



INCIDENT AND COMPLAINT SUMMARIES FOR SECOND QUARTER 2013*

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

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

**Incident and Complaint Summaries
2nd Quarter 2013**

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Incidents Opened Second Quarter 2013

I - 9063 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On April 4, 2013, the licensee reported that on March 27, 2013, one of its customers had informed the licensee that it had received two unit doses for the same prescription. The licensee's investigation determined the computer system it had just installed allowed two technicians to fill the same prescription number at the same time. No patient was involved or affected by the error. The licensee is debugging the software to prevent the recurrence of this event. The licensee has also implemented a bar code system to track the production and shipping of doses. No violations were cited.

File closed.

I - 9064 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On April 4, 2013, the licensee reported to the Agency that it had discovered on March 28, 2013, there were errors with the physician's name on the labels of multiple dosages that were dispensed. One of its customers had found the error and alerted the licensee. The licensee conducted an investigation and identified a software malfunction in its recently upgraded proprietary software. The problem was corrected and all locations in Texas have implemented the procedural steps to prevent recurrence. No violations were cited.

File closed.

I - 9065 - * - Doctors Hospital at White Rock Lake - Dallas, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9066 - Radioactive Contamination - Hi-Tech Testing Service, Inc. - Wheeler County, Texas

On April 15, 2013, the Agency was notified that radioactive contamination was found in the bed of a radiography truck working in Wheeler County, Texas. The licensee had the crew pack up and return to the office in Seiling, Oklahoma. The contaminant was removed from the vehicle by the licensee and it was later identified as iridium-192. The exposure device and associated equipment were also found to be contaminated and a small amount of contamination was found on the sleeve of one radiographer's shirt. The exposure device and associated equipment was new and had not been used at any other site. The Agency performed surveys of the work areas at the site in Wheeler County and found no contamination. The ultimate source of the contamination, which is suspected to have occurred during manufacturing or packaging, has not been determined. No violations were cited.

File closed.

I - 9067 - Transportation Event - Cudd Pumping Services - Crystal City, Texas

On April 16, 2013, the Agency was notified that one of the licensee's trucks had had been involved in a single vehicle accident near Crystal City, Texas, in which the driver was killed. The truck was equipped with a Thermo Model 5192 fixed gauge densitometer that contained 200 millicuries of cesium-137 (original activity). These devices are a USA DOT 7A Type A container. The licensee reported that the gauge was still affixed to the truck and there was no radiation leakage or exposures to any individual. The source was secured by two separate physical barriers and other employees of the licensee that were following the truck were on-scene within a short period of time. It was determined that there was no reporting requirement for this event. No violations were cited.

File closed.

I - 9068 - Abandoned Well Logging Source(s) Down Hole - Baker Hughes Oilfield Operations, Inc. - Oldham County, Texas

On April 7, 2013, the licensee contacted the Agency to report that it was abandoning one 15 curie americium-beryllium source and one 2.5 curie cesium-137 source down hole. On April 8, 2013, it was reported by the licensee that the sources were abandoned at 9,613 feet and 9,623 feet respectively. A plug with 125 linear feet of red colored cement was completed. An open whipstock packer was set as a deflection device at 9,400 feet. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9069 - X-ray Radiography Equipment Failure - Union Tank Car Company - Houston, Texas

On April 19, 2013, the Agency received a report from a registrant's employee that several incidents involving x-ray radiography safety systems had occurred. Specifically, the registrant reported the failure of a light beam designed to terminate x-ray operations on a fixed bay (a safety interlock failure) and the failure of audible and visual alarms in another fixed bay. The report also alleged that the key to initiate an x-ray had broken off in the on/off switch for a unit and allowed the switch to be moved from standby to on without the key. The registrant stated all problems had been corrected. The Agency performed an on-site inspection on May 22, 2013. The inspection determined that the failures had been corrected. The inspection also found that while the registrant had provided the required written reports, it failed to make the 24 hour phone notice of the events to this Agency. Three violations were cited.

File closed.

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

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9071 - Stolen X-ray Equipment - Oceaneering International, Inc. - Houston, Texas

On April 22, 2013, the registrant reported a missing/stolen industrial x-ray device. The unit was a Thermo Scientific Positive Material Identification (PMI) device, model XLP2800. A technician had placed the device in an unlocked drawer in his desk instead of placing it into the controlled room where the registrant's protocol dictates it is supposed to be kept. The technician reported he was coming in early on a Saturday and did not want to have to wait for a person with access to the controlled room to get it. When the technician came in the next morning he discovered the device was missing. The licensee conducted a thorough search of the premises. When the device was not found, the registrant notified the Agency and local law enforcement. The Agency notified the Texas Association of Pawn Brokers. To prevent recurrence, the licensee has revised its procedures, increased security audits, and has ordered installation of permanently mounted storage boxes with employee badge card entry locks at the PMI workstations with a utilization log at each box as a secondary measure. One violation was cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9072 - Badge Overexposure - Mistras Group, Inc. - Deer Park, Texas

On April 24, 2013, the Agency was notified by the licensee that its dosimetry processor reported that a radiographer's badge read 15.87 rem for the month of March 2013. The licensee's investigation determined that the radiographer was leaving his badge in a bucket every day in the back of the truck after working on the late shift. Another crew was using the truck on day shift and was using the same equipment resulting in the badge being exposed to the camera during day shift operations. The radiographer was assessed a dose of 28 millirem for the month based on his infrequent radiography operations and log readings he recorded from a pocket dosimeter. The radiographer was assigned additional training. No violations were cited.

File closed.

I - 9073 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On April 24, 2013, the Agency was notified by the licensee that on April 3, 2013, it had been notified by one of its customers that the customer had ordered 4 dosages of technetium-99m (Tc-99m) sestamibi but had received 5 dosages. One of the doses was a duplicate for the same prescription number and calibration time and activity. The licensee confirmed the correct pharmaceutical was dispensed and that it was a duplicate label attached to an extra dosage of Tc-99m which was dispensed as a duplicate. The licensee reported it had recently upgraded its proprietary computer software used by the pharmacist to input orders and dispense radioactive drugs. The system is designed to avoid the printing of duplicate prescribed dosage labels. However, a previously undetected error in the system allowed this to occur in this isolated incident. The licensee initiated a system diagnostic check for corrections and the staff will check each order for duplicate labels on each product to verify the products shipped matches the product ordered. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I-9074 - Radiography Equipment Failure - METCO - Houston, Texas

On April 24, 2013, the Agency was notified by the licensee that it was unable to fully retract an 82.8 curie iridium-192 source into a QSA model 660 radiography device. The licensee reported two radiographers working at a field location were unable to lock the source in the fully shielded position. The radiographers contacted the licensee's radiation safety officer who responded to the location along with the licensee's source retrieval supervisor. The supervisor attempted to retract the source and on the second attempt dose rates indicated that the source was fully shielded, but the locking device had not tripped. The supervisor inserted the source shipping plug into the device to secure the source in place. The source crankout device was dismantled and they discovered the connector on the end of the drive cable had separated from the drive cable. The crankout device had been placed in service by the licensee on April 11, 2013. The exposure device was inspected by the licensee and found to be operating normally. No significant exposure was received by any individual involved in this event. The manufacturer stated it inspected the cable and connector and determined that the connector was not fully engaged on the drive cable when it was produced. The manufacturer stated it tested the equipment used to produce the crankout device and verified it was working properly. No violations were cited.

File closed.

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

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

File closed.

Incidents Opened Second Quarter 2013

I - 9076 - Badge Overexposure - Blazer Inspection, Inc. - Texas City, Texas

On May 7, 2013, the licensee notified to the Agency that its dosimetry processor that a radiographer's badge had read 4, 727 millirem for the reporting period March 20-April 19, 2013, and that the radiographer had exceeded the annual occupational exposure limit. The licensee's investigation determined that the exposure was to the badge only. The radiographer stated that on one occasion during the exposure period he had found his badge lying on the ground as he was preparing to leave a job site. He and another radiographer working with him assumed at the time he had just lost the badge while loading equipment onto a truck. The area where the badge had been found was within the area they had been performing radiography and would have received exposure. The licensee assigned the radiographer 416 millirem for the exposure period. No violations were cited.

File closed.

I - 9077 - Badge Overexposure - Thermo Process Instruments LP - Sugarland, Texas

On May 3, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that one of its employees had received a deep dose equivalent (DDE) reading of 4,344 millirem for the February 2013 exposure period. This gave the individual 5.6 rem for the year, exceeding the annual regulatory limit. The RSO conducted an investigation. The RSO stated dose rate surveys of the area where the worker was assigned were performed and the dose rate was 2.3 millirem per hour. Two employees who worked in the same area performing similar tasks received exposures much less than the worker with the high reading. The worker with the high reading worked in the area for one third the time of the other workers. The worker was interviewed and could not provide an explanation for the exposure. Based on the results of the RSO's investigation, the RSO determined that exposure was to the badge only and assigned the worker a DDE exposure of 546 millirem, which is the average dose the worker had received prior to this event. The RSO stated that they have relocated the storage location for neutron sources to an area away from the workers' area to reduce background radiation in the work area. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9078 – Radiography Source Disconnect - Non Destructive Inspection Corporation - Galena Park, Texas

On May 15, 2013, the licensee reported that one of its radiography teams had been unable to retract a 32.6 curie iridium-192 source back into a QSA Model 880 radiography camera at a temporary field site in Galena Park, Texas. The licensee's radiation safety officer (RSO) and a supervisor responded to the site. They covered the collimator containing the source with lead shot bags, then an individual authorized to perform source retrieval secured the source. The pocket dosimeter readings for the three were: RSO received 60 millirem; the supervisor received 50 millirem; individual performing source retrieval received 40 millirem. The licensee reported that the drive cable had broken right behind the male connector. No member of the public received any exposure as a result of this event. The source, camera, and equipment were sent to the manufacturer. The manufacturer reported that some of the internal wires in the drive cable looked like they had been damaged by a previous impact and over time the cable weakened further and separated. The licensee had all of its equipment inspected by a third party. No violations were cited

File closed.

I - 9079 - Radiography Source Disconnect - Mistras Group, Inc. - La Porte, Texas

On May 15, 2013, the licensee reported to the Agency that on May 14, 2013, one of its radiography crews had been unable to retract a 59.6 curie iridium-192 source back into the QSA Model 880 camera it was using. The radiography crew had dropped and damaged the crank assembly when it was moving the equipment between shots. The crew apparently failed to thoroughly check the crank assembly prior to the next shot. Following the next shot, the source could not be retracted. The licensee's radiation safety officer (RSO) was notified and he and another licensee employee, with assistance from the radiographers, performed the source retrieval (the camera and equipment had to be lowered to the ground from 40 feet inside a tank where the radiography was being performed in order to retrieve the source). The RSO reported that the connector at the end of the cable, which connects the cable to the pigtail, had come off of the cable--it was apparently damaged in the crank assembly accident. Readings from the pocket dosimeters were: RSO received 240 millirem; the other employee performing source retrieval received 40 millirem; and, the 3 radiography crew members received 300 millirem, 110 millirem, and 80 millirem, respectively. No member of the public received any exposure from this event. The radiographers involved were suspended and underwent retraining. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9080 - Access Restricted For Greater Than 24 Hours - Thermo Process Instruments LP - Sugar Land, Texas

On May 16, 2013, the Agency was notified by the licensee that a contamination event which required access to an area to be restricted for more than 24 hours due to an unplanned contamination event had occurred. The licensee stated it had received a drum containing 18 nuclear gauges. The licensee was to dismantle the gauges and dispose of the sources. The licensee stated the gauges had been leak tested by a North Carolina (NC) licensee and the leak test results were below regulatory levels. A contamination survey of the drum was performed before the gauges were removed. No contamination was detected. A worker removed the first gauge in preparation to remove the source. The gauge was a Berthold model LB 7400 gauge containing a 350 millicurie (original activity) cesium-137 source. When the worker opened the shutter of the gauge to remove the source, he found a piece of lead inside the gauge cavity between the gauge shutter and the source. As the worker removed the piece of lead he noted the background radiation readings were increasing. The worker stopped work and notified his supervisor. A contamination survey found that the worker's hands, shirt sleeves, the table top, the floor in the immediate work area, and the worker's personal dosimetry were contaminated. The worker's contaminated shirt and dosimetry were removed and his hands were decontaminated. The worker's face was surveyed for contamination and none was detected. The licensee's radiation safety officer (RSO) stated the worker was decontaminated within 15 minutes of the event occurring. The licensee attempted to decontaminate the table top and the floor in the work area, but some areas remained contaminated. Lead plates with fixed contamination labels were placed over the contaminated areas. The licensee has changed its procedure to require leak tests to be performed on all devices received at its facility. The licensee also instructed its personnel to be more cautious when handling gauges that appear to have been altered. The licensee contacted the NC licensee and notified them of the event. No violations were cited.

File closed.

I - 9081 - Abandoned Well Logging Sources Down Hole - Schlumberger Technology Corporation - Franklin County, Texas

On May 21, 2013, the licensee notified the Agency that it was abandoning a 1.7 curie cesium-137 source at 7,905 feet and a 10 curie americium-241/beryllium source at 7,902 feet down hole in a 7,968 foot oil well in Franklin County, Texas. The drill pipe became stuck on May 14, 2013. The licensee made unsuccessful attempts to free the pipe followed by three unsuccessful attempts to retrieve the sources from the logging while drilling (LWD) tool. Red-dyed cement was pumped through the inside of the drill pipe and up the open hole annulus to 7,500 feet to cement the LWD bottom hole assembly in place and seal and isolate the sources. After cementing, the rig cut the drill pipe at 6,513 feet, leaving 1,389 linear feet of heavy weight drill collars and drill pipe on top of the sources to serve as a deflection device and prevent inadvertent intrusion on the sources. A second cement plug was then set and the well will be side-tracked. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons with the radiation control program contact information. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9082 - Transportation Event - FedEx - Canyon, Texas

On May 21, 2013, an Agency inspector was notified by Amarillo Emergency Management that a truck operated by a common carrier had turned over on a major interstate just south of Canyon, Texas. The truck was carrying two packages of radioactive material. The inspector went to the location and assisted the local emergency response in finding and recovering the two packages. Neither package appeared to be damaged. Radiation surveys taken of the packages were consistent with the shipping documents. The carrier was allowed to transport the packages to their final destinations. The Texas licensees listed on the shipping documents to receive the packages were contacted by the Agency and made aware of the event. No violations were cited.

File closed.

I - 9083 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On May 21, 2013, the licensee reported that on May 16, 2013, one of its customers had reported a dispensing error. The customer had ordered 30 millicuries of technetium-99m sestamibi. When it received the order, the dose shielded container was properly labeled but inside was a syringe labeled 6 millicuries of technetium-99m mebrofenin. The licensee had placed the wrong dose in the shielded container. The licensee counseled its employees on the incident and instructed them to verify the label on the syringe with the dose shielded container. No violations were cited.

File closed.

I - 9084 - Nuclear Pharmacy Error - Cardinal Health 414 LLC dba Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On May 22, 2013, the licensee notified the Agency that on May 20, 2013, one of its customers had found that a dosage of iodine-123 sodium iodide it received was labeled for another facility. The licensee contacted the other facility and found that the dosage ordered by each customer had been switched in the shipping containers. The licensee retrieved both dosages and delivered the correctly labeled product to each customer. There was no patient involved. To prevent recurrence, the licensee counseled its pharmacy dispensers and staff involved with the event to follow proper procedures for product dispensing, followed by a verification of the customer's order and label on the product with the appropriate unit dose container. The pharmacy has implemented a new bar code tracking system for monitoring dispensing, labeling, and packaging. The topic is scheduled for discussion at the next staff meeting. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9085 - Damaged Device Containing Radioactive Material - KXR Inspection, Inc. - Sheridan, Texas

On May 23, 2013, the Agency was notified by a licensee that while performing work at a temporary work site a radiography crew was unable to retract a 55 curie iridium-192 source into a Spec 150 exposure device. The event occurred when a pipe jack fell on the source guide tube and crimped it. This prevented the source from being retracted into the camera. The source was covered with bags of lead shot to reduce the dose rates in the area. The licensee's radiation safety officer (RSO) used a pair of pliers to un-crimp the guide tube enough to allow the source to be returned to the exposure device. The RSO received 45 millirem for the entire operation. No exposure limits were exceeded. The RSO stated that the guide tube was removed from service and disposed. The licensee conducted a safety meeting and training with all of its radiographers and instructed them to ensure objects are secure before conducting radiography. No violations issued.

File closed.

I - 9086 - Abandoned Well Logging Source Down Hole - Sentry Geophysical - Wichita County, Texas

On May 28, 2013, the Agency received notice that a 6-curie americium-241/beryllium well logging source would be abandoned down hole in a well in Wichita County, Texas, as all retrieval attempts had failed. Cement with red dye was placed from 3700 ft to 3393 ft with a deflection device on top. A plaque was mounted at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The source was abandoned in accordance with Texas Railroad Commission and Agency regulations. The licensee failed to submit a written report within the required 30 days. This severity level four violation was not cited.

File closed.

I - 9087 - Abandoned Well Logging Sources Down Hole - Halliburton - Galveston, Texas

On May 29, 2013, the Agency was notified by the licensee that it was abandoning a 19 curie americium-241/beryllium source, a 2 curie cesium-137 source, and two small activity cesium-137 check sources down hole in a well site off the shore of Galveston, Texas. A red dyed cement plug of 1300 feet was placed from 8,525 feet, the bottom of the well hole, and encompassed the logging tool. A second red dye cement plug of 500 feet was set at 3,769 feet and a 200 foot cement plug was set at 375 feet. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. The well will not be produced. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9088 - * - The Methodist Hospital - Houston, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9089 - Radiography Source Misconnect - IRISNDT Matrix Corp. - Deer Park, Texas

On June 5, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that on June 4, 2013, one of its radiography crews was unable to retract a 97 curie iridium-192 source into a SPEC 150 camera. The misconnect occurred in the licensee's fixed shooting bay after the first shot of the day. The RSO and two other employees performed the source retrieval. Exposure readings from the pocket dosimeters for those involved in the retrieval were less than 55 millirem. An inspection of the drive cable by the RSO indicated the connector was bent. The radiographer stated the connector was not bent prior to connecting it to the source. The licensee reenacted the event, but was unable to replicate the failure. The licensee performed a disconnect test and the drive cable used during the event did fail. The RSO stated the technician was having a hard time connecting the ball to the assembly due to the tension on the spring pin. The RSO confirmed spring pin was working properly. The licensee's investigation determined the probable cause for the event was the technician partially connected the cables and during the process of cranking out the source the pigtail did not stay attached to the source drive cable. The exposure device and source assembly were leak tested and results were negative. The drive cables were removed from service due to the pigtail stem being bent. The licensee inspected its entire inventory of crankout devices. A notice has gone out to all company personnel regarding this incident. No violations were cited.

File closed.

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

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

File closed.

Incidents Opened Second Quarter 2013

I - 9091 - Stuck Gauge Shutters - NRG Texas Power LLC - Thompsons, Texas

On June 13, 2013, the licensee notified the Agency that on June 12, 2013, after completing maintenance of cables on hoppers at its facility and during shutter testing that followed, eight of its fixed nuclear gauge shutters failed to operate. The gauges were all Thermo Fisher Model #5197 and each contained a 100 millicurie cesium-137 source. The shutters were stuck in the open position, which is the normal operating position for these gauges. There was no increased exposure risk to any individual. The licensee had the eight gauges removed and, on September 4, 2013, properly transferred to a source/equipment manufacturer. No violations were cited.

File closed.

I - 9092 - Radiography Source Disconnect - NDE Solutions, LLC - Kenedy, Texas

On June 16, 2013, the licensee reported to the Agency they it had experienced a source disconnect on June 15, 2013. The radiography team cranked the 47.6 curie iridium-192 source out of the Delta 880 camera for the first shot of the day and then it was unable to retract the source back into the camera. The source retrieval was performed by authorized persons. The highest pocket dosimeter reading was 195 millirem, which was a higher dose than all film badge values for the source retrievers and radiographers. The manufacturer reported that wear conditions exceeded design specifications for the plug assembly and drive cable and may have contributed to the disconnect. The RSO reported that the radiographer trainee, who had only been working for two weeks, did not adequately connect and challenge the drive cable to the pigtail. The RSO will conduct training on proper connecting and challenging drive cables and on proper supervision of the trainee. No violations were cited.

File closed.

I - 9093 - Badge Only Overexposure - Nondestructive & Visual Inspections, LLC - Cotulla, Texas

On June 21, 2013, the Agency was notified by a licensee's radiation safety officer (RSO) that one of its radiographers had received a deep dose equivalent (DDE) reading of 422.129 rem for the May 2013 exposure period. The radiographer had worked from the beginning of May until May 19, 2013, with another radiographer, and that radiographer received 215 millirem for the same period. The licensee interviewed the radiographer and found the radiographer had stored his dosimetry in his luggage when he flew to Pennsylvania for a company transfer. The radiographer could not think of any time he could have received that much exposure. The dosimetry report from the processing company stated the exposure was irregular. The licensee determined the exposure appeared to be to the badge only. The licensee counseled the radiographer about proper care of his dosimetry. The licensee assigned a dose of 221 millirem for the exposure period based on exposure records. No violations were cited.

File closed.

Incidents Opened Second Quarter 2013

I - 9094 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On June 25th, 2013, the licensee notified the Agency that an error had been made in dispensing technitium-99m sestamibi. The licensee reported that one of its customers had ordered thirty millicuries, but the unit dose it received was only ten millicuries. The customer used the dose as received for the study. The licensee's investigation determined the nuclear pharmacist incorrectly entered the dose to be dispensed as ten millicuries. The licensee stated it had counseled the pharmacist involved in the event. The licensee has also installed a new system for verifying customers' orders prior to shipping. No violations were cited.

File closed.

I - 9095 - Possible Overexposure to Extremity - American X-Ray & Inspection - Karnes County, Texas

On June 25, 2013, the licensee notified the Agency of a possible overexposure to a radiographer trainee's hand. Subsequent written statements by the radiographer trainee, radiographer trainer, and the licensee's local manager revealed that the radiographer trainee went to set up for the next shot before the radiography source was retracted. The radiographer trainer was not watching the radiographer trainee at the time. The radiographer trainee did not have a working alarming rate meter and was not carrying a survey meter at the time. The licensee estimated exposure was 300.12 millirem to the hand and 18.76 millirem whole body, which was corroborated by dosimetry badge processing. It was determined that there was no overexposure. Two violations each were cited for the licensee and the radiographer trainer.

File closed.

I - 9096 - Equipment Malfunction - Union Tank Company - Houston, Texas

On June 26, 2013, the Agency was notified by the registrant that a light on the control panel for an x-ray radiography device that indicated the x-ray tube was energized had failed. The light was replaced that same day and the device was operating normally. The cause for the failure appeared to be from normal use. The licensee has ordered additional bulbs for the indicator. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9030 - Stolen Radioactive Material - Rone Engineering - Houston, Texas

On January 2, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that a Troxler model 3430 moisture/density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source could not be located at the licensee's facility. The licensee conducted an inventory of all of its gauges and accounted for all but one. The licensee's records indicated that the gauge had been returned by a technician and locked in the storage area on December 31, 2012. The licensee's tracking system, which tracks the location of its vehicles, confirmed that the truck used by the technician had been returned to the licensee's location at the close of business on December 31. The RSO stated that the storage area had no signs of tampering. The RSO stated that the technician assigned to use the gauge had been interviewed, but the technician did not provide any information useful to recover the gauge. The RSO stated that the local police had been notified of the theft. The RSO stated that the gauge was locked inside a transportation case and the operating rod was locked in the shielded position. The RSO stated that he did not believe there was any risk of exposure to a member of the general public. The Federal Bureau of Investigation interviewed the technician, vice president and RSO. They did not obtain any additional information for the event. No violations were cited.

File closed.

I - 9035 - Radiography Source Disconnect - Desert NDT, LLC - Abilene, Texas

On January 22, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that a radiography crew performing radiography operations at a field location had experienced a source disconnect. The crew was using an INC IR 100 exposure device containing a 38 curie iridium-192 source. The crew had performed nine exposures and was moving the camera to the next location when they discovered the source was still in the guide tube. A source recovery team was sent to the location and the source was returned to the exposure device and locked in the fully shielded position. The licensee determined that the radiographers failed to challenge the pig tail connection to the crank cable and they failed to conduct surveys of the camera and source tube after each use. The incident resulted in a whole body exposure of 791 millirem and an extremity exposure to the left hand of 2.8 rem to one of the radiographers. Additionally, an inspection by the manufacturer determined that two small crimps at the connector could cause the source to disconnect from the drive cable. Both radiographers received an additional 8 hour training course and the licensee briefed all company radiographers on the lessons learned from the incident. Three violations were cited.

File closed

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9036 - Expired Radioactive Material License - Frontera Materials Incorporated - Elsa, Texas

On January 23, 2013, the Incident Investigation Program (IIP) was asked by the Agency's Radioactive Material Licensing Group to investigate a moisture/density gauge licensee that had not renewed its license. A review of documents in the licensee's file and information provided by previous employees of the company determined that the gauges had been transferred to entities licensed to possess them. A letter was sent by IIP to the licensing group concurring with license termination. No violations were cited.

I - 9045 - * _____ - Methodist Rehabilitation Hospital - Dallas, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9047 - Equipment Malfunction - Sterigenics US, LLC - Fort Worth, Texas

On March 1, 2013, the Agency was notified by the licensee that on February 28, 2013, one of two source racks in its irradiator, which is used to sterilize medical supplies, failed to fully lower into its storage pool. The rack had descended 11 of 24 feet and was in the pool, but not fully at the bottom of the pool, when it stopped. The licensee stated all alarms and interlocks functioned as designed. The licensee determined that the motor for the hoist mechanism had failed. The motor was removed from the hoist mechanism and the sources descended fully into the pool. No exposure was received by any individual as a result of this event. The licensee stated that on March 1, 2013, the motor was replaced and successfully tested. No violations were cited.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9050 - Stolen Moisture/Density Gauge - CMT Engineering, Inc. - Lubbock, Texas

On March 7, 2013, the Agency was notified by the licensee that on March 6, 2013, a Troxler Model 4640 moisture/density gauge was stolen out of the back of one of its trucks at a temporary work site in Lubbock, Texas. The licensee reported that the technician had secured the gauge in the back of the truck and left the immediate area to speak with the contractor about the job. When he returned, he got in the truck and began driving to the licensee's facility. While in route, he observed that the tail gate was down. He stopped and discovered the gauge was gone and both locks had been cut. The licensee stated that local law enforcement had been immediately notified. Within 2 hours of the licensee's report to the Agency, the licensee notified the Agency that the gauge had been found. The licensee stated that a member of the general public (MGP) had found the gauge the night of March 6, 2013, but it was dark when he found it so he did not know what it was. The MGP stated the next morning when he saw what it was he contacted the licensee. The licensee retrieved the gauge and returned it to its facility. The licensee reviewed the event with its employees and reviewed company's policies regarding the use of these gauges. No violations were cited.

File closed.

I - 9051 - Overexposure - Central Texas Day Surgery Center, LP - Killeen, Texas

On March 11, 2013, the registrant reported to the Agency that its two physicians had potentially exceeded the regulatory dose limit for 2012. The physicians use fluoroscopy equipment at the facility. The registrant conducted an investigation and reported to the Agency that the two physicians' annual doses were 6,494 and 6,084 millirem. The registrant reported that no badges for any of their employees had been processed for the second quarter 2012 and one of the two physician's had not been monitored for the portion of first quarter 2012 that he was employed there. The registrant performed dose assessments and assigned doses for these missing quarterly doses. The registrant has implemented corrective actions to include training for all staff, improved daily/weekly monitoring of fluoroscopy times for the physicians, added protection with the installation of lead table skirts and additional protective eyewear for one physician, reduction in the use of fluoroscopy during procedures when it is not necessary, proper placement of the dosimetry at the collar as required, and review of practices and procedures to identify areas to reduce dose for all staff. Three violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9052 - Lost Equipment Containing Radioactive Material - Burge-Martinez Consulting, Inc. - San Antonio, Texas

On March 12, 2013, the Agency was notified by the licensee that one of its technicians had lost a Troxler moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was lost somewhere between the licensee's office in San Antonio, Texas, and the job location in Pflugerville, Texas. The technician stated that when he arrived at the work site he found the tailgate of the truck was down and the gauge was missing. The chains and locks for securing the gauge during transport were not cut. The licensee's radiation safety officer (RSO) stated that both the case and operating rod were locked. The RSO stated the San Antonio police, the County Police, and Texas Department of Transportation had been notified of the event. At 1132 hours that same day, the local police contacted the RSO and stated they had located the gauge in the median of the access road at the exit to the licensee's facility. The RSO stated he went to the location and surveyed the gauge and all readings were normal. The gauge was not damaged. The licensee's investigation determined that the technician failed to lock the gauge into the truck prior to leaving the licensee's facility. The licensee conducted a safety meeting with all of its technicians to review the company's radiation safety policies. One violation was cited.

File closed.

I - 9053 - Abandoned Well Logging Sources Down Hole - Allied Wireline Services - Reagan County, Texas

On March 16, 2013, the licensee contacted the Agency to report that it was abandoning two well logging sources, 11 millicuries of californium-254 and 2 curies of cesium-137, down hole. The sources were abandoned at 6,291 feet. A plug with a 610 foot column of Class H red dyed cement was completed. A whip stock was installed at 5681 feet above the cement plug as a deflection device. A plaque was installed at the well site as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

I - 9058 - * - Seton Medical Center - Round Rock, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9059 - Medical Event - Rosa of North Dallas, LLC - Dallas, Texas

On March 28, 2013, the Agency was notified by the licensee that a medical event had occurred on March 27, 2013. The licensee stated the event occurred when the wrong length guide tube was used during 3 of 4 high dose rate brachytherapy treatments. The error was discovered prior to the fourth treatment. The radiation safety officer (RSO) stated the intended treatment area was underdosed by more than 50 percent. The treatment plan prescribed 2400 centigray (cGy) over four treatments, but the intended treatment site received 1,390 cGy instead. Two areas other than the intended treatment site received total doses in four treatments of 1,607 cGy and 1,549 cGy. The RSO stated that the patient and the patient's physician were notified as soon as the error was discovered. The patient's physician stated the patient would be monitored over the next several months for effects to tissue that received higher than intended exposure. To prevent recurrence of this type of event, the licensee made changes to its operating procedures and training program for physicists. The licensee also labeled all of the guide tubes to indicate their length. No violations were cited.

File closed.

I - 9060 - Damaged Radiography Equipment - Petrochem Inspection Services - Port Arthur, Texas

On March 27, 2013, the Agency was notified by the licensee that a pipe had fallen onto a Sentinel Model 880 Delta exposure device's guide tube at a temporary field site preventing the retraction of the 51 curie iridium-192 source. The source was recovered by a licensee employee according to the terms of its license. The employee received 475 millirem whole body exposure and 1.75 rem exposure to the hand. The radiographer trainer and radiographer trainee that had performed the initial setup received training regarding potential hazards. No violations were cited.

File closed.

I - 9061 - * - NIX Healthcare System - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2013

I - 9062 - * - Hill Country Memorial Hospital - Fredericksburg, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Complaints Opened Second Quarter 2013

C - 2468 - Regulatory Violations - Crossroads Animal Clinic - Houston, Texas

On April 4, 2013, the Agency received an anonymous complaint regarding scatter radiation to a person holding an animal during an x-ray at a registered veterinary clinic. The complainant sent a copy of the x-ray film of an animal showing a ring and hand on the film. On April 23, 2013, the Agency conducted an on-site investigation. The incident occurred on April 27, 2012, and was an isolated incident by a previous employee. Over 25 x-ray films from March to June 2012 were reviewed. The Agency was unable to find another occurrence where a hand was in the x-ray field. The registrant's radiation safety officer plans to discuss the incident during training. The facility demonstrated proper collimation of the x-ray field and procedures to hold animals for x-rays. No violations were cited.

File closed

C - 2469 - Regulatory Violations - NDT LLC - Henderson, Texas

On April 10, 2013, the Agency received a complaint alleging the licensee was not processing personnel dosimetry within the required time frame. The complaint also alleged that individuals were performing radiography duties they were not qualified for. On May 10, 2013, the Agency received additional information alleging that several individuals were not qualified to perform radiography operations. On May 29, 2013, an Agency inspector performed an on-site inspection at the licensee's location. The inspector found the licensee had failed to submit personnel dosimetry for processing within the required time frame on several occasions. The inspector could not substantiate the allegation regarding qualifications. The complaint was partially substantiated. One violation was cited.

File closed.

C - 2470 - Unauthorized Disposal - Lovins Trucking - Canadian, Texas

On April 8, 2013, the Agency received a referred complaint that the entity was disposing of scrap metal contaminated with naturally occurring radioactive material by burial. An Agency inspector was dispatched to investigate the site and take radiation measurements. There was no evidence of radioactive material disposal. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2013

C - 2471 - Uncredentialed X-ray Technicians - 1st Class Urgent Care Center, PLLC - Mesquite, Texas

On April 19, 2013, the Agency received an anonymous complaint alleging the registrant was allowing employees who were not properly trained and credentialed to take x-rays of patients at the facility. The complaint also alleged that the employees' radiation exposure was not being monitored. The Agency conducted an on-site investigation in conjunction with the facility's routine x-ray inspection. No violations of Agency rules and regulations were noted. The complaint was not substantiated.

File closed.

C - 2472 - Laser Injury - Shea Essence Day Spa - Sugar Land, Texas

On April 19, 2013, the Agency received a complaint stating the complainant had suffered a laser burn during a hyperpigmentation treatment. The burn was confirmed by medical records from the treating physician. On April 23, 2013, the Agency conducted an on-site investigation. The facility started offering laser hair removal (LHR) and hyperpigmentation services on April 6, 2013, using an LHR Technician who was registered with the Agency. However, the facility was not registered to conduct LHR, it had no physician agreement, and it did not report the injury to the Agency within 24 hours as required. The burn occurred while conducting test spots with an IPL device. The machine was purchased by the LHR Technician without a physician's prescription. This information was passed along to the Agency's Drugs and Medical Devices group. The complaint was substantiated. Three violations were cited.

File closed.

C - 2473 - X-ray Machine Operation - Texas Gulf Coast Medical Group - Webster, Texas

On April, 19, 2013 the Agency received a complaint alleging the registrant was using settings on x-ray equipment that were inappropriate for various examinations. An Agency inspector performed an on-site inspection/investigation on May 31, 2013. The inspector found that the registrant had the appropriate technique charts for the studies they conducted. The inspector was not able to substantiate the allegation. No violations were cited.

File closed.

Complaints Opened Second Quarter 2013

C-2474 - Unregistered Use of X-ray Machines - Victoria Radiology Associates - Victoria, Texas

On April 24, 2013, an individual called the Agency to request information concerning safety of employees working next to an x-ray imaging room and requirements for shielding, testing of the x-ray machines and their output, and for determining dose to all employees in the area. He referenced the registrant. The individual was provided with internet links to the Agency's rules and regulations and the open records request process. During the attempt to address the individual's concerns about the particular facility, the Agency investigator could not find a current registration for the facility. This complaint file was opened to address the individual's concerns and the registration issue. The individual then stated that the registrant had moved its machines and quit taking x-rays approximately 2 years ago and that his concerns were for the years prior. Agency records revealed the registrant had terminated its registration 2008 and there was no information in routine inspection reports to support the individual's concerns. The individual did request records through the open records request. The complaint was not substantiated. No violations were cited.

File closed.

C-2475 - Uncredentialed X-ray Technicians - Orthopedic Associates of Central Texas - Round Rock, Texas

On May 3, 2013, the Agency received several complaints about a registrant. The complainant reported that at one site the registrant used a Limited Medical Radiologic Technologist (LMRT) to take x-rays for several years after the LMRT's license had expired. Additionally, at another site a non-registered technician conducted fluoroscopy multiple times on patients. The Agency reviewed the LMRT license information and conducted two phone call interviews. The individual's Temporary LMRT license expired in May 2008; however, the LMRT continued operating an x-ray machine until February 2011 until the violation was discovered during an internal audit. A medical assistant that was interviewed by the Agency admitted to assisting a physician during fluoroscopic treatments and energizing the beam at least three times. One of the physicians and the medical assistant were not issued or using film badges while operating the fluoroscopy machine. The complaint was substantiated. Three violations were cited.

File closed.

Complaints Opened Second Quarter 2013

C - 2476 - Unregistered Laser Facility - Bella Vi Skin and Laser Center - Garland, Texas

On May 13, 2013, the Agency received an anonymous complaint that a facility was advertising it would be providing laser procedures and laser hair removal and the facility was not registered with the Agency. The Agency's investigation found that the facility was not yet open for business. Also, the facility will be run as a medical office by a licensed physician who will perform all laser hair removal procedures. All procedures will be performed with an intense pulsed light machine and not a laser. The facility was exempt from registration requirements. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2477 - Unregistered Laser Hair Removal Facility - M.Pulse - Plano, Texas

On May 15, 2013, the Agency received information that there were two facilities owned by the same entity that were alleged to be performing laser procedures and laser hair removal without being properly registered with the Agency. The Agency's investigation revealed that under the applicable rules, the facilities were not required to register with the Agency. However, the owner of the facilities had submitted applications for registration under laser and laser hair removal facility rules (the Agency received them after the initial search for registration). The facilities' owner knew there was no requirement to register, but elected to register anyway. The complaint was not substantiated. No violations were cited.

File closed.

C - 2478 - Regulatory Violation - Texas Alliance Medical Group - Houston, Texas

On May 14, 2013, the Agency received a complaint that the registrant was using an x-ray machine that was overdue for an equipment performance evaluation (EPE) on March 16, 2013. A review of the registrant's file documented the results of an Agency's inspection on November 30, 2012, in which the registrant was issued a violation for completing the EPE late. Additionally, a review of the file indicated that the registrant had over a half dozen violations for completing EPE's late at multiple sites. Agency personnel have been notified to monitor the registrant closely for future repeat violations. The complaint was substantiated. No violations were cited.

File closed

Complaints Opened Second Quarter 2013

C - 2479 - Unregistered Laser Facility - Clean Slate Laser Tattoo Removal - Amarillo, Texas

On May 22, 2012, the Agency received a complaint that the entity was performing laser tattoo removal with a class IV laser, was not registered with the Agency, and it was operating without medical director. On May 23, 2013, the Agency contacted the facility owner and confirmed they were in the possession of a class IV laser. The owner stated that he was not aware of the registration requirement and that he would submit the required documents and fees. On June 21, 2013, a search of VERSA did not find an application for the location. The owner was again contacted. He stated that the document and fee had been mailed on June 20, 2013. On July 10, 2013, the Agency received a registration application and payment from the entity. The application is being processed. No violations were cited.

File closed.

C - 2480 - Possible Exposure to Member of General Public - University of Houston - Houston, Texas

On May 22, 2013, the Agency received an anonymous complaint concerning the use of x-rays in a university's lab. The complainant was concerned for his/her safety and wanted someone to ensure that the users had adequate knowledge, experience, and/or certification to work with radiation. The Agency performed a survey of the laboratory configuration and reviewed area monitoring records. The operators of the device had received radiation training from the university. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2481 - Badge Overexposure - San Antonio Targeted Radiation Cancer Center, LP - San Antonio, Texas

On May 28, 2013, the Agency received a complaint alleging that a worker at the registrant's facility had received 313,950 millirem during an exposure period in 2013. The complainant stated that the registrant had not made any attempt to explain the exposure to the worker. The Agency conducted an on-site investigation at the facility on May 31, 2013. The inspection found that the registrant's records confirmed the exposure to a worker at the facility. The worker in question was employed by a company other than the registrant. The registrant stated that the worker's employer was working on the investigation into the exposure. The employee whose badge had received the exposure stated that she did not know how she could have received the exposure recorded by the badge. The registrant conducted additional surveys around the control area and found the readings to be consistent with the initial area survey. The registrant's investigation determined that the individual did not receive the exposure indicated on the badge and assigned a dose of 21 millirem to the individual for the exposure period. No violations were cited.

File closed.

Complaints Opened Second Quarter 2013

C - 2482 - Unregistered Laser Facilities - Amerejuve, Inc. - Houston, Texas

On June 4, 2013, during a search for requested information concerning whether a laser hair removal facility was registered, the Agency found that an entity was operating multiple laser/laser hair removal facilities in the Houston area and they were not registered with the Agency. An Agency investigator contacted the entity and the entity's representative agreed to submit proper applications and fees. In August 2013 the Agency received a laser registration application and a laser hair facility registration application for only one of the locations and the appropriate fees had not been submitted for the LHR facility registration. In October 2013 the entity's representative was contacted again. He stated they had sent only one through to make sure everything was correct/complete before sending the others. He was advised that the entity should immediately submit all appropriate applications and fees for all of its locations. The investigation into this complaint is ongoing.

File open.

C - 2483 - Unregistered Laser Facility - Eden Laser MedSpa and Salon - Portland, Texas

On June 4, 2013, the Agency received a complaint that alleged a technician had been performing laser procedures and was not properly registered to do so. During the Agency's investigation, it was discovered that neither the facility nor the technician named in the complaint were registered for laser hair removal as required. The facility owner stated that they had been performing laser hair removal procedures, but she did not realize they had to register. The technician is no longer employed at the facility. As corrective action, the owner opted to cease performing any hair removal procedures at the facility and immediately removed laser hair removal advertising from their website and ordered new brochures. The facility will continue to use an intense pulsed light (IPL) device for procedures other than hair removal. The owner was made aware of applicable regulations that must be followed and registration requirements should they get a class 3b or 4 laser or decide to perform hair removal in the future. The complaint was substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2013

C - 2429 - Unregistered Laser Facility - Skin Care LLC - McAllen, Texas

On September 18, 2012, the Agency received a complaint that a facility registered for laser use on humans had moved and not amended its registration, that the Laser Safety Officer was no longer associated with the facility, and that the facility was performing laser hair removal and had not registered as a laser hair removal facility. After extended communications with the registrant concerning compliance and receipt of another complaint, the Agency conducted an on-site investigation. During the on-site investigation, an Agency inspector found the registrant possessed one class 4 laser unit that was not fully assembled and was not in operation and two intense pulsed light machines. The registrant stated she was still seeking a doctor to oversee operations as required and would submit the proper application as soon as she could meet rule requirements. The complaint was substantiated. Since the registrant ceased operations until compliance could be attained, no violations were cited.

File closed.

C - 2440 - * - Texas Health Presbyterian Hospital WNJ - Sherman, Texas

*Health and Safety Code Chapter 241.051(d)

The complaint was not substantiated. No violations were cited.

File closed.

C - 2460 - Regulation Violations - Howmet Castings & Services, Inc. - Wichita Falls, Texas

On March 5, 2013, the Agency received an anonymous complaint alleging that the x-ray machines at the registrant's facility were not being properly checked for radiation leakage, that there was no active radiation safety officer present, and that there were employees operating the x-ray machines who were not properly certified. The Agency performed an on-site investigation on April 15, 2013. A review of maintenance documents did not find any discrepancies. A review of the last three exposure reports did not find any unusual exposure readings. A copy of the current operating procedures was located at each x-ray device. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2013

C - 2461 - Unsafe Practice/Unregistered Laser Facility - Aqua Blue Beauty and Bodyworks - Pflugerville, Texas

On March 8, 2013, the Agency received an anonymous complaint alleging the technician performing a photo facial had removed the complainant's eye protection. The complainant did not have an injury but was concerned that this could result in an injury to someone in the future. During the Agency's investigation the technician stated that on occasion she had removed the protective eyewear but left moist cotton rounds over the individual's eyes and also covered the eyes with her hand in order to treat the area between the eyebrows which would have been covered by the eyewear. The owner of the facility stated she has instructed the technician on the correct procedure and has ordered acceptable alternative eye protection to use in this type of situation. It was also discovered that the facility was not registered with this Agency for lasers or as a laser hair removal facility. The owner took immediate corrective action and submitted the appropriate applications and fees. The complaint was substantiated. No violations were cited.

File closed.

C - 2462 - Nonregistered Technicians - Brown Dental Health Management, Inc. - Fort Worth, Texas

On March 23, 2013, the Agency received a complaint from a dentist stating that non-credentialed clerical workers were sent out to take dental x-rays using a mobile unit. Additionally, they did not ensure lead aprons were used on patients and many exposures were not useable for diagnostics and had to be retaken. The Agency conducted an on-site investigation on April 16, 2013. The new x-ray technician was interviewed and operation of the equipment was tested. The new certified technician is using aprons and is the only person currently taking x-rays. One administrative assistant admitted helping a previous technician at least four times and pushing the button on the mobile x-ray unit while the technician was holding the film in the patients mouth. This information was forwarded to the Texas Dental Board. The other issues in the complaint could not be substantiated. Three non-related violations were cited.

File closed

C - 2463 - Regulatory Violation – Bexar County Hospital District dba University Health System – San Antonio - San Antonio,

On March 22, 2013, the Agency received a complaint alleging that the reviewing physician's name on mammography studies had been changed to a physician who had not reviewed the film. An on-site investigation was performed by the Agency on April 4, 2013. The investigation found that the reports provided by the complainant were for internal use only and were not used in any official capacity. The reports provided to the patients and their physicians included the appropriate physician's name. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2013

C - 2464 - Not Registered for Radiation Machine - Dr. Peter Mah - San Antonio, Texas

On March 25, 2013, the Agency received a complaint referred from the Texas Commission on Environmental Quality (TCEQ). An anonymous complainant had contacted them alleging that an individual was collecting, storing, and modifying new and old imaging and radiography equipment in his home. The complainant was concerned the equipment could generate radiation and he/she did not know if the equipment was registered and tested per Agency regulations or if it was being disposed of per TCEQ regulations. The Agency conducted an on-site investigation. The individual did have at least 5 x-ray devices at his residence but there was no evidence that they were being energized, that he was performing any salvage activities, and none of the units contained hazardous chemicals that would be an issue with disposal. There was no apparent risk to the public health and the individual is aware of the regulations concerning use and disposal. No violations were cited.

File closed.

C - 2466 - Regulatory Violation - Digital Motion X-ray - Palm Harbor, Florida

On April 25, 2013, the Agency was contacted by a registrant who reported that he had discovered that his x-ray device had been installed by a company who did not have a valid Texas registration. A review of the registrant's file did not find any document indicating the device had been installed by the company alleged to have installed it. There were documents indicating the company had removed the device from the registrant's location. The Agency made seven attempts to contact the company, which is located in Palm Harbor, Florida. Several messages were left with the company's receptionist, but company management did not return the calls. On May 28, 2013, the Agency contacted the State of Florida's Bureau of Radiation Control and made them aware of the complaint. Repeated attempts to contact the Texas registrant were also unsuccessful. No violations were cited.

File closed.

C - 2467 - Not Licensed For Radioactive Material - Lydick Engineers and Surveyors, Inc. - Clovis, New Mexico

On March 26, 2013, the Agency received a request from the Region IV Nuclear Regulatory Commission (NRC) office requesting the status of an allegation against a State of New Mexico licensee it had received in January 2013. The allegation was that the licensee had used radioactive material in the State of Texas without requesting reciprocity. The New Mexico licensee was contacted and the radiation safety officer (RSO) stated that they were not aware that the New Mexico license did not allow them to work in the State of Texas without authorization from Texas. The RSO stated the licensee had used radioactive material in Texas on one occasion in June 2012. The device was a Seaman moisture/density gauge containing licensable quantities of americium-241 and cesium-137. On March 28, 2013, the Agency received a copy of the application for reciprocity from the New Mexico licensee. One violation was cited.

File closed.