to the extent seen. The report stated that for the unwinding to occur about 4-6 inches behind the connector indicated that the cable was probably pinched or held in place at the point of the break and continued force was applied to stretch the cable until inner core and outer winding eventually failed. The licensee's investigation was unable to identify any instance in which the cable could have been damaged to the degree the manufacturer indicated would have been required to eventually result in the cable breaking as it did. The licensee reported that the drive cable assembly had only been in service for 6-8 months. One violation was cited for failure to report within the 24-hour requirement.

File closed.

Incidents Opened First Quarter 2012

I - 8923 - Badge Overexposure - Tuboscope Vetco International Inc - Odessa, Texas

On January 17, 2012, the Agency was notified by the licensee that four badge-only overexposures had occurred in November 2011. The badges' readings ranged from 205 rem to 500 rem for the exposure period. The licensee stated that none of the individuals wearing the badges showed any symptoms of exposure to this level of radiation. Blood samples were taken from the individuals and sent to Radiation Emergency Assistance Center/Training Site (REAC/TS) for analysis. All of the sample results indicated that the individuals had not received the recorded exposure. No explanation for the readings could be determined. The licensee interviewed each of the individuals involved and each signed a statement indicating that they had not tampered with their badge and could not provide an explanation for the high reading. The licensee assigned each of the individuals an exposure for the period based on a six month average of their previous exposure. Since the licensee was unable to determine the cause for the high readings, no corrective action was taken. No violation was cited.

File closed.

C - 8926 - Nuclear Pharmacy Error - Cardinal Health dba National Central Pharmacy - Abilene, Texas

On January 13, 2012, the Agency was notified by the licensee that the wrong form of technetium-99m was delivered to a hospital. The hospital had requested technetium-99m Medronate, but the pharmacy sent technetium-99m Tetrofosmin. The drug was administered to a patient. The licensee stated that the patient did not experience any adverse reaction to the error. The licensee stated that to prevent a recurrence of this error they counseled all employees involved with the event. No violations were cited.

File closed.

I - 8927 - Non-Reportable Event - The University of Texas Southwestern Medical Center at Dallas - Dallas, Texas

On January 24, 2012, the Agency was notified by the registrant that it had performed a computed tomography procedure on a patient who was not scheduled to receive one. The registrant's investigation revealed that a physician had had two electronic patient charts open at the same time and ordered the CT for the incorrect patient. The error was not identified until after the exam was completed. The registrant reported that to prevent recurrence of this type of event it is working with the manufacturer to make changes to its electronic chart system. This event did not violate any of the Agency's radiation rules or any condition of the registrant's registration. There is no reporting requirement for this event. No violations were cited.

File closed.

Incidents Opened First Quarter 2012

I - 8928 - Transportation Violation - RNLS, LLC dba Renegade Services - College Station, Texas

On January 23, 2012, the Agency was notified that a licensee had improperly shipped a container that held radioactive material. The licensee was returning the container to the manufacturer of its radioactive tracer material. Upon arrival, the manufacturer discovered that one can of the licensee's tracer material, 30 millicuries of antimony-124, was still inside. The container had "empty" labels affixed and did not have shipping papers indicating the container held radioactive material. The licensee's investigation determined that the employee who prepared and shipped the container had not properly surveyed the container and therefore failed to identify the material was present. The Agency's investigation revealed that the licensee had failed to train employees responsible for shipping as required. Three violations were cited.

File closed.

I - 8929 - Overexposure - Phoenix Non-Destructive Testing Company - Channelview, Texas

On January 27, 2012, the Agency was notified by the licensee that during an annual inspection it was noted that one of its employees had exceeded an annual exposure limit and it had failed to report the overexposure to the Agency as required. The employee's annual limit was exceeded during the August 2011 exposure period. The licensee's dosimetry processor had reported the dose to the licensee. At that time, the licensee removed the worker from all work which would expose him to any additional radiation for the remainder of the year. The licensee's Radiation Safety Officer (RSO) stated that he had been unaware at the time of the requirement to report the overexposure to the Agency. The exposure had accumulated over the months during the employee's normal work, but no one had been monitoring his accumulated total dose. The licensee stated that to prevent a recurrence of the event the RSO will review the dosimetry records for their radiographers weekly. Also, the licensee established a limit of 4,000 millirem for its company's radiographers that conduct work on high exposure jobs. One violation was cited.

File closed.

I - 8930 - * - Nacogdoches Medical Center - Nacogdoches, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened First Quarter 2012

I - 8931 - * - Memorial Houston Hospital System - Houston, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File is closed.

I - 8932 - Gauge Shutter Failure - B P Products North America Inc. - Texas City, Texas

On February 10, 2012, the Agency was notified by the licensee that the shutter on an Ohmart model SH-LG 2 nuclear gauge containing 8.5 curies of cesium-137 was found to be stuck in the open position. The gauge normally operates with the shutter in the open position so there was no additional exposure risk. The licensee contacted the manufacturer for assistance. The investigation into this event is ongoing.

File open.

I - 8933 - Lost Lasers - University of Houston - Houston, Texas

On February 13, 2012, the registrant notified the Agency that it was unable to locate two Class 3B and one Class 4 laser at its facility. The registrant's investigation into the event concluded that the devices had been removed from the storage location prior to a renovation project conducted in the storage area and it was unable to determine the current location of the devices. The registrant provided additional awareness training for all project managers involved in construction projects which included protocols for ensuring the safety of radiation devices during construction activities. One violation was cited.

File closed.

Incidents Opened First Quarter 2012

I - 8934 - Overexposure - Metco - Houston, Texas

On February 17, 2012, the licensee notified the Agency of an overexposure event involving one of its radiographers. The radiographer was working in a shooting bay at the licensee's facility using a QSA D880 radiography camera containing a 37 curie iridium-192 source. The radiographer entered the bay to set up her next shot while she was talking on her cell phone. Her head was about 12-inches beneath the collimator for about three minutes. When she exited the bay she attempted to crank out the source. She realized the camera was unlocked and the source was still cranked out and in the collimator from the previous shot. She did not perform a proper survey of the camera or the source guide tube after the previous shot. The shooting bay is equipped with an audible and visual alarm to indicate when a radioactive source is exposed. Another worker had opened a breaker that turned off ventilation fans in the building but also supplied power to the audible and flashing red light alarm for the fixed bay. An on-site investigation by the Agency was conducted on March 15, 2012. Based on two re-enactments, it was determined that the radiographer received a whole body exposure to her head of 8.116 rem. Corrective action included properly labeling and locking the breaker panel for the alarm power, training all of the licensee's radiographers on the incident, and banning the use of cell phones during radiography. Three violations were cited.

File closed.

I - 8935- Nuclear Pharmacy Error - Cardinal Health 414 LLC - Orange, Texas

On February 21, 2012, the Agency was notified by the licensee that while preparing unit doses for shipment, the licensee discovered that a unit dose of 10 millicuries of technetium-99m was missing. The unit dose was found in a shipment of doses sent to another facility. The unit dose was not administered to a patient. The licensee counseled all employees involved in the event and performed additional training for them. No violations were cited.

File closed.

I - 8936 - Gauge Shutter Failure - Equistar Chemicals LP - Pasadena, Texas

On February 22, 2012, the Agency was notified by the licensee that the shutter on an Ohmart SH-F1A nuclear gauge containing 50 millicuries of cesium-137 was found stuck in the open position. The gauge shutter was being closed to reduce dose rates in an area where calibration of equipment was to be done. The gauge normally operates with the shutter in the open position and did not create any additional exposure risk to any individual. The licensee contacted the manufacturer and the gauge was repaired on February 27, 2012. The manufacturer stated that the shutter would not operate due to a build up of rust and debris in the operating arm cavity. The licensee stated that a more weather resistant lubricant will be used in the future to prevent a recurrence. No violations were cited.

File closed.

Incidents Opened First Quarter 2012

I - 8937 - Medical Event - University of Texas Southwestern Medical Center at Dallas - Dallas, Texas

On February 17, 2012, the Agency was notified that on February 16, 2012, a patient received technetium-99m pertechnetate instead of the prescribed technetium-99m MAA. During administration, injection was complicated by infiltration at the injection site. Approximately 33 to 50% of the wrongly administered radiopharmaceutical infiltrated the skin which caused an estimated 400 centigray (rad) exposure subcutaneously. The licensee determined that the wrong pharmaceutical was administered because a technician had retrieved a unit dose scheduled for another patient and did not verify the activity with the dose calibrator. The technician gave the unit dose to another technician, believing that she had grabbed the correct compound. That technician then administered the unit dose to the patient without verifying the label on the syringe. The referring physician and patient were notified. No signs or symptoms were observed as a result of the incident. The licensee has modified its procedure so that each nuclear medicine technologist is responsible for a specific patient, drawing and assaying specific patient doses and verifying pertinent information prior to injection. No violations were cited.

File closed.

I - 8938 - Transportation Event - NDE Solutions LLC - Burleson County, Texas

On February 27, 2012, the Agency was notified that an industrial radiography truck belonging to the licensee had been involved in a single vehicle rollover accident on a rural road in Burleson County, Texas. The radiography camera, which contained 69.2 curies of iridium-192, remained secured inside the locked lockbox which was affixed inside the darkroom even though the darkroom separated from the vehicle. The Burleson County Emergency Management Coordinator (EMC) and the Snook Volunteer Fire Department responded to the scene followed by a licensee employee and the licensee's Radiation Safety Officer. The EMC and fire department conducted initial radiation surveys and determined there were no elevated radiation readings, which was confirmed by the licensee's staff. The driver was transported to a local hospital where he was checked for injuries and released. He suffered no major injuries. There was no damage to the camera and there was no exposure to any individual. The licensee's investigation revealed the accident had occurred because the driver had fallen asleep and overcorrected the steering when he awakened. No violations were cited.

File closed.

Incidents Opened First Quarter 2012

I - 8939 - Stolen Radioactive Material - Fugro Consultants LP - Mont Belvieu, Texas

On March 5, 2012, the Agency was notified by the licensee that a moisture density gauge had been stolen from one of its vehicles. The gauge was a Troxler Model 3430 containing an 8.0 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The gauge was recovered by the licensee later that same day. The investigation conducted by the licensee found that the technician had driven away from the job site with the gauge sitting unsecured on the tailgate of the truck. A member of the general public saw the gauge fall out of the truck and informed another technician sent to replace the first technician. The gauge was recovered with the sources in the shielded positions. A survey of the gauge and the surrounding area was conducted by the licensee and dose rates were found to be normal. The licensee stated that due to the shielded position of the sources, the location where the gauge was found, and the results of the dose rate survey, exposure to any individual was not likely. The gauge was sent to a service company for inspection and repair. The licensee terminated the employment of the employee who lost the source. The licensee reviewed the event and the company's procedure for handling and transporting nuclear gauges with all of its technicians. One violation was cited.

File closed.

I - 8940 - Not Licensed For Radioactive Material - AECI USA - Austin, Texas

On March 8, 2012, the Agency was forwarded an email from the State of Oregon regarding a company in Austin, Texas, that had purchased a Generally Licensed device for redistribution but was not licensed to do so. An Agency investigator conducted on-site investigation on March 14, 2012. The investigator found that the company had moved to Mesa, Arizona. The State of Oregon was informed of the results of the investigation. No violations were cited.

File closed.

I - 8941 - Lost Source of Radioactive Material - Probe Technology Services Inc. - Houston, Texas

On March 22, 2012, the Agency was notified by the licensee that a 350 millicurie (13 GBq) Americium-241/beryllium source was lost during shipment. The investigation into this event is ongoing.

File open.

Incidents Opened First Quarter 2012

I - 8942 - Overexposure and Radiography Source Disconnect - Non-Destructive Inspection Corporation - Pasadena, Texas

On March 24, 2012, the licensee notified the Agency that one of its radiography teams had experienced a disconnect of a 65 curie iridium-192 on a QSA Delta 880 radiography camera at a temporary work site in Pasadena, Texas. The crank out drive cable had broken at the pigtail and the source had completely disconnected. After an authorized individual performed the source retrieval, the licensee's RSO learned that the radiographer trainer disconnected the source guide tube from the camera and had carried the source guide tube around his neck while he climbed down the ladder of the scaffold. The source was still in the source guide tube at this time, but its exact location inside the tube is still uncertain. When the radiographer trainer reached the platform he removed the source tube from his neck. The radiographer trainer's film badge was sent for immediate processing. The badge reading was 812 millirem whole body dose equivalent. The licensee will complete dose reconstruction and its investigation of the incident. The licensee has arranged for medical surveillance of the radiographer trainer, which has already begun. An investigation into this event is ongoing.

File open.

I - 8943 - * - CHCA Clear Lake LP dba Clear Lake Regional Medical Center - Texas City, Texas

* Health and Safety Code Chapter 241.051(d)

An investigation into this event is ongoing.

File open.

I - 8944 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On March 23, 2012, the Agency was notified by the licensee that it had shipped the wrong form of technetium-99m to a hospital. The error was discovered when the hospital reviewed a patient's scan and found that it did not produce the image they had ordered. The hospital contacted the licensee and informed them of the error. The hospital reported that no adverse effects were experienced by the patient who had received the incorrect radiopharmaceutical. The licensee stated the error occurred when a unit dose prescription for technician-99m Oxidronate was placed within a stack of technetium-99m Sodium Pertechnetate and the technician failed to catch the error. The prescription was filled with technetium-99m Sodium Pertechnetate. The licensee counseled all employees involved in the error. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2012

I - 8871 - Stolen Radioactive Material - Acuren Inspection Inc. - La Porte, Texas

On July 19, 2011, the Agency was notified by the licensee that one of its radiography crews had discovered that the dark room on their truck had been broken into some time during the night. The radiographers stated that a QSA Global model 880 D radiography camera with a 33.7 curie iridium 192 source, its transportation container, and a portable electric generator had been stolen. The camera guide tube, collimator, crank out device, and a box containing the lead film marking numbers were also stolen. Local law enforcement was contacted and responded to the scene. State, federal, and local government agencies were notified of the theft. Several searches using portable radiation detection equipment in vehicles were conducted in the Austin area, but the camera was not found. Aerial monitoring was conducted by the Department of Energy using a fixed wing plane between the cities of Austin and San Antonio, Texas. No abnormalities were noted. During the investigation of the event, it was discovered that one of the radiographers had failed to reset the darkroom door alarm when he last left the truck. The radiographer and the licensee were each cited for a violation.

File closed.

I - 8912 - Badge Overexposure - Hi-Tech Testing Service, Inc. - Cotulla, Texas

On December 21, 2011, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that the licensee's November 2011 monthly dosimetry report indicated that a radiographer trainee received 7,754 millirem deep dose, whole body, for that month. The RSO's investigation determined that the excessive dose had been to the badge only. It occurred when the badge came off of the radiographer trainee's shirt and fell into a piece of pipe that was being radiographed at a temporary job site in Cotulla, Texas, on November 10, 2011. A portion of the badge was visible on the film exposed during one of the two shots that were performed before the radiographer trainee discovered the badge in the pipe. This, coupled with dose calculations and statements from radiographic personnel involved, supported the RSO's findings. The RSO assigned the radiographer trainee a dose of 354 millirem for the November 2011 reporting period based on his daily dosimeter records. To prevent recurrence, the RSO has instructed all of the licensee's radiographers to contact the licensee's Radiation Safety Department immediately if accidental exposure to a film badge is suspected and not to assume the badge was not exposed. The Agency concurs that the dose was to the badge only. The RSO also reported to the Agency that the radiographer accompanying the trainee in this incident had been mistakenly assigned by the licensee's operations staff as radiographer trainer and the radiographer had been performing the duties of radiographer trainer with the trainee above since July 2011. The radiographer trainee was reassigned to a certified radiographer trainer under whom he will repeat his required supervised hours. To prevent recurrence, the RSO instituted a process to ensure operations staff have a current, verified list of approved radiographer trainers and job assignments will be reviewed weekly by the licensee's Radiation Safety Department. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2012

I - 8913 - Therapy Event - Texas Oncology PA at Klabzuba Cancer Center - Forth Worth, Texas

On December 21, 2011, the Agency was notified by the registrant's Radiation Safety Officer that while a physician was reviewing a patient's records prior to a follow-up appointment he discovered that the therapy dose totaling 5,400 centigray delivered in three fractions in November 2011 had been delivered to the wrong site. The patient had two areas of concern within one organ. The smaller of the two had been biopsied and found to be malignant. The second, larger area had not been biopsied. The larger area was treated in error. The patient's physician stated that the treatment would have no deleterious effect on the patient and that the larger area would probably have needed to be treated at a later time. The licensee has changed its procedure to require a second method of identifying the correct treatment site prior to treatment. No violations were cited.

File closed.

I - 8914 - Radiography Source Disconnect - Phoenix Non Destructive Testing Company - Houston, Texas

On December 22, 2011, the Agency was notified by the licensee that a 32 curie iridium-192 source from a SPEC Model 150 radiography camera had disconnected from its drive cable. A radiographer, not qualified for source retrieval, attempted to retrieve the source after contacting the RSO who had been bedridden for two months. The RSO was the only person in the company authorized to retrieve a source. The radiographer inserted the source backwards into the camera to shield the source, taped the pigtail and source to the camera and placed the camera between the dark room wall and the transport container. The crank out device could not be disconnected from the camera, so the radiographer stored it outside the storage container and placed lead blankets over the area. The dose rate outside the vehicle was less than 2 mR/hr. The radiography truck was then involved in a four vehicle accident. As a result, the source moved about one inch and caused the radiation level to rise to 47 mrem/hr, as reported by Harris County hazmat personnel who responded to the accident. The radiographer discussed the situation with the hazmat team and got permission to move the source back into a better shielded position. Dose results and calculations determined that no one exceeded a worker or public dose limit. The hazmat team contacted the Agency which authorized transport of the camera back to the licensee's office since the dose rate was reduced to less than 2 mR/hr. The camera, guide tube, and crank out device were sent to the manufacturer for evaluation. The manufacturer found the S-tube was worn, which likely contributed to the initial hang-up. However, it could not replicate the source disconnecting from the cable. The licensee conducted training with all of its radiographers on the details of the incident, lessons learned, and source retrieval requirements. Two violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2012

I - 8924 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services – Dallas, Texas

On November 17, 2011, the Agency was notified by the licensee that it received a call from a customer stating that a unit dosage of technetium-99m Sestamibi it ordered resulted in a scan presenting primarily bone uptake. Technetium-99m Sestamibi is primarily used as a cardiac viewing agent. One individual was administered this product. The licensee stated that the error occurred because the vial for the technetium-99m Sestamibi was inadvertently placed with vials filled with technetium-99m Medronate. The licensee counseled all employees involved and a staff meeting was held to discuss the event. No violations were cited.

File closed.

Complaints Opened First Quarter 2012

C - 2375 - Laser Services Registration - Ford-Goodson Enterprises, Inc. - San Antonio, Texas

On January 12, 2012, the Agency received an anonymous complaint that a company that provides lasers to hospitals in San Antonio was not having the lasers calibrated by a service provider registered with the Agency and was providing falsified records concerning the calibrations. The complainant did not believe the company was registered with the Agency. The Agency's investigation revealed that the company was properly registered for laser services. The company (registrant) provided documentation that it uses service providers for service and calibration that are also registered with the Agency. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2377 – No Physician Supervision for Laser Treatment - Laser Therapy Clinic of Austin Inc. - Austin, Texas

On January 26, 2012, the Agency received a complaint that a laser hair removal facility in Austin was operating without a medical director. The Agency contacted the facility and requested a copy of a Medical Director agreement. The licensee sent a signed letter by a physician stating he was providing medical services for the licensee. Additionally, the Agency reviewed the licensee's registration file which has a complete signed agreement and contract between the Medical Director and licensee. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2378 - No Physician Supervision for Laser Treatment - Professional Laser Hair Removal Center - Austin, Texas

On January 24, 2012, the Agency received a complaint that a laser hair facility in Austin was operating without the required consulting physician. The Agency conducted an investigation and found that the facility does have physician supervision. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2379 - Laser Injury - R U Hairy, Inc. - Houston - Texas

On February 13, 2012, the Agency received a complaint from an individual alleging she had received burns and hyper pigmentation as the result of a laser hair removal procedure at a facility in Houston in October 2011. An investigation into this complaint is ongoing.

File open.

Complaints Opened First Quarter 2012

C - 2380 - Patient Treatment Error - Preferred Imaging of Denton LLC - Denton, Texas

On February 15, 2012, the Agency received a complaint stating that a parent had taken her child to the registrant's facility for an x-ray. When the parent asked the technician to cover part of their child with a lead shield, the technician did not do so. The parent believed that this might be a violation of the Agency's rules. A review of the information provided in the complaint found that no violation of Agency rules occurred. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2381 - Unregistered Dental Radiographic - Joe Schmidt, DDS - West Lake Hills, Texas

On February 17, 2012, the Agency received an anonymous complaint that a dentist was not registered with the Agency. On March 12, 2012, the Agency conducted an on-site investigation and found an expired registration from a previous dentist. That registration was terminated in April 2008. The investigation into this complaint is ongoing.

File open.

C - 2382 - Regulation Violation - ATI Enterprises, Inc. - Dallas, Texas

On February 22, 2012, the Agency received a complaint that a laser hair removal and training facility had failed to provide copies of records to the complainant as required by rule. The complainant also stated other issues concerning information that the staff at the facility had given or failed to give during and after the training course taken by the complainant that concerned certification and registration requirements for a technician. The investigation into this complaint is ongoing.

File open.

C - 2383 - * - Methodist McKinney Hospital LLC - McKinney, Texas

* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

Complaints Opened First Quarter 2012

C - 2385 - Unregistered Laser Facility - Dallas Wax Queen - Plano, Texas

On March 7, 2012, the Agency was notified that a company was performing laser hair removal in a residence and was operating without a certificate of registration. The Agency conducted an on-site investigation. There were no lasers at the residence and no business being conducted. The homeowner stated they had owned the home since 2008, but prior owners had run a massage business in the home. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2386 - Inadequate Credentialing - MedX Imaging - Southlake, Texas

On March 8, 2012, the Agency received a complaint alleging that the registrant is allowing individuals who do not hold the appropriate credentials to provide mammography services. It also alleged that the registrant is not performing quality control test on the mammography units. The investigation into this event is ongoing.

File open.

C- 2387 - Uncredentialed Technicians - Southmore Medical Clinic - Pasadena, TX

On March 9, 2012, the Agency received an anonymous complaint that a medical facility was allowing uncredentialed technicians to take x-rays. The complainant alleged multiple x-ray violations. On March 15, 2012, an on-site investigation was completed by the Agency. The complaints could not be substantiated. No violations were cited.

File closed.

C - 2388 - Regulatory Violations - MedX Imaging, LLC - Southlake, Texas

On March 14, 2012, the Agency received an anonymous complaint that stated that the registrant did not have protective shielding for use during procedures. The registrant is a diagnostic breast imaging facility. There are no Agency radiation regulations that require the use of protective shielding for patients during imaging procedures except one that concerns shielding of gonads. The complainant also stated the facility did not have ambu bags or medications for use in case of allergic reaction to contrast. No regulating authority or regulations for these issues could be identified. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2012

C - 2389 - Unregistered Use of X-ray Machines - All Tech Inspection Services - Corpus Christi, Texas

On March 21, 2012, the Agency received a complaint alleging an industrial radiography company was using x-ray devices for radiography operations and was not registered to do so. The investigation into this event is ongoing.

File open.

C - 2390 - Inadequate Credentialing - Greenhill Clinic PA - Frisco, Texas

On March 22, 2012, the Agency received a complaint alleging that a registrant was allowing individuals who are not credentialed to perform x-rays. The investigation into this complaint is ongoing.

File open.

C - 2391 - Uncertified Technicians - Laserium LLC - Plano, Texas

On March 26, 2012, the Agency received a complaint that the registrant was using technicians that were not certified with the Agency for laser hair removal. An investigation into this complaint is ongoing.

File open.

C - 2392 - Laser Injury - ADEN39 LLC dba Tri-City Med Spa - Willow Park, Texas

On March 26, 2012, the Agency received a complaint concerning an injury received during a laser hair removal procedure. The complainant alleged he/she had developed clear blisters that burst and became infected and the injury may result in scarring. An investigation into this complaint is ongoing.

File open.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2012

C - 2362 - Regulation Violations - ARENDS Inspection, LLC - Houston, Texas

On November 7, 2011, the Agency received a complaint alleging that the licensee was allowing radiographer trainees to work by themselves without the required supervision, that required surveys were not being conducted, and that documents were not being completed correctly. On December 19, 2011, a routine inspection of the licensee was conducted. The inspection substantiated that not all required surveys had been conducted by the licensee and that some records maintained by the licensee were incomplete. A field investigation was conducted on February 2, 2012, at a facility where the licensee was providing radiography services. No violations were identified in the field investigation. The complaint was partially substantiated. The licensee was cited for twelve violations.

File closed.

C - 2369 - Radiation Exposure to Member of the General Public - IOFINA - Godley, Texas

On December 5, 2011, the Agency received a complaint alleging that workers at an iodine extraction operation may be exposed to high levels of radiation. The operation extracts iodine from oil well production brine. An on-site investigation was conducted by the Agency at the facility on January 5, 2012. Radiation dose rates were found to be above normal, and the radionuclide in each case was identified as radium-226, a naturally occurring radioactive material. Based on the dose rates measured and the time spent by the workers in areas where dose rates are elevated, a worker would not exceed the exposure limits for members of the general public. The facility manager stated that he had never had a sample reading 300 rad/hr, which had been alleged in the complaint. He stated that they had a component that read 300 microrem/hr once. Both workers interviewed stated that they were not aware of any issues with radiation levels and had never been told to stay away from any component or trash bin due to radiation levels. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2371 - Regulatory Violations - LML Engineering -Arlington, Texas

On December 13, 2011, the Agency received a complaint alleging that a licensee who vacated a licensed site may have stored multiple moisture density gauges at a residence until it leased a new office space. The licensee responded to a call from the Agency and stated it had a new facility where it was storing the gauges but had not yet added the facility on its license. The licensee submitted a copy of a lease showing that it had a new facility when it moved out the licensed facility. The licensee did submit paperwork, after the fact, to the agency for a change of storage location. There was no proof the licensee stored the gauges at a residence. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2012

C - 2372 - Inadequate Credentialing - Texas Oncology PA - Tyler, Texas

On December 14, 2011, the Agency received a complaint alleging that a medical physicist at a cancer treatment center in Tyler, Texas, was not adequately credentialed and lacked training and sub-specialty certification. The complainant also alleged that the individual had operated a machine that was not properly calibrated and, coupled with the lack of training, had resulted dose errors to patients. The complainant further alleged that the individual was aware of the errors and had made a statement to staff for them not to notify a patient of the error in treatment. The Agency conducted an on-site investigation. The investigation found that the physicist was properly credentialed, had received training on the machines, and no other sub-specialty certification is required. Machine calibrations were documented and performed as required. The complaint did not provide specific patient information for the Agency to be able to check specific record(s). However, record reviews conducted revealed no evidence of reportable patient treatment errors. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2373 - Regulation Violations - METCO - Buna, Texas

On December 14, 2011, the Agency received a complaint referred by the Nuclear Regulatory Commission that employees of an industrial radiography company were not complying with survey requirements while performing radiography operations. It also alleged that the radiographers were not controlling access through the radiation boundaries, and that the Radiation Safety Officer would notify the radiographers prior to performing audits. The Agency performed an on-site investigation on January 12, 2012. The investigation found that the radiographers did not perform required radiation surveys after each exposure of the source or prior to changing the location of the radiography camera. The investigator also observed the radiographers and noted that they failed to adequately provide source security against unauthorized removal. The complaint was partially substantiated. The licensee and radiographers were cited for violations.

File closed.

C - 2374 - Improper Disposal - Keene Sanitation Company - Keene, Texas

On December 20, 2011, the Environmental Protection Agency referred a complaint to the Agency that alleged a sanitation company had improperly disposed of a dumpster that was contaminated with radioactive material by cutting the dumpster up and burying it on the company's property. On January 5, 2012, the Agency conducted an on-site investigation and surveyed the property for radioactive material. No radioactive material was found. The complaint could not be substantiated. No violations were cited.

File closed.