INCIDENT AND COMPLAINT SUMMARIES FOR FIRST QUARTER 2015*

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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.

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Incident and Complaint Summaries
1st Quarter 2015

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Incidents Opened First Quarter 2015

I - 9266 - Gauge Shutter Failure - MeadWestvaco Texas, LLP - Evadale, Texas

On January 12, 2015, the licensee notified the Agency that during routine fixed nuclear gauge inspections and shutter checks it discovered that the shutter on a Ronan Model SA1-C5 gauge, containing a 300 millicurie cesium-137 source, was stuck in the open position. This gauge normally operates with the shutter in the open position and is mounted on a vessel that the licensee does not enter. There was no risk of exposure to any individual. The licensee contacted the manufacturer and it repaired the shutter handle. The cause of the failure was determined to be exposure to the elements and corrosive environment. To reduce future failures, the licensee stated it will operate all of its gauge shutters on periodic 8-week outages in addition to its required 6-month inspections. No violations were cited.

File closed.

I - 9267 - Badge Overexposure - Westside Surgical Hospital, LLC - Houston, Texas

On January 12, 2015, the registrant notified the Agency that it had received its dosimetry report from its personnel dosimetry (badge) processor and the report indicated that one of its technologists had exceeded the 5 rem annual occupational exposure limit for 2014. An investigation was completed by the radiation safety officer and he found that the exposure was to the badge only. During the fourth quarter of 2014, the technologist had left their badge on a lead apron which was left on a rack next to the gantry in the computerized tomography room. Several procedures were completed by other technicians without the badge being noticed. The registrant assigned a new fourth quarter dose to the individual which was calculated using the previous three quarterly dosimetry reports for the person. The final quarterly dose was assigned as 4 millirem deep, 4 millirem eye, and 5 millirem shallow giving her a yearly dose of 14 millirem deep, 17 millirem eye, and 19 millirem shallow. The corrective actions were to move the rack into the control room area to avoid a future occurrence of exposing a badge. In addition, all technicians were reminded that their badges must be worn correctly when performing x-ray imaging and stored in the control room when not in use. No violations were cited.

File closed.

I - 9268 - Improper Disposal - Renegade Services - Odessa, Texas

On January 14, 2015, the Agency was notified by a landfill operator in Odessa, Texas, that a container of waste from a licensee's facility had caused the landfill's radiation monitor to alarm. The landfill operator stated they had identified the isotope as iridium-192. The Agency contacted the licensee who then responded to the landfill. The licensee identified a plastic bag containing trash as the source of radiation. The licensee returned the bag to its facility and stored it in its decay storage area. The licensee could not determine who placed the waste in the disposal container. The licensee has changed its procedure for handling trash to require all plastic bags of trash to be surveyed prior to being placed in disposal container. Two violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9269 - Gauge Shutter Failure - Chevron Phillips Chemical Company, LP – Pasadena, Texas

On January 21, 2015, the licensee notified the Agency that on January 20, 2015, during the process of closing fixed nuclear gauge shutters at its facility in order to perform detector calibrations, it discovered that the shutter on one of its Ohmart-Vega SH-F2 gauges, containing a 500 millicurie cesium-137 source, would not close. The gauge normally operates with the shutter in the open position and the failure does not pose a risk of exposure to any person. The gauge suffered from corrosion from water intrusion. Lubrication and cleaning of the collimator and shutter mechanism surface allowed the gauge to operate smoothly. The gauge is back in service. A replacement shutter with gasket has been ordered for installation by a service company to ensure protection from water intrusion in the future. No violations were cited.

File closed.

I - 9270 - Lost X-ray Fluorescence Device - E-Source - Houston, Texas

On January 16, 2015, the Agency received a report that an x-ray fluorescence device had been lost in May or June of 2014. This was discovered during a routine inspection on the 15th of January. It was reported by the registrant that the missing device was an Olympus INNOV-X. The registrant failed to report the missing device at that time. One violation was cited.

File closed.

I - 9271 - Radiography Source Disconnect - Fox NDE, LLC - Odessa, Texas

On January 26, 2015, the licensee reported to the Agency that on January 25, 2015, one of its radiography crews had experienced a source disconnect at a temporary job site. The radiography crew had been unable to retract an iridium-192 source into its QSA Delta 880 exposure device. An authorized person performed the source retrieval. The source retriever received 206 millirem whole body, per dosimetry badge report, and was assigned a calculated dose of 37 rem to his hands. The licensee attempted to replicate a disconnect and misconnect but could not. The camera and crank assembly were sent to the manufacturer for evaluation. The manufacturer could not replicate a disconnect or misconnect either. The manufacturer's evaluation indicated the condition of the controls may have contributed to the incident. The licensee removed the controls from service. One severity level 4 violation was noted.

File closed.

Incidents Opened First Quarter 2015

I - 9272 - Lost Moisture/Density Gauge - Reed Engineering Group - Fort Worth, Texas

On January 26, 2015, the licensee notified the Agency that one of its technicians had lost a Humboldt 5001 EZ moisture/density gauge. The technician had left a temporary job site and while he was traveling to the next job site he realized the tailgate of the vehicle was down and the gauge was missing. He retraced the route he had taken. The licensee's radiation safety officer (RSO) also retraced the route and contacted other contractors at the job site. The gauge was not recovered. The technician stated that the insertion rod handle was locked . The RSO has informed the local authorities and will continue to look for the device. The licensee determined the technician had failed to secure the device and follow proper blocking and bracing procedures before transporting the gauge. Two violations were cited.

File closed.

I - 9273 - Potential Exposure to Individual - Eastman Chemicals Company - Longview, Texas

On January 27, 2015, the Agency was notified by the licensee that it had an event that resulted in two employees being exposed to radiation from an unshielded source. The licensee was preparing to perform maintenance on two vessels that required TN model 5031S nuclear gauges, each containing a 28 millicurie cesium-137 source, be removed from them. The gauges were removed from the vessels, lowered to the ground, and transported to a storage shed where they were placed on a pallet. After the gauges were placed in the storage shed, the radiation safety officer (RSO) went to the shed to survey the gauges. As he entered the shed, he noted dose rates had increased above what he expected. He found a source rod had been removed from one of the gauges. After recovering the source, he inspected the other gauge and found that the source rod was missing. He located the missing source at it's former use location and recovered it as well. The RSO's investigation determined that the gauge was designed so the rod containing the source would slide out of the front of the gauge freely and into a well inside the vessel. It was held in place while inside the housing by a lock that engaged a grooved channel located near the operating end of the source rod. The RSO stated they had changed the lock that had been used to lock the source when it was shipped to them by the manufacturer to a different one. The new lock, which had a smaller bale, failed to secure the source rod. The smaller bale allowed the source rod and source to fall out of the gauge when it was tipped face down during handling. The individuals removing the gauges from service did not realize the radioactive source was inside the rod that fell out of the gauge. The RSO placed the old locks back on the gauges, thus securing the source rods in place. The licensee performed a reenactment of the event and used the video to determine times and distances the workers were around the unshielded sources. The RSO performed dose assessments for all individuals involved in the event. The highest dose assigned to an individual was 0.719 millirem whole body and 700 millirem to the hand of the individual who picked the source rod up and placed it against a gauge housing. The RSO's dosimeter was processed and the results indicated the RSO had received no measurable exposure. The licensee sent the gauges for disposal on March 12, 2015. No violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9274 - Badge Overexposure - Kelsey-Seybold Clinic - Kingwood, Texas

On January 28, 2015, the licensee notified the Agency that it had received a report from its dosimetry processor indicating one of its employees had received 11,912 mrem DDE on her dosimetry badge for the exposure period of July 01 to September 30, 2014. A registrant investigation determined that the large dose was to the badge only and that the employee did not receive the dose. The licensee assigned the worker a dose of 167 millirem for the period based on her average dose for a quarter over the last three years. Employee training was conducted on policy and procedures about wearing and controlling the location of dosimetry badges. No violations were cited.

File closed.

I - 9275 - Therapy Event - Texas Health Presbyterian Hospital Dallas - Dallas, Texas

On January 28, 2014, the licensee notified the Agency that on January 27, 2014, a yttrium-90 Sir-Spheres radiotherapy administration may have resulted in a dose to a patient of sixty-one percent of that prescribed, which exceeded the +/- 20 percent variation that requires reporting. After further investigation, the licensee determined that the dose administered was 82.6% of the prescribed dose and proper amendments to the written directive had been made. This event did not meet the reportable event criteria. No violations were cited.

File closed.

I - 9276 - Unlicensed Radioactive Material - R T Precision Machinery - Cypress, Texas

On February 9, 2015, the Agency was provided information by Harris County Sheriff's Deputies that they suspected a radiation source (gauge) was present in a pipe inspection trailer that had been parked approximately 14 years at a storage facility. The Agency contacted the owner of the trailer who stated this was one of two trailers he purchased at an auction approximately 14-15 years prior. He sold one trailer (see I-9278) and stored this trailer at the facility without ever using it. He did not have any of the purchase paperwork. The owner was not aware he was required to be licensed to possess the radioactive material in the gauge. The Agency conducted an on-site investigation and determined a cesium-137 source was present but the radiation levels did not pose a health risk. The trailer owner responded promptly and contracted with a licensed company who, on March 4, 2015, removed and took possession of the source for proper disposal. The Agency's investigation to identify the original owner of the gauge/source was unsuccessful. No violation was cited.

File closed.

Incidents Opened First Quarter 2015

I - 9277 - Unauthorized Waste Disposal - ProTechnics - Odessa, Texas

On February 12, 2015, a landfill operator reported to the Agency that a trailer/container had caused its radiation monitor to alarm. The isotope was identified as iridium-192 and radiation measurements were from 500-1000 microR/hr. The landfill operator stated the waste had come from an oil well operation and provided contact information. The trailer was set aside at the landfill. The Agency contacted the well logging licensee that had used tracer material at the well site. The material was recovered by the licensee for proper disposal. The licensee investigated and submitted a detailed report stating its procedures were not followed by one of its technicians. The licensee stated it is retraining its technicians on proper disposal practices and surveys for waste at a facility/jobsite. One violation was cited.

File closed.

I - 9278 - Radioactive Material Found - Houston Threading - Houston, Texas

On February 13, 2015, the Agency was contacted by the radiation safety officer (RSO) of a service company. The RSO stated he had been contacted earlier that week by a company concerning disposal of an unwanted radioactive source. The source was contained in a nuclear gauge installed inside a trailer used to test drill pipe. The RSO stated he was working with the company to dispose of the source. The investigation into this event is ongoing.

File open.

I - 9279 - Regulatory Violation - Kelly's Pipe Inspections, Inc. - Odessa, Texas

On February 13, 2015, the Agency's Radioactive Materials Licensing Group requested assistance from the Incident Investigation Program (IIP) to locate a source. The Licensing Group stated the licensee had been licensed for a source that was installed in a gauge in an inspection trailer, but the license had expired. They stated they could not get the licensee to respond to their inquiries concerning the disposition of the source. IIP contacted the licensee's radiation safety officer who stated the device had been sold to a company in Oklahoma and agreed to send IIP a copy of the transfer documents. On March 6, 2015, the Agency received the transfer documents showing the gauge had been transferred to a company in Oklahoma on May 31, 2012. The information was provided to the Licensing Group. No violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9280 - Gauge Shutter Failure - Equistar Chemicals LP - Deer Park, Texas

On February 19, 2015, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that during routine gauge testing, they were unable to close the shutter on a nuclear gauge. The gauge was an Ohmart model SHLG-2 containing 8,000 millicuries of cesium – 137. The RSO stated the gauge is used for level indication on a vessel and open is the normal operating position for the gauge. The RSO stated the gauge does not present an increased exposure risk to their employees or members of the general public. The RSO stated they had lubricated the gauge operating mechanism in an attempt to free up the shutter, but the shutter remained stuck. On February 20, 2015, a repair technician was able to free the shutter mechanism. The licensee has said that they will perform preventative maintenance monthly rather than every six months. No violations were cited.

File closed.

I - 9281 - Unable to Retract Radiography Source - Acuren Inspections, Inc. - Kennedy, Texas

On February 20, 2015, the licensee notified the Agency that on February 19, 2015, one of its radiography crews had been unable to retract a 39.1 curie iridium-192 source back into a QSA 880D camera at a temporary work site. The crew was using a magnetic stand. The stand fell over and crimped the guide tube. The crew was unable to move the source within the tube. An authorized person responded to the site and performed the source retrieval. No member of the public received any exposure as a result of the incident. Neither of the radiographers involved nor the source retriever received any overexposures. The licensee returned the exposure device/source to the manufacturer for inspection and leak testing--there was no damage. The guide tube was removed from service. The licensee reported is has covered the event with its employees and has reminded them to check the jig to make sure it is secure throughout the work being done. No violations were cited.

File closed.

I - 9282 - Equipment Malfunction - The University of Texas M. D. Anderson Cancer Center - Houston, Texas

On March 4, 2015, the licensee reported that a malfunction had occurred involving its J.L. Shepherd Mark I, Model 30, self-contained irradiator. The source would not fully raise nor would it lower into the fully shielded position. The interlock system functioned as designed and the irradiator door remained locked. The equipment was repaired by the manufacturer on March 11, 2015. The company found the cutter pin from the bolt assembly had broken causing the bolt to lock in place and not allow the door to open. The pin was replaced. During the repair it was found that the door solenoid needed to be replaced as well. Both parts were installed and the irradiator was checked for proper operation and placed back into service. No one received any exposures and there is no risk for exposure as a result of this event. No violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9283 - Medical Waste at Landfill - Harris Methodist Hospital - Ft Worth, Texas

On March 11, 2015, the Agency was notified by a landfill that a load of waste from a hospital had caused its radiation monitor to alarm. The isotope identified was technetium-99. The Agency contacted the licensee and informed it of the event. Following its investigation, the licensee reported to the Agency that it had been unable to determine how the radioactive material had been released. The licensee stated it has purchased a portal radiation monitor and will require all trash to pass through the monitor prior to being placed in the dumpster for disposal. This was a non-cited severity level IV violation.

File closed.

I - 9284 - Abandoned Well Logging Source Down Hole - Sonic Surveys, Ltd.- Chambers County, Texas

On March 16, 2015, the Agency was notified by the licensee that a well logging tool was being abandoned down hole in a well in Chambers County, Texas. A well logging tool with a 150 millicurie cobalt-60 source became detached from the wireline and fell to the bottom of the storage well. The source was irretrievable. The source was abandoned in accordance with Texas Railroad Commission and Agency regulations. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. No violations were cited.

File closed.

I - 9285 - Gauge Source Disconnect - Union Carbide Corporation - Seadrift, Texas

On March 19, 2015, the licensee notified the Agency that on March 1, 2015, one of its operators retracted a 2,400 millicurie (original activity in 04/1991) cesium-137 source back into its Ohmart SHLM-CR3 source holder in preparation for a maintenance shut down. On March 2, 2015, a different operator pulled on the cable and it became disconnected from the source. The operator was unaware the source had already been retracted and shuttered. The licensee performed a survey and confirmed the source was in the fully shielded position and placed a lock on the shutter. No individual received any exposure as a result of this event. The licensee is coordinating with the manufacturer to have the gauge repaired. No violations were cited. File closed.

Incidents Opened First Quarter 2015

I - 9286 - Gauge Shutter Failure - Union Carbide Corporation - Seadrift, Texas

On March 19, 2015, the licensee notified the Agency that on March 17, 2015, it was closing the shutter on an Ohmart SH-F2 gauge, which contained a 200 millicurie cesium-137 source, when the bolt on the shutter handle sheared off. The licensee performed a survey to confirm the source was in the fully shielded position and placed a lock on the shutter. No individual received any exposure as a result of this event. The licensee contacted a service company and the gauge was repaired and returned to service on March 19, 2015. No violations were cited.

File closed.

I - 9287 - Abandoned Well Logging Source Down Hole - Recon Petrotechnologies, Inc. - Ft. Worth, Texas

On March 23, 2015, the licensee notified the Agency that it had abandoned a 2 curie cesium-137 source down hole at a depth of 3,365 feet in a well in Hutchison County, Texas. A 200-foot red-dyed cement plug and a deflection device were set above the source. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 9288 - Overexposure - Texas Health Presbyterian Hospital - Dallas, Texas

On March 23, 2015, the licensee's radiation safety officer (RSO) reported to the Agency that they had been notified on February 20, 2015, that one of their employees had received a total annual occupational exposure of 15.358 rem lens dose equivalent (LDE) for 2014, which exceeded the regulatory annual limit. The RSO stated the employee had received an exposure of 8.217 rem lens dose equivalent (LDE) for the exposure period of September 1, 2014, to October 31, 2014. The RSO stated they had reason to suspect the exposure was in error due to a higher collar/waist ratio than would typically be expected for normal clinical conditions. On March 4, 2015, the licensee's radiation safety staff members met with the employee to further investigate the high reading and formulate a plan for corrective action. In the absence of any clear evidence of an inadvertent exposure of the badge, the dose was accepted as a true reading of occupational exposure. The registrant changed the dosimetry issue period from bi-monthly to monthly for all its employees who routinely receive high exposures due to their job assignments. The registrant also made changes to its ALARA program and procured software to improve personnel exposure monitoring. One violation was cited.

File closed.

Incidents Opened First Quarter 2015

I - 9289 - Lost Laser - Baylor College of Medicine - Houston, Texas

On March 24, 2015, a registrant notified the Agency that an Oculight SLx Diode TTT class 4 laser, used for human eye procedures, had been lost. The registrant reported it had conducted an extensive two week physical search and interviewed all department members. As a result, the registrant was only able to assume the laser was stolen or relocated without permission. Procedural changes were made by the registrant to require a daily inventory of all lasers and a formal check out of all laser equipment. No violations were cited.

File closed.

I - 9290 - Badge Overexposure - AUT Specialists, LLC - Flint, Texas

On March 24, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that they had received a radiation exposure report from their dosimetry processor that indicated one of their radiographers had exceeded the annual deep dose equivalent (DDE) exposure limit. The RSO's investigation found that the radiographer's badge had been left in the radiographer's backpack on February 3, 2015, which he had left near a work bench where other radiographers were working. The badge was exposed repeatedly to radiation during radiography that was performed that day using that work bench. The RSO believes the exposure occurred at that time. Information from the processor concerning the exposure to the badge also supported the RSO's findings. The radiographer was assigned 0.416 rem for the exposure period which reduced the total DDE to below the regulatory limit. The RSO reported all of the licensee's radiographers received additional training on work area controls and controlling their dosimetry. No violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9291 - Overexposure - Mistras Group, Inc. - Texas City, Texas

On March 25, 2015, the licensee notified the Agency that on March 15, 2015, one of its radiographer trainees had experienced an exposure to an extremity that may have exceeded the regulatory limit that required reporting. The licensee's radiation safety officer (RSO) conducted an investigation and the Agency conducted an on-site investigation on March 30, 2015, that included re-enactment. Information from both investigations revealed that the QSA 880D camera was up on a deck and the radiographer trainee had cranked in the source from below. He went up on the deck to disconnect the source guide tube while the radiographer trainer stayed below and was checking the images on the computer. The radiographer trainee reported he surveyed the camera and hadn't gotten any readings, but he failed to recognize there might be an issue. He then tried to disconnect the guide tube but he couldn't get the outlet port cover to rotate. He checked the back of the camera to ensure the selector was in the right position and then tried again. Unsuccessful, he looked again at the back of the camera and saw the slide bar of the lock was showing red, indicating the source was not locked in the fully shielded position. He climbed down, told the trainer, and the trainer cranked out about 1/4 turn and forcefully retracted it to its locked and shielded position. They checked the survey meter and found it wasn't working properly. They opened it, adjusted the terminals, and it worked properly. The trainee said he did not hear his alarming rate meter, which was working, due to the noise level at the site. The radiographer trainee's dosimetry badge had a reading of 384 millirem. Following re-enactments, the RSO calculated and assigned a dose of 23 rem to the trainee's hands and 450 millirem to his left knee. The RSO sent the camera and associated equipment to the manufacturer for evaluation. There were no deficiencies identified. One violation each was cited for the licensee and the radiographer trainer.

File closed.

I - 9292 - Medical Waste at Landfill - Texas Healthcare System of San Antonio, Metropolitan Methodist Hospital - San Antonio, Texas

On March 26, 2015, a landfill operator notified the Agency that a load of waste from a hospital had caused their radiation monitor to alarm. The landfill provided information from its radioisotope identifier, but a definitive identification could not be determined. The Agency conducted an on-site investigation and the isotope was identified as gallium-67. The licensee's radiation safety officer (RSO) confirmed a patient had been treated with gallium and that house keeping staff had failed to follow procedures when the patient room was cleaned. The RSO reported that procedures for waste collection and screening were reviewed with their housekeeping department and the hospital is checking into the feasibility of purchasing a monitoring system for all waste to be screened prior to release to the landfill. The licensee instituted corrective actions and no violations were cited.

File closed.

Incidents Opened First Quarter 2015

I - 9293 - Gauge Shutter Failure - Westlake Longview Corporation - Longview, Texas

On March 31, 2015, the Agency received a request from a nuclear gauge manufacturer to perform repairs to the shutter of a nuclear gauge at a licensee's facility. The Agency attempted, unsuccessfully, to contact the licensee's radiation safety officer. The manufacturer was contacted. The manufacturer's representative stated it was hired to complete work on a sealed source gauge for level measurements due to a stuck shutter. On April 2, 2015, the Agency received an email from the licensee stating the gauge shutter was not stuck, but it did not function as well as it should. The licensee had contacted the service company to perform maintenance on the gauge before a failure occurred. No violations were cited.

File closed.

I - 9294 - Equipment Malfunction - The University of Texas M. D. Anderson Cancer Center - Houston, Texas

On March 31, 2015, the licensee reported that a malfunction had occurred involving its J.L. Shepherd Mark I, Model 30, self-contained irradiator on March 30, 2015. The source would not fully raise nor would it lower into the fully shielded position. The interlock system functioned as designed and the irradiator door remained locked. The manufacturer repaired the unit on April 9, 2015. The door interlocking solenoid had burned out due to an incorrect spring replaced during a previous incident repair. The irradiator was placed back in service. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2015

I - 9230 - Transportation Event - Earth Engineering Inc. - Houston, Texas

On September 9, 2014, the Agency was notified by The Woodlands Fire Department that it was at the scene of a traffic accident involving a licensee's vehicle transporting a gauge containing radioactive material. The gauge was a Humboldt 5001EZ containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The gauge was undamaged and no overexposures resulted from the event. The gauge had remained secured in the back of the licensee's vehicle during the accident. However, the Agency determined during its investigation that the licensee's blocking and bracing of the gauge during transport was inadequate. One violation was cited.

File closed.

I - 9240 - Radiography Source Disconnect - Fugro Consultants - Houston, Texas

On October 1, 2014, the licensee notified the Agency that on September 30, 2014, a radiography source disconnect had occurred at a temporary field site in east Houston. The camera was a Sentinel 880D with 68.3 curies of selenium-75. The licensee reported that when the radiography crew attempted to crank the source out, the source could not exit the front of the camera because the crew had failed to open the port cover. They could not retract the source back into the fully shielded position because they had also failed to connect the drive cable to the source assembly. An authorized person performed the retrieval by opening the port cover and pushing the source from the front back into the fully shielded position using another drive cable. The licensee held a safety meeting with its radiography employees to discuss the incident and reinforce the importance of verifying drive cable connection prior to use. No overexposures resulted from this event. No violations were cited.

File closed.

I - 9245 - Source Retraction Failure - Desert NDT, LLC - Encinal, Texas

On October 20, 2014, the licensee notified the Agency it had experienced a radiography source retraction failure at a temporary field site. A pipe had fallen from a stand onto the guide tube, causing a crimp. The source was retrieved by squeezing the crimp with pliers several times, allowing retraction. The camera was an IR-100 with a 46 curie iridium-192 source. No overexposures resulted from the event. One non-cited severity level IV violation was noted.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2015

I - 9255 - Equipment Malfunction - Desert NDT, LLC - Wichita Falls, Texas

On November 21, 2014, the Agency was contacted by the licensee to report an equipment malfunction when the source assembly could not be fully retracted into an INC IR-100 industrial radiography camera with a 42 curie iridium-192 source. A malfunctioning locking assembly caused the source to be unable to be fully retracted. The source was temporarily put into a spare camera while parts of the locking mechanism were replaced. The source was returned to the original camera and its use was resumed. No overexposures resulted from the event. No violations were cited.

File closed.

I - 9256 - Equipment Malfunction - Desert NDT, LLC - Hermleigh, Texas

On November 25, 2014, the licensee reported to the Agency that on November 24, 2015, one of its radiography crews had been unable to retract a source into a camera at a temporary job site. The crew was using an INC IR-100 device with a 51 curie iridium-192 source. A person authorized to perform source retrieval responded and returned the source to the fully shielded position inside the camera. The licensee sent the camera and associated equipment to a repair/service company for evaluation. It was determined that excessive wear in the pistol housing and the drive gear had caused the event as the mechanism was unable to catch and retract the drive cable. During the Agency's investigation, the licensee provided documentation of quarterly and daily inspections. However, the Agency determined the inspections and the licensee's response to repair or replace worn equipment had been inadequate. The licensee reported it is revising its procedures and forms and providing training on inspections to its employees to prevent recurrence. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2015

I - 9257 - Badge Overexposure - Hi-Tech Testing Services - Longview, Texas

On December 5, 2014, the licensee reported to the Agency that on December 4, 2014, its dosimetry processor had completed processing its badges for the October 2014 monitoring period and notified it that an employee had received 2,405 millirem. This dose caused the employee, a radiographer, to exceed the annual occupational dose limit. The licensee's radiation safety officer conducted an investigation. He learned that one morning during October (exact date unknown) the radiographer was tearing down equipment at the end of the night shift and he noticed his dosimetry badge was missing. He notified the lead radiographer and some of the shop workers. His badge was located in an area where they had been working with a cobalt-60 source earlier in the shift and based on the location it was found it would have been subjected to excessive radiation exposure. The radiographer stated to the RSO that he had checked his self-reading dosimeter periodically and nothing abnormal was noticed, his rate alarm had not sounded, and his survey meter had not indicated any abnormal readings. He did not report the incident to the RSO when it occurred. Based on his complete investigation, the RSO determined the dose was to the badge only. He assigned a dose of 205 millirem for the October 2014 monitoring period based on the radiographer's daily radiation reports. The RSO stated the radiographer was reminded of personnel monitoring practices, a safety memo will be sent to all radiographic personnel about the importance of following company procedures, and information will be presented at the next monthly safety meeting. No violations were cited.

File closed.

I - 9258 - Badge Overexposure - QC Laboratories, Inc. - Houston, Texas

On December 8, 2014, the Agency was notified by the licensee that the dose report from its processor for April 2014 indicated one of its radiographers had received 5,556 millirem for that month. The licensee stated it discovered this during its annual audit in November 2014 and that the overexposure had not been reported to the Agency. The licensee stated an interview with the radiographer revealed he had dropped his badge in an exposure bay at their facility and exposed it several times before he realized it. The radiographer did not report what had happened to anyone. The radiographer reported he had received 10 millirem on his self-reading dosimeter for that day. The licensee made the determination that the exposure was to the badge only and assigned an exposure of 56 millirem for that monitoring period based on a six month average of exposure received by the individual. The radiographer’s total exposure for the year was 470 millirem. The radiation safety officer (RSO) stated he and one additional manager will now review all dosimetry records received from their processor upon arrival. The RSO stated the event will be discussed at the company’s next safety meeting with their radiographers and he will also discuss the appropriate action required if a radiographer drops their badge while performing work with radioactive sources. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2015

I - 9260 - Badge Overexposure - Hi-Tech Testing Service, Inc. - Longview, Texas

On December 17, 2014, the licensee notified the Agency that during its investigation of an abnormally high dosimetry badge reading for one of its radiographers for the October 2014 monitoring period (I-9257), it had sent the radiographer's November and December badges in for immediate processing. The results indicated an exposure of 2,050 millirem for the November 2014 monitoring period, which caused the employee to exceed the annual occupational exposure limit. The licensee's radiation safety officer (RSO) conducted an investigation and submitted a detailed report to the Agency. Based on his complete investigation, the RSO determined that the exposure had been to the badge only. The RSO found that the radiographer violated company policy by failing to perform proper surveys, failed to report an incident and worked with malfunctioning equipment. The RSO assigned a dose of 416 millrem for the November monitoring period. With corrections made for both October and November, the radiographer did not exceed the annual occupational dose limit. The RSO stated the radiographer was reminded of personnel monitoring practices and was removed from performing radiographic procedures for the remainder of the year. The RSO stated a safety memo emphasizing the importance of following company procedures would be sent to all of the licensee's radiographer personnel and the topics of performing proper surveys, reporting incidents, and working with malfunctioning equipment would be covered in the next monthly safety meeting. Three violations each were cited for the licensee and the radiographer.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2015

I - 9263 - Radiography Source Disconnect - Texas Gamma Ray, LLC - Houston, Texas

On December 23, 2014, the Agency was notified by the licensee that one of its radiography crews had experienced a source disconnect. The licensee reported after completing an exposure at one of its licensed sites the radiographers attempted to crank the 78 curie cobalt-60 source back into the SPEC300 exposure device (camera). The radiographers stated as they approached the camera their survey meter and alarming rate meters indicated the source was not fully shielded. The radiographers moved their boundaries back, secured the area, and called their supervisor. The licensee's radiation safety officer and two employees who are approved on the license for source retrieval responded to the site. They found that the source pigtail cable had broken a couple of inches back from the source. The source was determined to be in the collimator. Lead was placed over the collimator to reduce exposure rates. The source was retrieved from the guide tube and, using six foot tongs, placed back inside the exposure device. The safety plug was inserted to maintain the source in the fully shielded position. A survey confirmed the source was in the fully shielded position. The licensee sent the exposure device and all associated equipment from this event to the manufacturer for evaluation. No member of the public received any exposure and there were no overexposures to any of the radiographers or members of the source retrieval team. The manufacturer's report stated the source pigtail had been repaired January 2012. The repair involved placing a splice on the source pigtail about 3.75 inches from the source to repair a section of “severely frayed” cable. The manufacturer’s report states that this pigtail failure occurred immediately behind this connection. The report states the crimped sleeve on the connector created a section of the source assembly that cannot flex. This caused the cable adjacent to the connector to flex more than is typical in a normal (unrepaired) cable. This repeated local “extreme flexures” combined with a potential abrasion eventually resulted in the failure. The manufacturer stated they were looking for a new connector to use in making this type of repair. No violations were cited.

File closed.

I - 9264 - Stolen Radioactive Material - T S I Laboratories, Inc. - San Antonio, Texas

On December 30, 2014, the Agency was notified by the licensee that a Humboldt model 5001EZ gauge containing a 40 millicurie americium-241/beryllium source and a 10 millicurie cesium-137 source was stolen out of the back of a company pickup truck. The licensee reported its technician had parked the truck at a movie theater and entered the theater to be with family. The gauge was unattended for one hour and forty-five minutes. When the technician returned to the truck he found the chains securing the gauge to the truck were cut and the gauge and locks were missing. On January 19, 2015, an individual searching near a river in San Antonio for used items to sell or recycle found the gauge. He contacted the Agency and the gauge was returned to the licensee. Based on interviews with the individual, exposure to the public was minimal. The gauge was inspected and placed back in service. To prevent recurrence, the licensee is reviewing its procedures and evaluating equipment for securing its gauges. No violations were cited.

File closed.

Complaints Opened First Quarter 2015

C - 2611 - Regulatory Violations - Woodland Heights Medical Center - Lufkin, Texas

On January 20, 2015, the Agency received a complaint alleging that x-rays received by the complainant on May 13, 2012, caused paralysis and skeletal issues. The complainant also alleged that two views were taken and the registrant would not provide him a copy of one of the views. He also questioned the qualifications of the x-ray technician. The Agency's investigation revealed that all records associated with the exam indicated only one view was ordered and it was completed with one exposure. The technician who performed the exam was an experienced technician with a current medical radiologic technologist certificate. It was explained to the complainant that an x-ray would not have caused the paralysis or skeletal issues he alleged. Complaint was not substantiated. No violations were cited.

File closed.

C - 2612 - Unregistered Facility - Mia Bella Esthetics/Texas Laser Source - Houston, Texas

On January 21, 2015, the Agency received a written complaint form dated January 15, 2015, from a complainant expressing a monetary issue with a laser hair removal facility. In addition, the complainant alleged that the technician burned him. The complainant was contacted and the injury was discussed. He stated the injury was redness of the skin with no blistering and he was seen by a dermatologist who prescribed a topical cream to reduce inflammation. No medical records were submitted to our Agency. There was insufficient evidence to support a reportable injury had occurred. The complainant also wanted an inspection of the facility and proper registration to be confirmed. An investigation was completed and found that the facility was not registered. Complaint was partially substantiated. One violation was cited.

File closed.

C - 2613 - Regulatory Violation - Claude Williams Jr. DDS - Irving, Texas

On January 27, 2015, the Agency received an allegation that a dental office was using a x-ray device that had not been certified since 2008. The current registrant had purchased the business from a previous registrant. A search of the previous registrant's records discovered the units had been inspected and the Equipment Performance Evaluations had been completed in April 2014. The registrant obtained copies of the reports and provided copies to the Agency. No violations were cited.

File closed.

Complaints Opened First Quarter 2015

C - 2614 - Regulatory Violations - Bonded Inspections, Inc. - Dallas, Texas

On January 29, 2015, the Agency received a complaint referred from the Nuclear Regulatory Commission. The complaint alleged multiple radiography regulatory violations including the use of survey meters that had not been calibrated within the required interval and conducting incorrect surveys of cameras. On February 9, 2015, the Agency conducted an unannounced investigation at a temporary jobsite. On March 11, 2015, the Agency conducted a record review at the licensee's site office. Observations of the team and a review of records could not substantiate the complaint. No violations were cited.

File closed.

C - 2615 - Regulatory Violations - Jack County Hospital District - Jacksboro, Texas

On January 30, 2015, the Agency received an anonymous complaint that the registrant was allowing uncredentialed technologists to operate computed tomography (CT) machines. An unannounced inspection was performed on February 18, 2015. It was found that uncredentialed technologists were performing substantial portions of CT exams. Other regulatory violations were also identified. The complaint was substantiated. Eleven violations were cited.

File closed.

C - 2616 - Regulatory Violations - WorldSpec NDT Training - Vancouver, British Columbia

On February 2, 2015, the Agency received a complaint alleging that a company that provides online industrial radiography training courses told the complainant that its radiation safety training was approved in Texas. After the complainant completed the course, he learned it was not approved/accepted by the Agency. The Agency conducted an investigation. The investigation was unable to determine if the company intentionally provided incorrect information or if it was just a misunderstanding. The company has refunded the complaninant's money. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2617 - Inadequate Credentials Industrial Radiographer - Ace NDT, LLC - Perryton, Texas

On February 16, 2015, the Agency received a complaint alleging an unlicensed individual was performing industrial radiography work at a job site. The Agency found the individual held a valid Oklahoma radiographer certification, which the Agency recognizes. The radiographer was employed directly by the Texas licensee and was not working under reciprocity. Compliant was not substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2015

C - 2618 - Inadequate Credentialing - Harris County Hospital District - Houston, Texas

On February 16, 2015, the Agency received a complaint alleging the registrant was allowing a technologist with a certified dosimetrist license to work as a medical physicist, the oncologist had altered a medical device, and the quality assurance requirements were not being followed in the radiology department. An on-site investigation was conducted on February 26, 2015. Staff interviews were conducted and procedures and quality assurance documents were reviewed. The issue regarding the alteration of a medical device was referred to the Agency's Drugs and Medical Devices Group for further investigation. Issues concerning job description and qualifications to perform certain duties as a dosimetrist were referred to the Texas Medical Review Board for its input. During its investigation, the Agency also found the registrant had failed to update its registration as required, one of their medical physicist's license had lapsed, and a quality assurance document lacked review by the medical physicist in a timely manner. The complaint was substantiated. Three violations were cited.

File closed.

C - 2619 - Regulatory Violation - Desert Imaging Services - El Paso, Texas

On February 23, 2015, the Agency was notified that a registrant had failed to provide a copy of mammography images within 30 days of a written request as required. The Agency conducted an investigation and determined that that a mammography registrant had bought an older facility and were unable to access images from the original registrant. The new registrant made multiple attempts to recover the requested images but have been unable to access the older software. The complaint is partially substantiated. No violations were cited.

File closed.

C - 2620 - Inadequate Credentialing - Central Texas Medical Center - San Marcos, TX

On February 23, 2015, the Agency received a complaint that the registrant was using technologists that were not credentialed in a fluoroscopy cardiac cath lab and that patients were receiving excessive radiation. Other portions of the complaint were referred to the Patient Quality Care Unit. An on-site investigation on March 11, 2015, revealed that radiation protocol committee protocols were not followed regarding total dose action levels. No evidence was found to support uncredentialed technologists operating fluoroscopy units. The complaint could not be substantiated. Five violations were cited.

File closed.

Complaints Opened First Quarter 2015

C - 2621 - Regulatory Violations - Ace NDT, LLC - San Antonio, Texas

On March 24, 2015, the Agency received a complaint alleging multiple regulatory violations against the licensee. The allegations included: individuals who transport radioactive material have not had the required training, the licensee possessed quantities of material that exceeded license authorization, leak tests on sources were not performed within the required interval, and other violations of security and control regulations. The Agency conducted an on-site investigation in conjunction with the site's initial inspection that was due. The Agency inspector's findings did support some of the allegations while others were not. The licensee has stated it has made necessary corrections. The complaint was partially substantiated. Nine violations were cited.

File closed.

C - 2622 - Regulatory Violations - Clinical Imaging Management Systems - Harlingen, Texas

On March 25, 2015, the Agency received a complaint in which the complainant described x-ray equipment installation procedures and an equipment evaluation performed in March 2014 by a registered agent to be misleading and improper. The documentation submitted displayed two customer names for the same unit and two different dates. The complainant stated the x-ray equipment had previously had a metal cover and now has a plastic cover, which heats up when the unit is on, and the unit is not bolted to the floor as it is supposed to be. The Agency reviewed the submitted documents and found that although they were misleading they had been completed as required for installation of the equipment. The Agency requested the registrant provide the manufacturer's specifications. No document was received. The Agency conducted an inspection at the registrant's facility and documented violations for misalignment of the beam and distance requirements and record availability. The Agency contacted the registered equipment installer and learned that a year after installation the beam had become misaligned and the registrant had had it repaired by the installer. His records appeared to be correct. A new equipment performance evaluation must be completed to resolve the violations cited. The complaint could not be substantiated without manufactures specification. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2015

C - 2551 - Regulatory Violations - Amerejuve, Inc. - Houston, Texas

On March 10, 2014, the Agency received complaints for 8 laser hair removal facilities owned by the same company. The complaints alleged that at each location there was not a Senior Laser Hair Removal (LHR) Technician or LHR Professional present as required, the consulting physician had not performed audits, the laser safety officer had not performed audits, records of LHR procedures did not include the required information, the technicians' continuing education requirements were not being met, and certified LHR technicians (certificates) were not posted. The Agency's investigation confirmed that the required activities were either not performed and/or the facilities did not have any documentation to support they were in compliance. The company is under new management and has reported activities it is taking to come into compliance. The complaint was substantiated. These issues of non-compliance will be included for consideration by the Agency in violations being cited for each of the facilities for failure to be registered as a laser hair facility (C-2484).

File closed.

I - 2593 - Inadequate Credentialing - Advanced Corrosion Technologies & Training - Lake Jackson, Texas

On September 9, 2014, the Agency received a complaint referral from the Nuclear Regulatory Commission. The Agency sent a request via email to the complainant requesting additional information. The complainant contacted the Agency on September 19, 2014, and stated the registrant was allowing individuals to operate x-ray radiography devices without proper training or dosimetry. On October 30, 2014, the Agency went to the registrant's facility to conduct an investigation. Upon arrival, the Agency's inspector was informed that the radiation safety officer (RSO) was not available. On December 5, 2014, the Agency returned to the location and performed an on-site investigation. The investigation determined that the registrant had allowed individuals to work in Texas without receiving reciprocity for six radiographers who held cards from other states. The investigation also found the registrant did not have an RSO for this registration from August 15, 2014, to October 29, 2014. On December 23, 2014, the RSO stated certain required records could not be provided to the Agency. The complaint allegation was not substantiated. Four violations were cited.

File closed.

C - 2595 - Panoramic Dental X-ray Concern - Unidentified Registrant - Texas

On September 24, 2014, the Agency received an anonymous complaint that expressed concerns about a panoramic dental x-ray unit installed near an office door at a facility that the complainant would not name. Subsequent diagrams and pictures provided by the complainant were reviewed and no violations of Agency rules were identified. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2015

C - 2596 - Uncredentialed X-ray Technologist - St. Elizabeth Family Care, LLC - Dickinson,

On September 26, 2014, the Agency received a complaint that a facility was using a medical assistant to take x-rays when the regular x-ray technologist was not at work. The complaint also alleged that the regular technologist may also not be properly credentialed as there was no certificate displayed in a visible location showing she was certified. The Agency conducted an on-site investigation and found that the medical assistant held a current non-certified technician certificate (NCT). The investigation revealed the NCT had performed exams outside the scope of her credentials. The regular technologist held a current medical radiologic technologist (MRT) license. The registrant stated it will only use MRTs, not NCTs, in the future to prevent recurrence. There is no requirement for MRT/NCT certificates to be displayed. The information obtained on the NCT was referred to the DSHS Professional Licensing and Certification Unit. During the investigation, the Agency discovered the registrant had failed to monitor the occupational exposure of individuals performing x-ray exams at its facility and had failed to monitor dose to the public in unrestricted areas. Complaint was substantiated. Violations were cited.

File closed.

C - 2597 - Regulatory Violations - General Inspection Services - Hempstead, Texas

On September 30, 2014, the Agency received a complaint that the licensee was allowing trainees to conduct radiography alone, that various required equipment was broken, missing, or unused, and that various other violations were occurring regularly. The Agency conducted an investigation on November 18, 2014, with the radiography company and records were reviewed. Also, a temporary job site investigation was completed on January 13, 2015, to observe the work practices of a radiography crew at a temporary job site. The inspection produced one violation for not having the safety and operating manual available at the temporary site as required. The company printed a copy of the manual and placed it in the vehicle. The crew was performing the requirements established for gamma imaging using an industrial radiography camera. The complaint was not substantiated. One violation was cited.

File closed.

C - 2600 - Monitoring Not Provided - University General Hospital - Houston, Texas

On October 23, 2014, the Agency received a complaint that monitoring had not been provided by the registrant to the complainant for a period exceeding requirements. Investigation revealed that for two quarterly monitoring periods between May 2012 and February 2013, badges for the complainant were not returned for processing. For another monitoring period between February 2013 and May 2013 the monitoring badge was allowed to expire and could not be processed. It was also discovered that the registrant failed to notify the agency of a change in radiation safety officer within thirty days. The complaint was substantiated. Two violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2015

C - 2601 - Regulatory Violations - American Laser Med Spa - Amarillo, Texas

On October 24, 2014, the Agency received a complaint alleging the registrant was violating multiple laser hair removal regulations at several locations in Texas. The Agency conducted an investigation and found that the facilities were exempt from the laser hair removal regulations and were properly registered otherwise under laser regulations, though registration fees were delinquent. The registrant immediately brought the registration current. The complaint was not substantiated. No violations were cited.

File closed.

C - 2603 - Uncredentialed Technologist - Palestine Regional Medical Center - Palestine, Texas

On November 12, 2014, the Agency received information from the Texas Department of State Health Services, Health Facility Licensing and Compliance Division (HFLC). The HFLC reported that during their investigation of the registrant they discovered an individual was performing diagnostic cardiac catheter procedures while no physician was present and did not hold the required credentials. The individual had credentials as a Registered Cardiovascular Invasive Specialist (RCIS). The Agency contacted a charge nurse and a hospital administrator. Both stated they were aware that the individual was not qualified to perform the procedure by themselves, but thought as long as the physician was in the hospital it was permissible. The hospital administrator stated the RCIS was no longer employed by the hospital and they did not intend to replace them. The complaint was substantiated. One violation was cited.

File closed.

C - 2604 - Regulatory Violations - Baker Hughes Oilfield Operations - Perryton, Texas

On November 14, 2014, the Agency received an anonymous complaint alleging multiple regulatory violations related to inventory, shipment, and surveys of densometers containing radioactive sources. On January 15, 2015, the Agency conducted an on-site investigation. Multiple shipping documents, leak test results, and inventories were reviewed during the visit. No discrepancies were noted. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2015

C - 2605 - Laser Injury - Amerejuve - The Woodlands, Texas

On November 12, 2014, the Agency received a complaint that alleged an individual was performing laser hair removal (LHR) procedures and did not possess a certificate of registration to do so. The complaint also alleged that the individual had caused burns to a customer's face and underarms during a laser procedure. The Agency conducted an on-site investigation. The investigation confirmed that the individual had been performing LHR procedures and did not possess a certificate of registration. The was insufficient evidence to support that a reportable injury had occurred. The complaint was partially substantiated. One violation was
cited.

File closed.

C - 2606 - Unregistered Laser Hair Removal Facility - De Hita Skin Care Spa - Humble, Texas

On December 3, 2014, the Agency received an inquiry from an individual concerning whether a spa, which offers laser hair removal, was registered with the Agency. During an initial search of Agency records, no certificate of registration for the facility was located. The Agency contacted the facility owner and the owner stated that they were not currently performing laser hair removal but they were planning to offer such services in the future. The owner was advised as to what kind of registration with the state would be required. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2608 - Laser Injury - Rockwall Laser Center and Academy - Rockwall, Texas

On December 11, 2014, the Agency received an allegation that two individuals may have received burns during laser treatments that were not reported to this Agency as required. An on-site investigation was conducted by the Agency on February 9, 2015. The investigation found documents showing the training class did not start until after the facility received its registration to do so. The investigation did not find any documentation related to burns that would have required reporting to the Agency. The investigation was unable to substantiated that any individuals were allowed to perform laser hair removal prior to receiving the required certifications. The investigation did produce contact information for the two individuals alleged to have received the burns during treatment. The individuals were contacted and neither individual sought medical treatments for their burns, nor could they remember who had performed the treatments. There was insufficient evidence to determine if reportable injuries had occurred. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2015

C - 2609 - Regulatory Violations - Team Industrial Services, Inc - Pasadena, Texas

On December 16, 2014, the Agency received an anonymous complaint reporting multiple regulatory violations at a fixed radiography site. The alleged violations included radiographer trainees not being supervised, surveys not being performed, dosimetry not being worn, and one radiographer walking up on an exposed source. On January 21, 2015, the Agency conducted an on-site investigation of two radiography teams. Additionally, the Agency reviewed dosimetry records for personnel listed in the complaint. Observations of the teams and a review of records could not substantiate the complaint. One unrelated violation was cited.

File closed.

C - 2610 - Unregistered Fluoroscopy Unit - Beltway Foot Clinic - Houston, Texas

On December 22, 2014, the Agency received a complaint that the clinic may be operating a fluoroscopy unit and laser unit without proper registration. The Agency's on-site investigation on January 7, 2015 revealed two fluoroscopy units in use by the clinic at two locations. It was found that the clinic was not registered with the Agency. It had not monitored personnel or public exposure to radiation. Also, required testing by a licensed medical physicist had not been performed. The clinic has discontinued radiographic services and placed the units in storage pending disposal/sale. A clinic representative stated that the clinic had previously contracted with another company to perform laser procedures, but had stopped doing so approximately two years ago. The complaint was partially substantiated. Eleven violations were cited.

File closed.