



INCIDENT AND COMPLAINT SUMMARIES FOR THIRD QUARTER 2013*

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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.shtml>

Incident and Complaint Summaries
3rd Quarter 2013

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Incidents Opened Third Quarter 2013

I - 9097 - Medical Waste at Landfill - Methodist Healthcare System of San Antonio - San Antonio, Texas

On July 18, 2013, the Agency was notified by a landfill that it had received a load of waste from a local hospital that had caused its radiation monitor to alarm. The landfill performed a radionuclide survey of the container and sent it to the Agency. The Agency identified the radionuclide as indium-111 (In-111). The licensee investigated and could not determine a definitive sequence of events that would have allowed the material to get past its radiation monitoring system. However, it suspects a new employee may not have been trained and/or bypassed the alarms because a freight elevator was not working for a few hours. In response, the licensee has ensured that all environmental staff have been re-trained and new procedures were implemented for handling patients receiving In-111. This was a non-cited severity level IV violation.

File closed.

I - 9098 - Equipment Malfunction - Blanchard Refining Co. - Texas City, Texas

On July 19, 2013, the Agency was notified by the licensee that a 300 millicurie cesium-137 source in a Thermo Fischer Scientific (TFS) model 5221 fixed nuclear gauge fell to the bottom of its insertion tube inside a process vessel. The chain connecting to the source in the gauge broke. A radiation survey was conducted and radiation levels were determined to be normal. The manufacturer responded to the site and retrieved the source, repaired the device, and placed it back in service by July 22, 2013. No one involved in the event received an exposure that exceeded any regulatory limit. No member of the general public was exposed to any radiation due to this event. No violations were cited.

File closed.

I - 9099 - Equipment Malfunction - Fox NDE, LLC - Big Spring, Texas

On July 23, 2013, the Agency was notified by the licensee that on July 20, 2013, a radiography crew had been unable to retract an 84 curie iridium-192 source into a QSA 880 D exposure device. A spool had fallen on the guide tube while the source was out and crimped the guide tube. The source could not pass through the crimp during attempts to retract it. The radiographers isolated the area, placed bags of concrete over the source to reduce area dose rates and contacted their radiation safety officer (RSO). The RSO drove to the location and reached the site about six hours later. The RSO was able to remove the crimp enough to allow the source to pass and lock back in the exposure device. The exposure device was returned to the licensee's facility for further inspection. No one involved in the event received an exposure that exceeded any regulatory limit. No member of the general public was exposed to any radiation due to this event. To prevent recurrence, the licensee has stated that all radiography on pipe will be performed either reinforced on a shooting table or on the ground. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9100 - Radiography Source Retraction Failure - Fugro Consultants LP - Houston, Texas

On July 30, 2013, the Agency received a call from the licensee regarding a source retraction failure on July 29, 2013. The 93 curie iridium-192 source could not be retracted into the INC model IR-100 exposure device due to a malfunction with the safety latch plate engaging before the source was retracted. The licensee's radiation safety officer (RSO), who was authorized to perform source retrievals, performed the operation to retract the source into the exposure device. The mechanism was flushed with solvent and returned to normal operation. It was thought that a piece of grit caused the failure. No overexposures resulted from this event. No violations were cited.

File closed.

I - 9101 - Fire at Licensed Facility - Texas MPM Products, Inc. - Arlington, Texas

On August 1, 2013, the Agency was notified by one of its inspectors that she had seen a news report on television about a fire at a facility that possessed radioactive material. The Agency reviewed the report and found the fire department had stated that there were no abnormal radiation levels. The Agency contacted the licensee's radiation safety officer (RSO). Once the RSO was able to enter the facility, he reported it did not appear the sources had been damaged by the fire. The licensee leak tested the sources and the leak test results were satisfactory. The licensee sent the source devices to the manufacturer for inspection. On October 23, 2013, the RSO reported the manufacturer had completed the inspection and determined the devices were not damaged by the fire and did not require any repairs. No violations were cited.

File closed.

I - 9102 - Abandoned Well Logging Sources Down Hole - Allied Wireline Services - Upton County, Texas

On August 5, 2013, the licensee contacted the Agency to report that it was abandoning two well logging sources down hole in a 10,600 foot well. The sources were an 11 millicurie californium-254 source at 10,527.5 feet and a 2 curie cesium-137 source at 10,537.5 feet. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A red-dyed cement plug was set with the top at 10,135 feet with an anchor installed on top to act as a deflection device. 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. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9103 - Radiography Source Disconnect - Mistras Group, Inc. - Tilden, Texas

On August 6, 2013, the Agency was notified by the licensee that on August 5, 2013, one of its radiography crews at a temporary work site was unable to fully retract a 65.8 curie iridium-192 source into a QSA model 880D camera. The radiographers had placed the camera on the tailgate of the truck between jobs. The cranking device was left on the ground and still attached to the camera. A crew working in the area asked the radiographers to move their truck so they could pass by. When the radiographer backed the truck, he ran over the crankout device and cable. The radiographer inspected the device and determined it was operational. The crew later set up and took their next shot and when they attempted to retract the source they could not get the source to lock in the camera. The radiographers contacted their radiation safety officer (RSO) and extended their barriers. They placed additional shielding over the source and waited for the RSO. The RSO arrived at the location and performed the source retrieval. No individual involved in the event exceeded any exposure limits. No member of the public received an exposure. The equipment was returned to the manufacturer for inspection. The manufacturer stated the drive cable connector separated from the drive cable because of the stress placed on the cable when the cable was run over by the truck. The source was not damaged in the event. No violations were cited.

File closed.

I - 9104 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On August 6, 2013, the Agency received notice from the licensee that it had sent out iodine-123 capsules on July 31, 2013, from a distribution center to other pharmacies in its network. These capsules were calibrated for July 30, 2013, but labeled for July 31, 2013. As a result, patients were rescheduled. Based on its investigation, the licensee believes the pharmacist performing the product drug selection did not recognize the differences of the product label calibration dates on the incoming shipments when selecting inventory for the outgoing shipments. To prevent recurrence, the licensee counseled its employees that were involved in the product distribution procedures and modified distribution procedures at the Dallas distribution center. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9105 - * - Hunt Regional Medical Center - Greenville, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9106 - Damaged Device Containing Radioactive Material - Caribbean Inspection & NDT Services, Inc. - Victoria, Texas

On August 15, 2013, the licensee reported to the Agency that on August 14, 2013, the nipple to which the source guide tube attaches on one of its SPEC 150 exposure devices had broken off. The source was secure inside the camera at the time. There were no exposures as a result. The licensee contacted the manufacturer who provided a replacement part for the camera. The cause of the nipple breakage was not determined. The part was replaced and the camera tested. The camera operated properly. No violations were cited.

File closed.

I - 9107 - Stolen Dental X-ray Machines - Contemporary Endodontics, PLLC - Houston, Texas

On August 16, 2013, the Agency was notified that two NOMAD dental x-ray machines had been stolen. A manufacturer had shipped a rental machine to the registrant and it was delivered on June 6, 2013, by a common carrier who left it on the registrant's porch. When the registrant did not receive the machine, it called the manufacturer and it was discovered that the wrong shipping address had been used by the manufacturer. The registrant checked and the machine was not on the porch where it had been left. A replacement unit was delivered on June 11, 2013, again to the same wrong shipping address. It, too, was not on the porch when the registrant checked. The incorrect address the manufacturer used was the dentist's residence, but the property was for sale and was not occupied. Both units had apparently been stolen following delivery. Local law enforcement was notified by the manufacturer. The manufacturer has identified the cause as failure to follow its procedure of verifying the correct address when the rental agreement was set up and the practice of marking incorrect addresses as "inactive" instead of replacing them with the new address in its system. The manufacturer updated procedures and retrained staff. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9108 - Damaged Device Containing Radioactive Material - CMJ Engineering - Fort Worth, Texas

On August 17, 2013, the Agency was notified by the licensee that a moisture/density gauge had been damaged during work at a temporary field site. The technician was taking a reading with the Humboldt model 5001 EZ gauge which contained a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. A truck backed, without a backup alarm sounding, into the area. The technician had to jump out of the way. The truck struck the gauge and damaged the case. The technician was able to return the cesium source to the fully shielded position. A radiation survey of the gauge was conducted and the dose rates were found to be normal. The gauge was sent to a service provider for inspection and repair. No violations were cited.

File closed.

I - 9109 - Found Radioactive Material in Waste - Effective Environmental – Mesquite, Texas

On July 26, 2013, the licensee reported that it received 4 drums of waste material that had radiation levels as high as 40 millirem/hour and contained iridium-192 tracer material. The Agency conducted an on-site investigation of the barrels on July 26, 2013. Iridium-192 was identified in two of four barrels of waste. The radiation levels were 10 microrem/hour. On September 24, 2013, the customer hired a contractor to take soil samples from all four barrels. The Agency received results of the sample analyses on November 21, 2013, which revealed only a trace of iridium-192 in the contents of the barrels. One barrel had 985 picocuries/gram of Scandium- 46, which is a concentration that requires Agency approval for disposal in a landsite. The investigation into this event is ongoing.

File open.

I - 9110 - Equipment Malfunction - Fox NDE LLC - Big Spring, Texas

On September 5, 2013, the Agency was notified by the licensee that on September 4, 2013, a radiography crew was unable to retract a 65.4 curie iridium-192 source into a QSA 880 D exposure device. The licensee's radiation safety officer stated the guide tube was damaged when the camera fell from the pipe it was sitting on. When the camera struck the floor, the guide tube near the outlet nipple was crimped and the source could not be returned to its shielded position. The source was cranked out into the collimator and bags of concrete were placed over the source for additional shielding. The RSO stated he had to cut both the guide tube and the drive cable so that the guide tube connection to the camera could be broken and the connector removed. The drive cable was then threaded through the camera and the cable pulled by hand to return the source to the fully shielded and locked position. The camera was returned to the licensee's facility for further inspection. No one involved in the event received an exposure that exceeded any regulatory limit. No member of the general public was exposed to any radiation due to this event. The camera was not damaged. The RSO stated the company policy has been changed to state how radiography on pipe will be conducted to prevent it from falling. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9111 - Abandoned Well Logging Source Down Hole - ThruBit, LLC - Cherokee County, Texas

On August 10, 2013, the Agency received a report from the licensee stating it had abandoned a 1.61 curie cesium-137 source down hole in a well in Cherokee County, Texas. The source was abandoned at a depth of 8,216 feet. A whipstock was set at a depth of 7,616 feet. Five hundred feet of red dyed cement was placed above the source and 200 feet of conventional cement was placed above that. 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 source was abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 9112 - Radiopharmaceutical Labeling Error - Cardinal Health - Houston, Texas

On September 13, 2013, the licensee notified the Agency of a dispensing error that involved mislabeling of a radiopharmaceutical dose. The labeling error had occurred on September 9, 2013. A dose of 10 millicuries of fluorine-18 Fludeoxyglucose (FDG) was ordered but the customer assayed the dosage and measured 50 millicuries at calibration. The customer did not wish to receive a replacement dosage, but opted to adjust the dosage prior to patient administration. The licensee's investigation determined that the pharmacy technician dispensing multiple F-18 dosages did not refresh the dosage fulfillment system prior to dispensing and labeling the customer's F-18 FDG unit dosage. The staff involved with the event have been counseled by the licensee to follow procedures for the proper use and for refreshing the dosage fulfillment system on a regular basis while dispensing. No patients were affected by the mislabeling. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9113 - Unable to Retract Radiography Source - Mistras Group, Inc. - Tilden, Texas

On September 16, 2013, the Agency received notification from the licensee that on September 12, 2013, one of its radiography crews working at a temporary work site in Tilden, Texas, had been unable to retract a 99 curie iridium-192 source back into its SPEC 150 exposure device. After several attempts, the connector on the end of the drive cable came off. This allowed the cable to come all the way through the device and left the source inside the guide tube. Source retrieval was performed by an authorized person who received 120 millirem, an assistant received 55 millirem, the radiographer trainer who also assisted received 100 millirem (including the day's work) and the radiographer trainee received 32 millirem (including the day's work). No member of the public received any radiation exposure as a result of this event. On November 25, 2013, the Agency conducted an on-site investigation, including interviews of the radiographers, and found no personnel errors. Additionally, the licensee presented records showing inspections of the cable over the last four quarters. The licensee had the crank assembly, cable, and connector evaluated by the two manufacturers who built and tested the cable. The end connector on the cable appeared to have failed due to cycling and excessive use over the last two years. The licensee purchased all new crank-out assemblies for its exposure devices. No violations were cited.

File closed.

I - 9114 - Unable to Retract Radiography Source - Mistras Group, Inc. - Tilden, Texas

On September 16, 2013, the licensee notified the Agency that on September 13, 2013, one of its radiography crews had been unable to retract a 99 curie iridium-192 source back into a SPEC 150 exposure device at a temporary work site in Tilden, Texas. The radiography crew, using the same exposure device, had experienced a source disconnect the previous day (see I-9113). Then, following the first exposure of the morning, the source pigtail would not retract fully into the device. An authorized person performed the source retrieval. This individual received 20 millirem and the individual that assisted him received 10 millirem. The licensee's radiation safety officer inspected the source guide tube using a scope and found that the end piece that connects to the camera was not crimped properly causing some obstruction to the source. The source tube was inspected by the repair facility which had crimped on a new swivel end piece. The retest for the source tube after repair included cycling a dummy source in and out of the source tube, including a 250 pound pull test, five times. The repair facility performed the test and it failed when the source tube was at specific angles. The repair facility changed retest procedures to conduct a visual inspection inside the source tube with a bore scope. On November 25, 2013, the Agency conducted an on-site investigation, including interviews of the radiographers, and found no personnel errors. No violations were cited.

File closed

Incidents Opened Third Quarter 2013

I - 9115 - Stuck Nuclear Gauge Shutter - Bayer Material Science - Baytown, Texas

On September 16, 2013, the Agency received notice that the shutter on one of the licensee's Ronan SA-1 nuclear gauges containing a 20 millicurie cesium-137 source had stuck in the open position. This had been discovered during the morning shutter check. The gauge normally operates with the shutter in the open position. The source did not represent a threat to the general public or workers. The licensee was able to repair the shutter later that day with assistance from the manufacturer. No violations were cited.

File closed.

I - 9116 - * - Brownsville Doctors Hospital LLC - Brownsville, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 9117 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On September 23, 2013, the licensee notified the Agency that two of its customers had reported receiving unexpected imaging results following the use of doses of technetium-99m exametazime from the licensee on August 30, 2013. Based on the licensee's investigation, it is believed that the radiopharmaceutical oxidized post-preparation thus giving rise to Tc-99m sodium pertechnetate bio-distribution observed in the patients. The licensee performed an extensive review of established procedures and pharmacy protocols to confirm no errors were made in the preparation of the drug product. The licensee will focus on reducing the Tc-99m pertechnetate eluate age used in preparing Tc-99m exametazime according to the manufacturer's recommendations. No adverse health effects to the patients were reported by the physicians. No violations were cited.

File closed.

Incidents Opened Third Quarter 2013

I - 9118 - Stolen Radioactive Material - Paradigm Consultants, Inc. - Houston, Texas

On September 25, 2013, the Agency was notified by the licensee that one of its Humboldt Model 5001EZ moisture/density gauges was missing and presumed stolen from its facility. The gauge contains a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The gauge could not be located on Friday, September 20, 2013, during a routine inventory. On Monday, September 23, 2013, after completing a search for the gauge, the licensee made the determination that the gauge was missing. The gauge had been secured inside a locked storage area inside the facility with several other gauges. No other gauges were missing. The licensee notified local law enforcement and a gauge sales/service company in Houston, Texas. The Agency notified the Texas Pawnbrokers Association. In an effort to prevent recurrence of this event, the licensee built a new storage area and storage bins in the storage area where the gauges could be locked in place independently. No violations were cited.

File closed.

I - 9119 - Lost Lasers - Alcon Research, LTD - Fort Worth, Texas

On September 26, 2013, the Agency was notified by the registrant's laser safety officer that two class 3B lasers were missing from the registrant's facility. The lasers were last accounted for during a 2012 annual inventory. The optic lasers were over 15 years old and no longer useful. After an employee who had kept the lasers in his work areas retired, new employees packed up older machines for surplus or disposal. A detailed search of the facility was conducted but the lasers were not located. They had no value and it is suspected that they were disposed of with other waste. Training was conducted on the security, inventory, and turnover of all lasers at the facility. No violations were cited.

File closed.

I - 9120 - Radioactive Material in Landfill-Bound Waste - Renegade - San Angelo, Texas

On September 30, 2013, the Agency received notice of a waste trailer that had set off radiation alarms at the landfill in San Angelo, Texas. The material was determined to be pump components with contamination from tracer sands used in petroleum drilling. The items were retrieved and identified by the licensee and will be held by the licensee for decay in storage. No violations were cited.

File closed.

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

I - 9125 - See I – 9112. Incident duplicated in error.

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 - 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 in 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 in a Previous Quarter and Closed in Third 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 in a Previous Quarter and Closed in Third 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 Texas licensee contacted the NC licensee and notified them of the event. No violations were cited.

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.

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

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

*Health and Safety Code 251.051(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 the 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 crank out devices. A notice has gone out to all company personnel regarding this incident. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Third 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. No one exceeded any regulatory dose limits as a result of this event. 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 connection of drive cables, challenge of connectors, and proper supervision of the trainee. No violations were cited.

File closed.

I - 9093 - Badge 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 they could not determine any time he could have received that much exposure. The licensee determined the exposure appeared to be to the badge only. The employee did not display any effects of an exposure to a high dose of radiation. 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 in a Previous Quarter and Closed in Third 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 millirem to the hand and 18 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.

Complaints Opened Third Quarter 2013

C - 2484 - Unregistered Laser Hair Removal Facility and Technician - Be U Beautiful Center - El Paso, TX

On July 1, 2013, the Agency received a complaint that a technician performing laser hair removal at a facility was not registered with the Agency and the complainant had experienced reddening of the skin that lasted several days following a laser hair removal procedure. The Agency's investigation revealed that the complainant had no evidence that he had sustained an injury. He stated to the investigator that his skin is back to normal. The owner of the facility reported hair removal and other procedures using an intense pulsed light device had been performed, but that another individual had been coming to the facility and bringing the device to perform the procedures. The owner of the facility provided assurance to the Agency that the facility would immediately cease offering any of these procedures and hair removal advertising was immediately removed from the facility's website. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2485 - Inadequate Shielding - Gulf Coast MRI & Diagnostic, Inc. - Pasadena, Texas

On June 8, 2013, the Agency received a complaint that the registrant may have been exposing workers and patients to unnecessary levels of radiation due to inadequate shielding. An inspection was performed with additional attention to shielding. The maximum dose over the time worked was concluded to be less than 6 millirem. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2486 - Unregistered Laser Facility - Ageless Med Spa - Katy, TX

On June 26, 2013, the Agency received a complaint that the registrant was operating a laser facility without registration or credentialed technologists. Further, it was alleged that there had been burns. A search of the VERSA database found that the entity was registered with this Agency under 25 TAC§289.301. The Agency performed an on-site investigation at the facility on August 21, 2013. The investigation found the facility did perform laser hair removal as part of its services. They also perform medical services at the facility and are not required to comply with 25 TAC§289.302. The investigation was not able to confirm any injuries to a patient that would have required notification to this Agency. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2013

C - 2487 - Regulatory Violations - Anderson Perforating, Ltd. - Albany, Texas

On July 12, 2013, the Agency received a complaint alleging that the licensee was not performing the required surveys and calibrations. During the Agency's investigation, which included an on-site visit, it was found that the calibrations were current on the radiation survey meters. However, the licensee had failed to perform required surveys. Other violations concerning personnel monitoring and dosimetry, record keeping, and posting were also discovered. The complaint was partially substantiated. Six violations were cited.

File closed.

C - 2488 -Malfunctioning X-Ray Unit - Vasquez Family Chiropractic - Bedford, Texas

On July 18, 2013, the Agency received a complaint alleging that the registrant had a company test the x-ray machine a few months ago and knew the unit wasn't operating correctly and did not pass the test. The complainant stated that the doctor was friends with the testing company and believes the testing company wrote a pass rating on the machine regardless of operational capacity. An investigation was completed on-site and an equipment performance evaluation was completed to verify operational capacity. The x-ray unit was within acceptable regulatory limits. The complaint was not substantiated. No violations were cited.

File closed.

C - 2489 - Response To Public Concern - Contestant on "Americas Got Talent" Television Show - San Antonio, Texas

On July 23, 2013, the Agency received a call from an individual who expressed a concern regarding a contestant on a television show. The contestant was swallowing multiple swords while being monitored by a fluoroscopic device. The individual was concerned that the use of the device may have violated Agency rules. A search of information on the internet identified the contestant. The contestant lives in Moscow, Idaho. On August 1, 2013, the Agency e-mailed the contestant requesting information on who supplied and operated the device. A second request was made via e-mail on August 16, 2013. On September 11, 2013, the Agency located a phone number for the individual and contacted him. The individual refused to provide any information. Therefore, the Agency could not investigate further. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2490 - Unregistered Laser Facility - Kaaya Salon and Spa - Katy, Texas

On August 5, 2013, the Agency received a complaint that the entity may be operating without safety signs or registration. An investigation into this event is ongoing.

File open.

Complaints Opened Third Quarter 2013

C - 2491 - Naturally Occurring Radioactive Material - Enviroklean Product Development, Inc. - Midland, Texas

On August 12, 2013, the Agency received an anonymous complaint that the licensee had kept a roll-off container of waste containing naturally occurring radioactive material (NORM) at a location in Midland, Texas, for over 30 days. The complainant was concerned about radiation exposure from the container. The Agency's investigation revealed that the licensee had moved a roll off container with soils/sludge containing NORM to its facility from a temporary work site. The NORM concentration in the material exceeded the regulatory exempt levels. The licensee was licensed to use radioactive material only at temporary work sites. The radiation exposure from the material did not exceed any regulatory limits. The complaint was partially substantiated. One violation was cited.

File closed.

C - 2492 - X-ray of an Individual for Training Proposes - Dexis - Alpharetta, GA

On August 14, 2013, the Agency received an internal complaint that a dental service company in Texas was encouraging multiple facilities to take x-rays on employees for quality assurance testing and training. Additionally, the service company representative asked for volunteers to test a panoramic/cephalometric unit. An investigation of the complaint produced no credible evidence of prohibited x-ray practices. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2493 - Regulatory Violation - NQS Inspections - Corpus Christi, Texas

On August 15, 2013, the Agency was notified by the licensee that it was not able to locate records required by this Agency. The investigation into this event is on going.

File open.

C - 2494 - Unlicensed Radioactive Material - MTEC Companies, Inc. – Humble, Texas

On August 21, 2013, the Agency received a complaint that a company in Humble, Texas, owned and was using 8 Humboldt 5001 moisture/density gauges and the company was not licensed to possess radioactive material. The complainant also alleged that the employees that were using the gauges were not properly trained and they were not provided dosimetry badges. The Agency conducted an on-site investigation and found that the moisture/density gauges owned and used by the company are all electronic and do not contain any radioactive material. Therefore, no license or dosimetry is required. The complaint not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2013

C - 2495 - X-ray of Students for Training Purposes - Wheatland Dental Care - Dallas, Texas

On August 27, 2013, the Agency received a complaint that the registrant was x-raying students for the purpose of training. The Agency performed an on-site investigation and interviews. The complaint could not be substantiated. An unrelated non-cited severity level IV violation was found.

File closed.

C - 2496 - Personnel Monitoring Not Provided - Brazos Valley Inspection Services, Inc. - Abilene, Texas

On August 26, 2013, an Agency radioactive material inspector reported that he had received information from anonymous sources that a company had recently begun performing industrial radiography operations in the Abilene, Texas, area and its radiography crews had shown up at job locations without any personnel monitoring equipment as required. Other information he received prompted concerns over the company's recent activity in determining employees to be trustworthy and reliable (T&R). The Agency conducted an on-site investigation. The results of that investigation did not support the personnel monitoring allegations and the licensee had not violated regulations in its T&R process. The complaint was not substantiated. There was one unrelated non-cited violation that was corrected by the licensee.

File closed.

C - 2497 - Regulatory Violations - Lone Star Orthodontics, PA - Austin, TX

On August 28, 2013, the Agency received a complaint alleging a dental office's new x-ray machine was installed without proper testing, no radiation signs were posted in the area of the machine, and that workers stood within 6 feet of the x-ray machine when operating the unit. The complainant was also concerned about shielding and pregnant women taking the x-rays. An Agency on-site inspection and investigation was conducted. No issues were found with shielding, distance, testing or pregnant women. The unit was properly installed but the paperwork was not completed and operating procedures were not updated. The signs were not posted as required. The complaint was partially substantiated. Three violations were cited.

File closed.

Complaints Opened Third Quarter 2013

C - 2498 - Laser Injury - Tres Jolie Laser - Houston, Texas

On September 11, 2013, the Agency received a complaint alleging that an individual had developed second degree burns following laser hair removal procedures at the registrant's facility. An on-site investigation was conducted by the Agency on November 14, 2013. The inspection found they were performing laser hair removal procedures, but did not possess a registration for laser hair removal. The inspection was unable to find any records of the complainant being treated by this entity. The inspector informed the laser safety officer (LSO) of the requirements under 25 TAC289.302 and gave her contact information for the laser registration group. Repeated contacts were made with the registrant in attempt to assist them in the registration process. On December 18, 2013, the LSO requested their registration under 25 TAC 289.301 be terminated. The LSO stated they would request a registration under 25 TAC 289.302 once a new office was opened. No violations were cited.

File closed.

C - 2499 - Unregistered Laser Hair Facility/Technicians - Affinity Laser & Med Spa - Galveston, Texas

On September 17, 2013, the Agency received a complaint that a facility in Galveston, Texas, was performing laser hair removal and other laser procedures and neither persons performing the procedures nor the facility were properly registered with the Agency. The Agency contacted the facility and determined that the facility did not believe it was required to have its laser registered since it had a physician on site. The Agency's laser rules were reviewed. During the next month, the facility had an employee take a 40 hour Laser Safety Officer course and it mailed in the proper registration application for its class 4 laser. No violations were cited.

File closed.

C - 2500 - Abandoned Radioactive Material - The University of Texas Health Science Center at San Antonio - San Antonio, Texas

On September 17, 2013, the Agency received information that an individual was alleging that radioactive material in a nuclear powered artificial mechanical human heart had been buried in a time capsule between 1969-1972 at the licensee's location. Neither the Agency's nor the licensee's investigations into the allegations revealed any information or evidence that indicated this type of research had ever been conducted at the facility. The licensee performed radiation surveys in suspected areas but no measurement taken was above background radiation levels. Also, the licensee has never been licensed to possess plutonium, which research indicates was the radioisotope used in research attempts to power an artificial mechanical heart with nuclear material. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2013

C - 2501 - Uncredentialed Technologists - North East Family Urgent Care Clinic - Humble, Texas

On September 9, 2013, the Agency received a complaint that the registrant may have uncredentialed technologists taking x-rays. The Agency conducted an on-site investigation November 18, 2013. The investigation revealed that one technologist had neglected to apply for non-credentialed technologist status with the state. The complaint was substantiated. One violation was cited.

File closed.

C - 2502 - Uncredentialed X-Ray Technicians - Assurance Urgent Care - Houston, Texas

On September 27, 2013, the Agency received an anonymous complaint that the registrant was allowing uncredentialed individuals to perform x-ray procedures and alleged other "questionable practices". The Agency conducted an on-site investigation on October 22, 2013. During the investigation, the Agency found that the registrant failed to provide personal monitoring devices for one physician and one x-ray technician. The uncredentialed technologist allegation was unsubstantiated. Two violations were cited.

File closed.

C - 2503 - Regulatory Violations - Blazer Inspection, Inc. - Texas City, Texas

On September 30, 2013, the Agency received a complaint alleging multiple violations against an industrial radiography licensee. On November 14, 2013, the Agency conducted an on-site investigation at the licensee's facility. The owner of the company, current radiation safety officer, and a worker named by the complainant were interviewed. Records for the time frame given by the complainant were reviewed. The inspectors also went by locations found during the record review where the licensee performed work on a routine bases. No radiography work was in progress at any site. The complainant could not provide any additional information to help substantiate the allegations. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2013

C - 2504 - Regulatory Violations - Eagle NDT, LLC - Abilene, Texas

On September 30, 2013, the Agency received a complaint alleging the licensee had 13 regulatory violations including trainees transporting cameras, trainees working without the supervision of a trainer, and inadequate daily paperwork including increased controls documentation. Per Agency records, the licensee had two site inspections and one unannounced temporary job site inspection in 2013. No violations were noted. On October 21, 2013, the Agency conducted an on-site investigation at the licensee's Abilene site office. A spot check of equipment maintenance, qualification of radiographers, survey records and the increased control program was completed. An interview with the licensee's radiation safety officer was conducted to discuss the alleged violations. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Third 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 alleging 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 - 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 a 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,

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 their 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.

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

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.