



**INCIDENT AND COMPLAINT SUMMARIES
FOR THE
THIRD QUARTER 2011***

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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.

**Incident and Complaint Summaries
3rd Quarter 2011**

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Incidents Opened Third Quarter 2011

I - 8866 - *

- Christus St. John Hospital - Nassau Bay, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8867 - Source Disconnect - Texas QA Services, Inc. - Grand Prairie, Texas

On July 6, 2011, the Agency received a written report from the licensee's Radiation Safety Officer (RSO) that on June 27, 2011, there was a source disconnection on an Amersham Model 660B device containing 22 curies of iridium-192 at a temporary field site in Weatherford, Texas. Upon discovering the disconnection, the radiographers roped off the area at the 2 millirem/hour boundary and notified the RSO. The RSO arrived on site and confirmed that the source was disconnected. The RSO performed the retrieval by removing the source tube from the camera, shaking the source out of the source tube and placing a lead shield and bag(s) of lead shot over the source with the pigtail exposed. He reconnected the drive cable and the source was cranked back into the camera. The camera was disconnected so that the drive cable and the pigtail connectors could be inspected. No damage was noted and the camera was immediately returned to service. The RSO stayed on site approximately one hour to make sure there were no more issues. As a result of his investigation, the RSO determined that the radiographers had failed to connect the pigtail to the drive cable before cranking out the source. The RSO reported that he received a dose of 52 mrem. There was no other occupational dose or dose to any member of the public. Corrective action by the licensee included discussion of the event at the next safety meeting and the radiographers were instructed to pay attention to safety and the process of connecting the drive cable to the source. No violations were cited.

File closed.

I - 8868 - Therapy Event - North Texas Cancer Center at Wise - Decatur, Texas

On July 7, 2011, the Agency was notified by a cancer center licensee that there had been a therapy event in which a treatment was given to the wrong patient. The event occurred when a technologist had loaded a treatment plan anticipating the arrival of a patient to be treated with an external beam from a linear accelerator. When the patient failed to arrive for treatment, another patient was pushed forward on the schedule and the plan was not changed to the new patient. The treatment lasted less than one minute and delivered a dose of 36.2 centigray to an area of the patient's body that was not part of that patient's treatment plan. The dosimetrist, health physicist, and physician concurred that the radiation delivered to the patient did not pose a health risk or have a measurable effect on the patient. The licensee conducted in-service training with the staff to review the event and the patient identification policy. No violations were cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8869 - Gauge Shutter Failure - Sherwin Alumina LP - Gregory, Texas

On July 15, 2011, the Agency received an email from the licensee's Radiation Safety Officer (RSO) stating that the shutter on a Kay-Ray model 7062P nuclear gauge containing 100 millicuries of cesium -137 was loose and it would completely shield the source when it was in the closed position. The manufacturer was contacted and the gauge was replaced by the manufacturer on October 18, 2011. No violations were cited.

File closed.

I - 8870 - Gauge Shutter Failure - Sherwin Alumina LP - Gregory, Texas

On July 15, 2011, the Agency received an email from the licensee's Radiation Safety Officer (RSO) stating that the shutter on a Texas Nuclear model 5176 nuclear gauge containing 500 millicuries cesium-137 was stuck in the open position. Open is the normal operating position for this gauge and it does not present an exposure hazard to any individual. The licensee contacted a service provider to repair or replace the gauge. The service provider determined that the gauge was not repairable and replaced it on October 18, 2011. No violations were cited.

File closed.

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. No abnormalities were noted. The investigation into this event is on going.

File open.

Incidents Opened Third Quarter 2011

I - 8872 - Gauge Shutter Failure - Invista SARL - La Porte, Texas

On July 19, 2011, the Agency received a call from the licensee's Radiation Safety Officer reporting that the shutter handle on an Ohmart/Vega gauge model SHLG-1, containing 300 millicuries of cesium-137, broke off during a routine inspection on April 7, 2011. The gauge failed in the open position, which is its normal operating position. The gauge had been exposed to condensation from a steam leak from above which caused the handle to rust. A vendor shut the gauge shutter on June 30, 2011. Because the tank is no longer used, the gauge will be removed and disposed. The failure did not create any additional exposure to any individual. The licensee failed to report the event to the Agency within 24 hours as required. One violation were cited.

File closed.

I - 8873 - Safety Device Failed To Operate As Designed - Brazos Valley Inspection Services - Bryan, Texas

On July 20, 2011, the Agency was notified by the licensee that the locking device on an INC IR-100 radiography camera containing an 82 curie iridium-192 source had failed. The radiographer had completed an exposure and retracted the source to its fully shielded position. The radiographer surveyed the camera and found the readings to be normal. When he disconnected the drive cable from the source pigtail, he found that the pig tail was no longer protruding from the back of the camera, but was now flush with the rear of the device. The shipping plug and the front dust cover were placed on the camera. The device was returned to the manufacturer for inspection and repair. The manufacturer determined that the locking device had failed due to normal use and wear. The camera was manufactured in June 1997. No violations were cited.

File closed.

I - 8874 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On July 14, 2011, the Agency was notified by a nuclear pharmacy licensee that a unit dose for a hospital was inadvertently delivered to the wrong hospital. The receiving hospital found the error and notified the licensee. The licensee retrieved the package and delivered the correct radiopharmaceutical to the hospital. The incorrect radiopharmaceutical had not been administered to any patient. The licensee's investigation determined that the individual packaging the shipment inadvertently switched the unit doses for two hospitals. The licensee has reviewed this event and counseled all the employees responsible for packaging of doses to make certain the correct material is shipped. No violations were cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8875 - Stolen Radioactive Material - Coastal Testing Laboratories, Inc. - Houston, Texas

On July 26, 2011, the Agency was notified by the licensee that a Humbolt 5001 EZ moisture/density gauge was stolen out of one of its trucks in Houston, Texas. The gauge contained a 40 millicurie americium-241/beryllium source and a 10 millicurie cesium-137 source. The gauge was locked in the back of a pickup truck parked at a training center where the user was attending safety training. When the user returned to the truck, he found the lock and chain securing the gauge had been cut and the transport case with the gauge was missing. The user contacted his employer who then contacted local law enforcement. The Agency's investigation found that the gauge had been secured in the truck using only one barrier instead of two independent barriers as required by rule. The licensee has changed its procedure to require two independent locking devices when the device is not under direct surveillance by the technician. The licensee was cited for one violation.

File closed.

I - 8876 - Radioactive Material Identified at Landfill - ProTechnics - Itasca, Texas

On July 27, 2011, the Agency was notified by a landfill in Itasca, Texas, that its radiation monitor had alarmed when a roll off container entered its gate. The landfill had used its portable radioisotope identification equipment and identified the material as iridium-192. According to the shipping manifest for the container, the contents was from a single source—an well site in northern Texas. During the Agency's investigation it was learned that the licensee had performed tracer studies during well fracturing operations at the well site. The well operator failed to notify the licensee of a sandout/flowback event and the frac sand was taken to the landfill for disposal without being surveyed by the licensee. The frac sand containing the radioactive tracer was disposed at an authorized facility. No violations were cited.

File closed.

I - 8877 - Radioactive Material Identified at Landfill – ProTechnics – Itasca, Texas

On August 6, 2011, the Agency was notified by a landfill in Itasca, Texas, that its radiation monitor had alarmed when a roll off container entered its gate. The landfill had used its portable radioisotope identification equipment and identified the material as iridium-192. The container was being brought from a gas/oil well in Johnson County. During the Agency's investigation it was learned that the licensee had performed tracer studies during well fracturing operations at the well site. The well operator failed to notify the licensee of a sandout/flowback event and the frac sand was taken to the landfill for disposal without being surveyed by the licensee. The frac sand containing the radioactive tracer is being stored pending authorized disposal. No violations were cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8878 - Gauge Shutter Failure - Zilkha Biomass Crockett Energy LLC - Houston, Texas

On August 17, 2011, the Agency was notified by the licensee that it was unable to open the shutter on a Ronan Engineering model GS 400 nuclear gauge containing 20 millicuries of cesium-137. The gauge had been taken out of service by the licensee to conduct maintenance in the area around the gauge. Once the work was completed, they were unable to open the gauge shutter. The licensee took the gauge out of service until it could be replaced. The gauge did not present an exposure hazard to anyone. The licensee's Radiation Safety Officer stated that the gauge had been opened/closed several times since it was installed. The gauge was replaced by the manufacturer. The manufacturer inspected the gauge and found that a cotter pin had bent preventing the shutter from opening far enough for the detector to see an increase in radiation levels, thus giving a closed indication. No violations were cited.

File closed.

I - 8879 - Damaged Moisture/Density Gauge - Geotech Engineering and Testing - Houston, Texas

On August 18, 2011, the Agency was notified by a licensee that on August 17, 2011, one of its Humbolt 5001 EZ moisture density gauges, containing a 44 millicurie americium-241/beryllium source and an 11 millicurie cesium-137 source, was run over by a dirt compactor at a work site. Following its investigation, the licensee reported that the gauge user was in the process of standardizing the gauge prior to use. He had placed the gauge on the ground and then returned to his pickup, which was approximately 10-12 feet away, to retrieve paper to record the standard counts. It was at that time that a soil compactor entered the area and ran over the gauge. The user attempted to get the driver's attention but was unable to stop him before he ran over the gauge. The sources were in the fully shielded position at the time. Following the incident, radiation surveys were performed and it was determined that the sources were still fully shielded. A licensed service company took the gauge to its facility and performed survey and source leak tests--the results were all negative. A decision will be made by the licensee whether to repair or replace the device, at which time (for either decision) the device will be returned to the manufacturer. One violation was cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8880 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On August 24, 2011, the Agency received written notice that the licensee was notified by a hospital that it had received a unit dose of the wrong radiopharmaceutical. The licensee reviewed its orders and found that the unit dose delivered should have gone to a different hospital. The licensee contacted the second hospital and confirmed it had also received the wrong radiopharmaceutical. The licensee retrieved the unit doses and delivered the correct doses to the hospitals. No patients were treated with incorrect radiopharmaceutical. The licensee's investigation found that the unit doses had been placed in the wrong shipping package by the dispensing pharmacist and the individual preparing the packages for shipment failed to verify the prescription labels with the shipping papers. The licensee counseled all employees involved in the event. No violations were cited.

File closed.

I - 8881 - Nuclear Pharmacy Error - Cardinal Health National Nuclear Pharmacy - Abilene, Texas

On August 31, 2011, the Agency was notified by the licensee that on August 24, 2011, a package containing an iodine-123 unit dose was delivered to the wrong hospital. The licensee contacted the hospital that had received the package and informed them of the error. The licensee went to the hospital and retrieved the package and delivered it to the correct location. The licensee counseled all employees involved in the event and held a staff meeting to discuss the event. No violations were cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8882 - Equipment Malfunction - IRIS NDT – Deer Park, Texas

On September 6, 2011, the Agency was notified by the licensee that while using a Spec150 radiography camera containing a 47.2 curie iridium-192 source, the guide tube disconnected from the camera and the source disconnected from the drive cable. The radiographer noted the problem when he began cranking the source out for the eighth exposure of the day and saw the drive cable spooling in front of the camera. The radiographer made two attempts to retract the source into the camera, but dose rate surveys taken as the radiographer approached the camera indicated that the source was not shielded. The radiographer walked around to the side of the camera at a distance of 30 feet and saw the source laying in front of the camera. He contacted the licensee's Radiation Safety Officer and a source recovery team was sent to the location. The source was shielded with bags of lead shot using eight foot tongs. The camera was placed near the source and seven feet of drive cable was cranked out of the front of the camera. The recovery team did three mock connections and retractions simulating the conditions. The recovery team then performed the source recovery without incident. No individual involved in the recovery received an exposure greater than 35 millirem for the recovery. The licensee determined that the quick disconnect on the guide tube was worn and failed. The disconnect was replaced. The licensee inspected the quick disconnects on all of its cameras and replaced them as needed. The licensee also instructed its radiographers to periodically check the connection of the guide tube to the camera throughout their shift. No violations were cited.

File closed.

I - 8883 - Medical Event - The University of Texas M. D. Anderson Cancer Center - Houston, Texas

On September 13, 2011, the Agency was notified by the licensee that it had determined that a medical event had occurred at its facility. The licensee reported that on September 9, 2011, a patient had undergone a therapy procedure which involved insertion of yttrium-90 microspheres into the treatment site. The patient's prescribed dose was to be 80 gray. It was determined that the patient had received a dose of 49 gray (22.3 millicuries administered), which is 39% less than the prescribed dose. A thorough examination of the device was completed by the manufacturer and licensee on October 26, 2011. The device showed that the white needle injector assembly had not been fully engaged with the dose vial acrylic shield and that the needles had penetrated the septum at an angle. There were no apparent defects noted with the device or any associated pieces, including the dose vial acrylic shield. Re-assembly of the parts showed that the injector could be properly engaged. Apparently the leakage, which prevented complete delivery of the dose, occurred between the needles and the septum due to the angle of insertion. The root cause was concluded to be that the injector assembly was not properly engaged with the dose vial acrylic shield. The cause of the event has been discussed with the licensee's personnel that provide this type of therapy. The licensee has made changes to its internal procedure for delivering this therapy to ensure that the injector assembly is properly engaged with the dose vial acrylic shield. No violations were cited.

File closed.

Incidents Opened Third Quarter 2011

I - 8884 - Overexposure -Weld Spec Inc - Groves, Texas

On September 14, 2011, the Agency was notified by the licensee that a radiographer exceeded the 5 rem occupational dose limit for the year. On September 12, 2011, while operating an INC IR102 camera containing a 67 curie iridium-192 source, the radiographer failed to fully retract the source into the camera. The portable radiation meter was turned off and no radiation pagers alarmed. Both radiographers noted that their 0-200 millirem pocket dosimeters were off scale. They stopped work, fully retracted the source in the camera, and reported the incident to the RSO. Their dosimetry badges were sent off for emergency processing and the results were received on September 14, 2011. The trainer had received 3.31 rem and the trainee had received 2.79 rem. The total exposure for the year for the trainer equaled 5.152 rem and he was removed from duty for 2011. During the investigation it was determined that the trainee had attempted to conduct a survey after cranking in the source but the meter was off for all three shots on the first weld and post use survey. Both radiographers stated they tested their electronic rate meters but the batteries appeared to be weak when tested after the incident. Three violations were cited.

File closed.

I - 8885 - Gauge Shutter Failure - Ticona Polymers, Inc - Bishop, Texas

On September 19, 2011, the Agency was notified by the licensee that the shutter on an Ohmart-Vega SH-F2 nuclear gauge containing a 100 millicurie cesium-137 source had failed in the open position during a routine maintenance inspection check. Open is the normal operating position for the shutter so the gauge did not present a radiological exposure hazard to the public or employees. The gauge was repaired on September 28, 2011. The manufacturer determined that the cause for the failure was bird droppings building up in the area of the operating arm. A protective device has been installed to prevent a recurrence of the failure. No violations were cited.

File closed.

I - 8886 - Overexposure - Caribbean Inspection & NDT Services, Inc. - Port Lavaca, Texas

On September 19, 2011, the Agency received an email stating that a radiography trainee may have received an overexposure to his right hand and was seeking medical attention. The Agency has not been able to confirm that the burn received by the radiographer occurred on the date and time reported. The radiography trainee is currently receiving treatment in Houston, Texas. The investigation into this event is ongoing.

File open.

Incidents Opened Third Quarter 2011

I - 8887 – Gauge Shutter Failure - BASF Corporation - Freeport, Texas

On September 26, 2011, the Agency was notified by the licensee that a shutter on a Ronan SA-1 nuclear gauge containing a 2,000 millicurie cesium-137 source failed in the open position during preparations for a planned vessel entry. The gauge did not present an exposure hazard to the public or employees. Vessel entry was suspended pending repair or replacement of the gauge. On October 1, 2011, the manufacturer found that the gauge was operating as designed. The initial determination by the licensee that the shutter had not closed was based on an elevated dose rate reading taken after the shutter was closed. The investigation into the higher dose rate found that the reading had been compared to a reference reading made a distance further from the gauge. No repairs to the gauge were required. No violations were cited.

File closed.

I - 8900 - * - Columbia Medical Center of Arlington dba Medical Center of Arlington - Arlington, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Third Quarter 2011

I - 8804 - Missing Equipment Containing Radioactive Material - Lockheed Martin Aeronautics Company - Fort Worth, Texas

On December 22, 2010, the Agency received a written report from the company stating that 84 tritium exit signs containing an estimated total of less than 630 curies of tritium could not be located. The signs had been boxed in preparation for return shipping to the manufacturer in February 2010, but were being held until they could be repackaged to conform with the manufacturer's packaging requirements. In November 2010 the company decided to re-package and ship the signs but they could not locate them. The company searched its facility and investigated all potential routes by which the signs could have left the premises. During the investigation, the manufacturers/distributors of the signs were contacted by the company for assistance in determining the serial numbers of signs supplied to its facility. Serial numbers were available for only 17 of the signs. It was discovered that there were 23 additional signs that were unaccounted for, thereby raising the total number of missing signs to 107. The current (decay-corrected) total activity of those signs is approximately 625 curies. The company had an evaluation conducted that considered the most likely scenarios--incineration by its hazardous waste disposal vendor, burial in the municipal landfill, or the signs are still on the company's premises. According to the evaluation, no dose exceeding regulatory limits to any member of the public would result from any of these scenarios. The company determined the cause of the incident was lack of communication and handling the signs outside of its normal hazardous waste procedures. The company stated that in the future all hazardous items will be processed through the existing hazardous waste management system with no exceptions. It will notify this Agency if the signs are located. No violations were cited.

File closed.

I - 8843 - Radiography Source Disconnect - METCO - Houston, Texas

On April 19, 2011, while performing radiographic operations with a QSA Global 880-D camera, a radiographer found that the 58.6 curie iridium-192 source could not be retracted into the safe storage position. The radiographers established barriers at the 2mR/hr line and ensured that others were alerted to stay clear of the area. The device was positioned 40 feet in the air on the side of a tank. The camera was lowered to the ground using a lift. The guide tube was covered with bags of lead shot. The company source recovery team (SRT) responded to the location. The SRT disconnected the guide tube from the camera and noticed the source had disconnected from the drive cable and was sticking out of the front of the camera. Using remote handling tools, the SRT removed the source from the camera and reinserted the source into the camera backwards so that the source capsule was positioned in the center of the camera shielding. No individual involved in this event exceeded any exposure limit. The cause for the disconnect was determined to be that the coupling on the drive cable had separated from the drive cable due to excessive force. The licensee's investigation into the event revealed that the camera, with the crankout device attached, had fallen 40 feet just prior to the disconnect. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Third Quarter 2011

I - 8846 - Equipment Malfunction - Ineos USA, LLC - Alvin, Texas

On May 12, 2011, the Agency was notified that the operating mechanism on an Ohmart Model SHLM-BR-2 nuclear gauge containing 1,000 millicuries of cesium-137 had failed. The gauge's operating mechanism consists of two rods. The source is mounted on one rod and the other rod is used to move the source into and out of the source holder. The roll pin used to connect the two rods together sheared so the source could not be manipulated. The gauge was repaired on June 27, 2011. The technician who repaired the gauge recommended more frequent inspections of the roll pin for major wear. The licensee is training its gauge inspectors to increase the frequency of inspections and to look for wear on the pins. No violation was cited.

File closed.

I - 8847 - Gauge Shutter Failure - Solo Cup Operating Corporation - Dallas, Texas

On May 12, 2011, the Agency was notified by the licensee that the shutter on an Ohmart/Vega Model BAL nuclear gauge containing 100 millicuries of strontium-90 was stuck in the closed position. The gauge had an electronic shutter and it was not functioning. The licensee contacted its service provider for assistance in repairing the gauge. The service provider stated that it did not have any personnel who could repair the gauge. The manufacturer was contacted and it stated it did not have parts nor the expertise to make repairs to the device. The licensee decided to replace the device. No violation was cited.

File closed

I - 8851 - Device Leaking Radioactive Material - Texas A & M University - College Station, Texas

On May 18, 2011, the Agency was notified by the licensee that during the removal of 16 tritium exit signs (TES) from a student dorm scheduled for demolition it was noted that the short tube making up the "X" was broken on one of the TES being removed.. A contamination survey of the sign and the floor below it indicated readings above the limit for tritium. The licensee stated that they could not determine how much influence the luminescent material in the sign had on the readings. The area was decontaminated and the area released. The individuals involved in the event received bioassay analysis. The results indicated that they had not received any internal deposition of tritium. The sign was packaged and returned to the manufacturer for disposal. The licensee is proposing the removal of most tritium exit signs and has increased inventory frequency for those remaining. No violations were issued.

File closed.

Incidents Opened in a Previous Quarter and Closed in Third Quarter 2011

I - 8852 - Gauge Shutter Failure - ExxonMobil Oil Corporation - Beaumont, Texas

On May 19, 2011, the Agency was notified by the licensee that the shutter on an Ohmart/Vega model SH-F2 containing 1.6 curies of cesium-137 would not close. The licensee stated The failure occurred when workers were attempting to close the shutter in preparation to enter a vessel to perform maintenance. No access to the tank was made. Open is the normal operating position for the shutter, therefore the gauge did not present any additional exposure hazard outside the tank. Access into the tank was secured to prevent entry until the gauge was repaired on June 15, 2011. The service company determined that the cause for the failure was rust deposits preventing the operating arm from turning. A shield box has been placed over the gauge to prevent recurrence. No violations were cited.

File closed.

I - 8853 - Lost Equipment Containing Radioactive Material - Texas A & M University - College Station, Texas

On May 19, 2011, the Agency was informed by the licensee's Radiation Safety Officer (RSO) that while making preparations to demolish a student dormitory it was discovered that a tritium exit sign (TES) was missing. The RSO stated that there was verification the sign was still there on April 14, 2011, but when it was to be removed it on the May 19th it was missing. The RSO questioned maintenance personnel about removing the sign but they stated that they had not. The RSO sent a request to dormitory residents requesting any information on the location of the sign but received no responses. The licensee stated that it has proposed the replacement of a majority of the tritium exit signs and it will increase the inspection frequency for the signs. No violations were cited.

File closed.

I-8855 - Damaged Source of Radioactive Material - Harrington Cancer Center - Amarillo, Texas

On May 24, 2011, the Agency was notified that an iodine-125 seed was damaged when the authorized user attempted to remove it from the applicator. The patient's treatment continued without event using second applicator located in the operating suite. No contamination of the patient, personnel, or facility was reported. The 0.3 millicurie seed had apparently become lodged in the barrel of the applicator and was damaged while being removed. Some activity was discharged into the sanitary sewer and the seed with two towels used in the clean-up were retained and placed in storage for decay and subsequent disposal. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Third Quarter 2011

I - 8858 - Stolen Tritium Exit Signs - AMC American Multi-Cinema, Inc. - Houston, Texas

On May 26, 2011, the Agency was notified that during the performance of routine inspections for the facility's site safety systems, it was discovered that two tritium exit signs mounted above exit doors were missing. These signs were affixed using security mountings, but they had been essentially pulled off the walls leaving evidence that they were removed without the knowledge of site personnel. Each sign contained 9.5 curies of tritium. The facility filed a report with local law enforcement. The company has ordered wire cages from the sign manufacturing company to mount over the exit signs of this and other facilities in Texas as a deterrence of future thefts. No violations were cited.

File closed.

I - 8864 - Abandoned Well Logging Source(s) Down Hole - Schlumberger - San Jacinto County, Texas

On June 20, 2011, the licensee reported that a 16 curie americium-241/beryllium source and a 1.7 curie cesium-137 source were abandoned down hole in a San Jacinto County well. The sources were abandoned at depths of 8,197 and 8,210 feet respectively. The hole also contained almost 5,500 feet of cable above the tool containing the sources. A 1,623 foot red dye cement plug was placed above the cable from 7,623 feet to 6,000 feet. The well also has production casing above the tool to prevent intrusion on the tool. Under current plans, the well will be side tracked and produced. A plaque for placement at the well head has been ordered. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 8865 - Radiography Source Disconnect - Team Industrial Services Inc. - Alvin, Texas

On June 23, 2011, the Agency was notified by the licensee that a 67.5 curie iridium-192 source disconnected from its drive cable on a QSA Global 880D camera during the first radiographic operation of the day at a field site. The disconnect occurred because the connector on the drive cable separated from the drive cable. The licensee's source recovery team was able to return the source to the fully shielded position in the camera. No exposure exceeding a regulatory limit was received during the source retrieval. The drive cable, connector, and the camera were returned to the manufacturer for inspection. The manufacturer's report stated that the drive cable had been exposed to a force great enough to cause the plastic coating on the cable to stretch and become thinner, allowing the connector to slip off of the cable. When, and the manner in which, this force was applied was not identified. The cable was repaired and returned to the licensee. The manufacturer retained the connector and a section of the drive cable for additional testing. No violations were cited.

File closed.

Complaints Opened Third Quarter 2011

C - 2344 - Regulatory Violations - Los Alamos Imaging Center LP - Alamo, Texas

On July 12, 2011, the Agency received a complaint alleging that the registrant was not servicing the x-ray devices as required and was "over-radiating" patients, that the registrant had not maintained any records for the x-ray devices, that the facility did not have enough x-ray shields for protection, and that students were allowed to take x-rays without supervision of a physician. The complaint also stated that a licensee operating at the same location had not corrected violations noted in a radioactive materials inspection performed by this Agency in October 2010. The Agency conducted an on-site inspection and investigation. The inspector found the following: the dose measurements for the computerized tomographic unit had not been completed within the required 12 month interval; the tube housing assembly support on one of the x-ray units was not stable; required inventories, inspections/tests and documentation and records were not present; and, other issues with collimation and technique factors/charts. The inspector found that the students had appropriate supervision. The allegation that a licensee at the same location had not made corrections to violations noted in a previous inspection was not substantiated. The licensee had ceased using their gamma camera and radiopharmaceuticals and have no plans to use them any time soon. Ten violations were cited.

File closed.

C - 2345 – Unregistered Laser Hair Facility - Skin Glow - Irving, Texas

On July 13, 2011, the Agency received a complaint alleging that a med spa was providing laser hair removal services without proper registration. The complaint also stated that the licensed practitioner is not licensed in the State of Texas to practice medicine. A review of Agency records indicated that the med spa was not registered with this Agency. Several attempts were made to contact the med spa. On August 4, 2011, the Agency received a phone call from the med spa owner. She stated she was not aware of the requirement to register to conduct laser hair removal. On August 16, 2011, the owner provided copies of her laser registration forms, which listed the name of the licensed practitioner of the healing arts for the registration. A search of the Texas Medical Board records confirmed that the practitioner listed in the registration form is licensed in the State of Texas. The complaint was partially substantiated. One violation was cited.

File closed.

Complaints Opened Third Quarter 2011

C - 2346 - * - Brownwood Hospital LP dba Brownwood Regional Medical Center - Brownwood, Texas

* Health and Safety Code Chapter 241.051(d)

The complaint was not substantiated. No violations were cited.

File closed.

C - 2347 - Unregistered Laser Hair Facility - Oasis Med Spa and Laser Center - Dallas, Texas

On July 26, 2011, the Agency received an anonymous complaint that a facility in Dallas was not registered with the Agency, was not under the supervision of a physician, and that the technologists working with the lasers did not know what they were doing. The Agency's investigation revealed that the facility had begun performing hair removal with a laser prior to receiving a certificate from the Agency authorizing it to do so. The investigation further revealed that the facility did have a contract with a consulting physician, the technologists' training did meet current regulatory requirements, and it had begun the application process for a certificate of registration. During the investigation the facility's application was received by the Agency. It was also discovered during the investigation that the facility had not had a physician's prescription/order when it purchased its lasers in July 2011. The complaint was partially substantiated. Two violations were cited.

File closed.

C - 2348 - No Physician Supervision - R U Hairy, Inc. - Houston, Texas

On July 28, 2011, the Agency received a complaint that there was no physician supervision at a laser hair removal facility in Houston, Texas. The complainant stated he had experienced hyper pigmentation following a procedure for laser hair removal. He stated when he asked about who the physician for the facility was and about seeing the physician for the condition, the answers he received made him suspect there was no physician. The Agency's investigation into the complaint revealed that the facility did have a contract with a consulting physician as required by their laser hair facility certificate of registration with the Agency. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2011

C - 2349 - Uncredentialed X-ray Technologists - Family Clinic - Bridgeport, Texas

On July 29, 2011, the Agency received an anonymous complaint that at least one person taking x-rays at the registrant's facility was not trained or credentialed to do so. The Agency's investigation of the complaint revealed that the facility had been granted a hardship exemption and that several employees of the clinic have been trained, and more are being trained, by the Radiologic Technologist to take permissible x-rays when he is not available. The complaint was not substantiated. No violations were cited.

File closed.

C - 2350 – Uncredentialed X-ray Technologists - Varsha Shah - Lewisville, Texas

On August 11, 2011, the Agency received a complaint alleging the registrant was not providing personnel monitoring devices, was requiring non-credentialed individuals to take x-rays, and was not providing personnel protection devices to individuals in the room while x-rays are being performed. The Agency conducted an on-site investigation on October 5, 2011. The inspector was not able to substantiate the allegations. No violations were cited.

File closed.

C-2351 - Rubidium Generator -Valley Cardiology PA - McAllen, TX

On August 12, 2011, the Agency was contacted by the Nuclear Regulatory Commission concerning an anonymous complaint. The complainant alleged that a cardiology office was using a rubidium-82 generator past its useful life, was not conducting required quality control checks, and that strontium-82 loose contamination was present in the clinic. Additionally, the complainant alleged patients may have been overexposed since the generator was operating past its useful life. On August 29, 2011, the Agency conducted an on-site investigation. Direct contamination surveys and wipes showed no contamination. The office was conducting required quality control checks daily. During a review of the records it was noted that four patients were injected with the pharmaceutical from the generator slightly above the allowable ratio of strontium-82/rubidium-82 according to manufacturer procedures. The complaint could not be substantiated. One violation was cited.

File closed.

Complaints Opened Third Quarter 2011

C - 2352 - Injury from Intense Pulsed Light Device - NBH Lifetime Health, LLC - Austin, Texas

On August 19, 2011, the Agency received a complaint concerning a burn injury resulting from a procedure involving an intense pulsed light device that occurred in October 2010 at a facility in Austin, Texas. Several attempts to contact the location were made, but the Agency did not receive a response. An on-site investigation was conducted by the Agency on November 10, 2011. The investigation found a class 4 laser was in use at the facility and the facility was not registered as required. The investigation was unable to substantiate that a reportable burn injury had occurred. One violation was cited.

File closed.

C - 2353 - Unregistered Use of X-ray Machines - Texas Institute For Medical Education - Plano, Texas

On August 30, 2011, the Agency received a report that a training facility was using a C-arm device and was not registered with this Agency. Several attempts were made by the Agency to inspect the location, but the facility was closed each time. Attempts were made to contact the individual listed on the door, but received no response. On December 7, 2011, the Agency was able to contact the parent company in California and received a response from the Business Development Officer. He stated that the company did not provide training for the C-arm device, it only leased out the space. He stated that the medical facility located below the educational facility provided the equipment and training. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2354 -Improper Mammography Quality Control - Medical Arts Imaging, Inc. - Kerrville, Texas

On September 8, 2011, the Agency received a complaint stating that a mammography services company had not provided the Agency with the required acceptance testing documents to use a review workstation (RWS) for interpreting mammography pictures. The complaint concerned acceptance testing on the RWS prior to clinical use, timely interpretations, interpretations via jpeg files to a laptop computer and timely submission of clinical images for accreditation review. On September 12, 2011, an Agency inspector conducted an unannounced visit of the facility. The inspector found no items of non-compliance. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2011

C - 2355 - Regulation Violations - Lazersmooth - College Station, Texas

On September 28, 2011, the Agency received a complaint that a laser hair removal facility in College Station, Texas, had been operating for over five years without physician supervision and that the persons performing laser hair removal were not certified. During the Agency's investigation, the owner of the facility stated they did have a working relationship with a physician but there was no written contract and he could not provide any documentation that identified physician supervision. The persons performing laser hair removal had not registered with the Agency, but during the investigation one technician applied for and received a certificate and the other was to begin the required training in order to meet certification requirements. The facility had not registered with the Agency as a laser hair removal facility as required. The complaint was substantiated. Two violations were cited for the facility and two violations were cited for the technicians.

File closed.

C - 2356 – Unregistered Laser Hair Facility - Round Rock Medical Aesthetics - Round Rock, Texas

On September 29, 2011, the Agency received a complaint alleging a company was using a laser for hair removal without being registered with this Agency. A review of Agency records found that the entity was registered with the Agency under the original laser rules and had applied for registration under the hair removal section of the rules in June 2011. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Third Quarter 2011

C-2313 - Regulation Violations - Castle Dental Centers - Austin, Texas.

On February 9, 2011, a complaint was forwarded to the Agency from the State Board of Dental Examiners. The complaint alleged that the registrant was needlessly irradiating the public and failing to use protective equipment. A phone interview with the registrant and an on-site inspection conducted on June 10, 2011, verified that the operation and location of the panoramic x-ray unit did not endanger the public. The complaint was not substantiated. No violations were cited.

File closed.

C - 2328 - Laser Injury - Aspasia Medical Solutions - Bee Caves, Texas

On March 31, 2011, the Agency received a complaint alleging that an individual was injured while being treated with an intense pulsed light (IPL) device during a photofacial treatment and without physician supervision. On April 11, 2011, investigators from the Agency's Drugs and Medical Devices Group and Radiation Incident Investigations conducted a site visit. A laser and IPL devices were detained because the facility could not present a medical director's agreement. The facility presented the agreement the next day after retrieving a copy from its lawyer. A physician's examination of the person who complained of an injury documented the alleged injury as a skin eruption that had nothing to do with the IPL treatment. The complaint was not substantiated. No violations were cited.

File closed.

C - 2333 – Unregistered Laser Hair Facility - Laser Beauty Medical Spa - Dallas, Texas.

On April 23, 2011, the Agency received a complaint that a facility using a laser for hair removal was not registered with the Agency. It also alleged that the facility did not provide patients with appropriate eye protection. The facility was contacted and an inspection was performed which verified that the facility was not registered with the Agency but eye protection was being provided. One violation was cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Third Quarter 2011

C 2334 - Laser Injury - Status Body Studio - Anna, Texas

On May 3, 2011, the Agency received an anonymous complaint alleging that a spa was performing laser hair removal and other laser procedures without being registered with the Agency, without physician supervision, without adequate training, and had burned clients. The Agency conducted an on-site investigation. The investigation revealed that the facility was not properly registered with the Agency. The facility did have a contract with a physician, the owner/technician had received training which fulfilled the current training requirements, but there was no evidence to support that any individual had been burned. The complainant called the Agency to follow up on the complaint. When asked for more detail concerning the allegation of burns, the complainant could only report that they had seen someone leave the facility wearing a gauze bandage. The facility had not been properly registered with the Agency, but none of the other allegations could be substantiated. One violation was cited.

File closed.

C - 2335 – Unregistered Use of X-ray Machines - South Texas Diagnostics - San Antonio, Texas

On May 7, 2011, the Agency received a complaint alleging that a clinic was operating an accuDEXA x-ray device and was not registered. The complaint also alleged that the individuals operating the device had not been properly trained. An on-site investigation was conducted by the Agency. The investigation found that the device was located in the office, was plugged in, and connected to a printer. A manager stated that the device had been used a few times by a doctor who worked at a different location and came to their office to operate the device for them. He could not provide a valid registration for the device. The complaint was substantiated. One violation was cited.

File closed.

C - 2336 - Exposure to the Public - Apple Dentists - Houston, Texas

On June 13, 2011, the Agency received an anonymous complaint alleging that the registrant was exposing its workers and members of the general public to radiation every time it operated its x-ray machine. On July 7, 2011, the Agency conducted an on-site visit. The panoramic x-ray unit was found to be in compliance and the staff conducted visual checks for personnel in the area and announced "clear" before operating the unit. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Third Quarter 2011

C - 2338 - Radiation Injury - Spine Team Texas - Southlake, Texas

On May 13, 2011, the Agency received a complaint that an individual claimed to have received burns during x-ray procedures. It was suspected by the complainant that the markers used as positioning indicators may have caused an electrical discharge during the exposure. An investigation and inspection was performed and the machine was found to be in normal working order. The review of the x-ray machine documentation revealed that there was a current physicist survey with no deficiencies noted and previous Agency inspection reports showed no violations on the last three inspections. The facility's staff reported that they had not received any other complaints of thermal or radiation burns. During records review, it was noted that the complainant had had previous surgeries and/or invasive procedures. Also, the physician assistant that examined the lesion(s) that the complainant suspected had resulted from the x-rays noted that they were possibly a specific illness (not related to radiation or thermal burn). The complaint could not be substantiated. No violations were cited.

File closed.

C - 2341 - Unlicensed For Radioactive Material - Hicks Industries - Garland, Texas

On April 27, 2011, the Agency received an allegation that an individual was performing well-logging services utilizing radioactive materials in the State of Texas without possessing a license. On June 26, 2011, the Agency received a response to a letter sent to the company's owner stating that it was not in possession of any radioactive material. On June 28, 2011, the owner was contacted and he stated that he does not perform any activities in the State of Texas that would require a license from this Agency. He stated that all activities related to the complaint were conducted at a facility located in Phoenix, Arizona. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2342 - Regulatory Violations - National Laser Institute LLC - Dallas, Texas

On June 21, 2011, the Agency received a complaint concerning the way an Agency-approved laser training provider was conducting business. The complainant alleged the training facility was telling the students they were "certified" when they weren't yet; telling students they will be able to buy a laser when they won't be able to; and, misleading the students and "ripping them off". The complainant was upset that the training school was performing free hair removal and this threatened the complainant's and others' business and the complainant felt the state should protect them from these schools giving away their services. The Agency determined that allegations were not regulatory issues under its authority but were consumer-type complaints. The Agency did contact the training facility and made it aware of the complaint and asked it to evaluate and address the issues if applicable. The complainant was informed that the complaint could be pursued through other consumer advocacy/complaint systems. No violations were cited.

File closed.