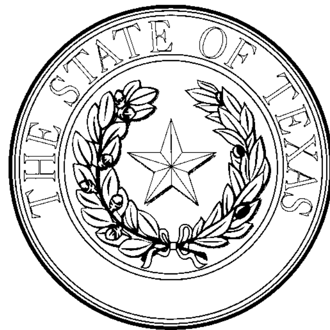

INCIDENT AND COMPLAINT SUMMARIES FOR FIRST QUARTER 2016*

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Texas Department of State Health Services
Regulatory Services Division
Inspections Unit
Radiation Branch

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

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

Incident and Complaint Summaries
1st Quarter 2016

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Incidents Opened First Quarter 2016

I - 9369 - Nuclear Pharmacy Error - Triad Isotopes, Inc. - Dallas, Texas

On January 7, 2016, the Agency received notice from the licensee that on December 3, 2015, technetium-99m (Tc-99m) Medronate was administered to eight patients instead of the required technetium-99m (Tc-99m) Sestambi. The Medronate vials were inadvertently placed in dispensing shields labeled Sestambi. No exposure limits were exceeded and the users did not report any adverse effects to the patient. The patients and their physicians were notified of the error. The licensee determined the root cause for the error was failure of the technologist to scan the barcode on the vial before putting it in the correct vial shield in accordance with policies and procedures. The licensee conducted training on the incident and the importance of following procedures. No violations were cited.

File closed.

I - 9370 - Unable to Retract Radiography Source - QualSpec Services Inc - Corpus Christi, Texas

On January 12, 2016, the Agency received notice that on January 11, 2016, a radiography source could not be retracted to the shielded position. The camera was a QSA 880D with a 99.8 curie iridium-192 source. An extension to the guide tube had not been connected, and the drive cable slipped the gears of the crank assembly. The drive cable and crank assembly were reassembled and the source was returned to the shielded position. No overexposures resulted from this event. No violations were cited.

File closed.

I - 9371 - Transportation Event - Southwest Research Institute - San Antonio, Texas

On January 14, 2016, the licensee notified the Agency that it had received an exclusive use shipment of sources in Type A containers that originated in Maryland. The dose rate on one of the containers, which held an 8.4 curie cobalt-60 source (current activity/decay corrected), exceeded the 1,000 mR/hr limit. The highest dose rate reading on the exterior of the container was 1,900 mR/hr. The licensee surveyed the transport vehicle and all exposure rates were below regulatory limits. The licensee reported that none of its workers received any overexposure. A determination was made that the Agency does not have any regulatory authority for this event and the licensee was not responsible. A referral was made to, and all information collected was shared with, the State of California where the shipper is licensed. Event information was also shared with the State of Maryland as the shipper was working under reciprocity in that state.

File closed.

Incidents Opened First Quarter 2016

I - 9372 - Regulatory Violations - SGS North America - Deer Park, Texas

On January 20, 2016, the Agency received a referral from the Nuclear Regulatory Commission. The information alleged that the licensee was going out of business, the radiation safety officer (RSO) no longer worked for the licensee, and the whereabouts of the licensee's four moisture/density gauges were unknown. On February 18, 2016, the Agency conducted an on-site investigation. There was no RSO and the employee who assisted the investigator did not know the location of the gauges. The employee contacted another of the licensee's company offices in Illinois and learned that three of the gauges were on-site in a storage bunker there at the licensee's Texas location and the fourth gauge was in the possession of a company in Kentucky. The licensee had ceased operations in May 2015 and had failed to maintain required activities and records (i.e. area surveys, dose monitoring, leak tests, and others). The State of Kentucky was notified and they confirmed the company in possession of the fourth gauge was not licensed to possess it. Twelve violations were cited.

File closed.

I - 9373 - Therapy Event - Valerian Chyle, Jr., MD PLLC - Kerrville, Texas

On January 22, 2016, the registrant notified the Agency that on January 21, 2016, a therapy event occurred when the wrong patient was treated with a linear accelerator.
The registrant reported that the treatment plan for the next scheduled patient had been entered into the treatment control unit. The patient did not show up at the scheduled time so the next patient was taken into the room and positioned for treatment. The treatment plan was not changed. The operator noted a discrepancy in the active field and the planned treatment field as the second fraction started. The operator immediately terminated the treatment. The prescribing physician and the patient were notified of the event. The patient's treatment plan was altered and completed. The registrant calculated the dose to the unintended tissue was less than 0.5 gray and stated no significant clinical effects would be felt by the patient. The registrant stated a new policy for patient identification has been implemented to prevent the event from occurring again in the future. All staff involved in this form of treatment were trained in the new policy. No violations were cited.

File closed.

Incidents Opened First Quarter 2016

I - 9374 - Radioactive Material Identified at Landfill - Charter Waste Landfill - Odessa, Texas

On January 25, 2016, the Agency responded to a technical assistance request at a landfill in Odessa, Texas. The landfill had segregated an empty windshield wash jug containing tygon tubing and a test tube that had caused its radiation monitor to alarm on January 21, 2016. The landfill had been unable to identify the isotope. Agency investigators identified the isotope of the residual material in/on the items as scandium-46 and transported them to Austin, Texas, to store for radioactive decay. The material was picked up on a residential waste route so the licensee could not be identified. The material was most likely thrown away by a technician who used the material in tracer sands used in petroleum drilling. The Agency contacted the four licensees in Odessa and Midland that are licensed to use scandium-46 and requested that they determine if any of their employees live along the residential waste route and they were asked to conduct training with their staff on proper disposal of residual radioactive material. All four licensees reported that no employees lived along the route. No violations were cited.

File closed.

I - 9375 - Transportation Event - Terracon Consultants Inc. - Cumby, Texas

On January 26, 2016, the licensee notified the Agency that at approximately 1815 hours CST on January 25, 2016, one of its technicians had been involved in a vehicle accident while transporting a Troxler Model 3430 moisture/density gauge. The accident occurred near Cumby, Texas. The technician was hospitalized as a result of injuries received in the accident. The gauge contained a 40 millicurie americium-241 and an 8 millicurie cesium-137 source. The licensee reported that the gauge's insertion rod was locked and the gauge was secured inside its transport case which was secured to the vehicle. A wrecker service removed the vehicle from the scene and took it to it business location where the vehicle was placed behind a fence with a locked gate. The licensee was notified of the accident after midnight. A licensee's employee retrieved the gauge from the vehicle at approximately 0830 that morning. The employee reported the shipping papers were on the seat of the vehicle. The licensee reported that it does not appear anyone was aware of the presence of the gauge until the employee removed it. The gauge was not damaged. No violations were cited.

File closed.

I - 9376 - Gauge Shutter Failure - MEMC Pasadena, Inc. - Pasadena, Texas

On January 28, 2015, the licensee notified the Agency that during routine leak test and shutter checks it had discovered that the shutters on two Ohmart-Vega SH-F1 gauges were stuck in the open position. Open is the normal operating position for these two level gauges that are mounted on the sides of tanks. Each gauge contains a 120 millicurie cesium-137 source. Due to the location of the gauges, there was no risk of exposure to any individual. The gauges were removed and returned to the manufacturer in February 2016. During the Agency's investigation it was discovered that the licensee had failed to perform shutter operation checks at the required time interval. One violation was cited.

File closed.

Incidents Opened First Quarter 2016

I - 9377 - Radioactive Material Found - Gulf Copper Dry Dock & Rig Repair -Galveston, Texas

On February 2, 2016, the Agency was notified that a company employee retrieved a device off a crane that contained radioactive material. The Agency has made arrangements to retrieve the device/gauge from the company. The device is located in an isolated area and does not produce any reading level until directly on contact with a survey meter. No hazard to employees or public is expected. The device was collected, transported and place in Agency storage until disposal can be arranged.

File closed.

I - 9378 - Gauge Shutter Failure - Covestro LLC - Baytown, Texas

On February 12, 2016, the Agency was notified by the licensee's radiation safety officer (RSO) that on February 11, 2016, while performing a routine inspection of a Berthold model LB 300 L nuclear gauge they found the source shutter was stuck in the open position. Open is the normal operating position for the gauge shutter. The gauge contains a cobalt-60 source with a current activity of 0.07 millicurie. The RSO stated the dose rates at and around the gauge were normal. He stated no individual including members of the general public will be exposed to any additional radiation due to the failure. On May 18, 2016, the RSO reported the manufacturer was able to free the shutter operator up and the shutter is now operating as designed. The RSO stated a new gauge has been ordered and the gauge will be replaced in the July 2016 outage. The RSO stated they are now using a lubricant recommended by the manufacturer to prevent problems in the future. No violation was cited.

File closed.

I - 9379 - Equipment Malfunction - Texas Children's Hospital Diagnostic Imaging 2-2521 - Houston, Texas

On February 18, 2016, the Agency was notified by the licensee, in accordance with a license condition, that the turntable for a Gammacell 1000 irradiator failed to turn and would not be repaired within 24 hours. Neither the source safety nor shielding were affected. The canister had been dropped and damaged which prevented rotation of the turntable due to the shape of canister. The canister was replaced on February 21, 2016. Additionally, the unit's turntable motor and wire housing were replaced based on a three to five year lifecycle. The unit was tested after repair and functioned normally and was returned to service. No violations were cited.

Incidents Opened First Quarter 2016

I - 9380 - Lost Source of Radioactive Material - Basic Energy Services LP - Eastland, Texas

On February 22, 2016, the Agency received notice that on February 18, 2016, while under reciprocity in Louisiana, the licensee had lost a Thermo Fisher model 5192 density gauge that contained 200 millicuries of cesium-137. Exposure to the public is unlikely due to the gauge's design. It is not known whether the gauge was lost or stolen. It has not been recovered. The Louisiana Department of Environmental Quality conducted the investigation. They cited the licensee for three areas of concern.

File closed.

I - 9381 - Overexposure - Hendrick Medical Center - Abilene, Texas

On February 23, 2016, the Agency received notification from the registrant that a physician that performs fluoroscopy at its facility, whose exposure they monitor, had exceeded the annual occupational exposure limit of 5,000 millirem for the year 2015. They registrant had assigned an annual dose of 5,686 millirem. An investigation into this event is ongoing.

File open.

I - 9382 - Radiation Exposure to Member of the Public - Equistar Chemicals LP - La Porte,

On February 23, 2016, the Agency was contacted by the licensee's consultant. The consultant stated that the licensee was calibrating a level detection gauge using a procedure not previously used. During the calibration, an individual who was monitoring dose rates in the area noted the dose rate where they were standing was 15 millirem per hour. The individual also found the dose rate where two non-radiation workers were working was 12 millirem per hour. The workers had been working in the area for approximately 45 minutes. The licensee's investigation determined the calculated exposure to the workers was 9.8 millirem, which exceeded the regulatory exposure limit of 2 millirem in any one hour for members of the public (non-radiation workers). The investigation revealed the gauge calibration technicians had followed the established procedure. However, this time the product vessel was empty during gauge calibration. Without the shielding normally provided by product inside the vessel, the radiation levels were greater than normal where the technicians were working. A new procedure is being written to prevent a future occurrence. One violation was cited.

File closed.

Incidents Opened First Quarter 2016

I - 9383 - Equipment Malfunction - Ticona Polymers, Inc. - Bishop, Texas

On March 1, 2016, the Agency was contacted by the licensee and informed that while performing routine inspections on February 29, 2016, it discovered the shutter on a Berthold fixed gauge was stuck in the open position. The gauge normally operates with the shutter in the open position. The licensee stated no individual, including members of the general public, will be exposed to any additional radiation due to the failure. The gauge is a model MB7442D containing 30 millicuries of cesium-137 (original activity.) On March 3, 2016, a manufacturer's representative arrived at the licensee's facility and inspected the gauge. The representative determined the operating rod for the shutter had been sheared in half. It was decided the gauge housing should be replaced. The source was removed from the housing and placed in a new gauge housing. The new gauge was installed on the vessel and is operating properly. As corrective action, the licensee will evaluate the lubricant it is using to ensure it is not contributing to the problem, it will enclose the gauge if it determines the environment is contributing to the problem, and in the future it will contact the manufacturer as soon as the shutter becomes difficult to operate. No violation was cited.

File closed.

I - 9384 - Gauge Shutter Failure – Ticona Polymers Inc. - Bishop, Texas

On March 7, 2016, the Agency received notification from the licensee's radiation safety officer (RSO) that the shutter on an Ohmart SH-F2 gauge, containing a 100 millicurie cesium-137 source, failed to shut during an operational check. Open is the normal operating position of the gauge shutter. No licensee employee received any exposure as a result of this event. A service company inspected and repaired the shutter on March 8, 2016. The shutter was difficult to operate due to grit and rust. The shutter and source holder were cleaned and the shutter mechanism greased. The licensee will continue with semi-annual inspections and if the shutter is difficult to exercise the service company will be contacted. The licensee is researching better source holder designs that could eliminate this common problem that occurs due to the corrosive environment. No violations were cited.

File closed.

I - 9385 - Public Overexposure - Ben Taub General Hospital - Houston, Texas

On March 14, 2016, the license reported that an overexposure occurred to a member of the public on January 30, 2016. Specifically, a relative stayed overnight in the hospital next to a patient who was undergoing a low dose rate brachytherapy treatment with a 164.4 millicurie cesium-137 source. It was determined that the visitor slightly exceeded the public dose rate of 2 millirem in any one hour. One violation was cited.

File closed.

Incidents Opened First Quarter 2016

I - 9386 - Stolen Moisture/Density Gauge - Geotest Engineering, Inc. - Houston, Texas

On March 15, 2016, the licensee notified the Agency that one of its technicians had stopped at an apartment complex on his way to a temporary job site and had left a Troxler model 3430 moisture/density gauge secured with two chains in the back of the company truck while he went inside. When he returned to his vehicle, he found that the chains had been cut, the transport case was on the ground near the vehicle, and the gauge had been removed. The licensee's radiation safety officer (RSO) reported that the insertion rod on the gauge was locked and the technician had the key. The RSO notified local law enforcement and licensee's employees searched the area. They found other vehicles' windows had been broken but they did not find the gauge. The licensee posted signs offering a reward. As of May 3, 2016, the gauge has not been recovered. The licensee provided additional instructions and re-training to its technicians requiring them to never leave gauges without surveillance. No violations were cited.

File closed.

I - 9387 - Lost/Recovered Source of Radioactive Material - FedEx - Pasadena, Texas

On March 16, 2016, the Agency was notified by a manager for a common carrier that a package containing radioactive material had fallen out of one of their vehicles during tranport. The package was found by a member of the public on a highway. The person collected the package and called the phone number on the package, which was the source manufacturer's. The radiation safety officer (RSO) from the manufacturer's La Porte, Texas, facility met the member of the public to collect the package. The RSO completed a survey of the package and performed leak testing. The container was a type B package containing two iridium-192 sources. The RSO found the package's outer shipping box was damaged although the type B container was in good condition and was not leaking. The sources were taken to the manufacturer's La Porte facility and placed in storage. The sources were on route to the manufacturer's Baton Rouge, Louisiana, facility when the container fell out of the transport vehicle onto the freeway. The investigation revealed that the member of the public had the package for less than an hour. A dose estimate for the member of the public was calculated by the carrier's health physicist to be less than 0.5 millirem, which is below regulatory exposure limits for a member of the public. The carrier demonstrated that its employee did not follow operating procedures for transporting dangerous goods. The Agency has also provided the US Department of Transportation with a notice of the incident. Two violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2016

I - 9352 - Radioactive Material Found - U.S. Customs and Border Patrol - Dallas, Texas

On October 29, 2015, the Agency was contacted by a radiation safety officer (RSO) from the United States Customs and Border Patrol at DFW airport. The RSO stated they had detained a package coming through customs that had alarmed a radiation detector. The radionuclide was identified as iodine-125. The RSO asked if the Agency could take possession as they do not have appropriate storage for the material. The package was picked up by the Agency on October 29, 2015, and taken to its office in Arlington, Texas. The package was picked up by an inspector from Austin, Texas, on November 3, 2015. The inspector noted the weight of the item was much heavier than expected. The inspector performed a radiation survey of the package and found the dose rate appeared to be collimated. The radionuclide identified by the inspector was americium-241. The inspector notified their supervisor of their concerns regarding the contents of the package. The supervisor instructed the inspector to take the package to a fire department located near Austin to have additional analysis done on the package contents. The package was tested for explosives, chemical, and radiological hazards. No chemical or explosive hazards were found. The radioactive material was identified as eight small cardboard wafers. The wafers were taken to the Agency's laboratory and analyzed. The radionuclide was identified as iodine-125. All of the material that was determined not to be a radiological hazard was taken to the Agency's laboratory to be tested for biological hazards. None were identified. The material was transferred to the appropriate federal Agencies. No violations were cited.

File closed.

I - 9353 - Occupational Overexposure - DNA Vascular Center - Dallas, Texas

On November 5, 2015, the registrant notified the Agency that the report it had received from its personnel monitoring dosimetry processor for October 2015 indicated one of its physicians had exceeded the annual occupational exposure limit of 5,000 millirem. The physician received a dose of 5,824 millirem thus far for the year. The registrant's investigation supported that the physician, who routinely performs fluoroscopy, received the reported dose and has had similar annual doses for the past five years. The physician was suspended from work with radiation for the remainder of the year. The facility has established new operating procedures and policies to prevent recurrent overexposures. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2016

I - 9358 - Overexposure - Nondestructive & Visual Inspection LLC - Carthage -Texas

On November 13, 2015, the Agency was notified by the licensee that one of its radiographers had experienced an overexposure. The radiation safety officer stated the radiographer was performing radiography using a Spec 150 exposure device containing a 124 curie iridium-192 source. The radiographer had completed a shot and exchanged the film and went to the exposure device to unlock the source when he found the source was already unlocked. The radiographer looked at his dose rate meter and found the needle pegged high. The radiographer went to the source crank outs and found the source was still cranked out about one-quarter of a turn from the fully shielded position. The radiographer returned the source to the fully shielded position. The radiographer found his self-reading dosimeter was reading off scale. The radiographer contacted the licensee and it them of the event. The licensee removed the radiographer from the field and sent his dosimeter to its processor for reading. The processor's report indicated the radiographer had received a dose of 11.345 rem DDE. The radiographer's total exposure for the year 2015 was 12.167 rem DDE. The radiographer has not reported any adverse physical effects from the exposure. The licensee was cited for two violations.

File closed.

I - 9360 - Overexposure - Symphony Diagnostic Services - Houston, Texas

On November 25, 2015, the Agency received notice that a worker had potentially exceeded radiation dose limits for the year. Investigation revealed that the worker had indeed gone over the limit. Additionally, the worker's second quarter badge had not been processed, and the worker performed x-rays for six days without a badge during November. The licensee calculated based on workload that the worker's assigned dose for the year would be 13,632 millirem. Two violations were cited.

File closed.

I - 9363 - Medical Waste at Landfill - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

On December 7, 2015, a landfill reported it had received waste containing technetium-99m from the licensee's facility. The licensee reported it believes the trash with the radioactive material was placed in the container by a contract employee who failed to follow current protocols for trash disposal. The licensee stated it was replacing the contract staff who were disposing of trash with hospital personnel. An on-site inspection was conducted at this facility on March 11, 2016. The inspector observed several people disposing of trash and all followed the licensee's protocol for trash disposal. Per policy, this severity level four violation was not cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2016

I - 9364 - Lost/Recovered Moisture/Density Gauge - Speesoil, Inc. - El Paso, Texas

On December 11, 2015, the licensee notified the Agency that a Troxler Model 3440 moisture/density gauge had been lost from the back of one of its trucks. The gauge contained a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The technician stated he did not have locks to lock the gauge to the truck, but did wrap the chains through the handles of the transport container. Several miles later as he drove away from the work site, he noted the pickup tailgate was down and the gauge was missing. He searched for the gauge and contacted local law enforcement. Several hours later, a truck driver for another company contacted the licensee and reported that he found the gauge on the side of the road. The gauge was recovered by the licensee. No damage occurred to the gauge and no exposure to the public was received since the operating rod was locked. The licensee conducted training with all technicians on security of gauges during transport. Two violations were cited.

File closed.

I - 9365 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On December 14, 2015, the Agency was notified by the licensee's radiation safety officer that while performing routine test of gauge shutters they found a gauge where the shutter failed to operate. The gauge is an Ohmart Vega model SHF2 containing a 200 millicurie cesium-137 source. The shutter was left in the normal operating open position. The source does not pose any additional risk of exposure to the workers or members of the general public. The licensee has obtained an exception to operate the gauge until it is repaired. The gauge is scheduled for repair during the next plant shutdown. No violations were cited.

File closed.

I - 9367 - Badge Overexposure - Mistras Group Inc. - Deer Park, Texas

On December 23, 2015, the licensee's radiation safety officer (RSO) notified the Agency of a badge only overexposure for a radiographer. The RSO stated one of its radiographers had lost their badge at a site after wearing it for three days. The radiographer was issued another badge and was allowed to continue working. Later, the first badge was found and sent for processing. The first badge read 4.7 rem, causing the year-to-date total dose to be 6.27 rem. The RSO's investigation confirmed the dose had been only to the badge. The radiographer was assigned a dose of 24 millirem for the month. The RSO counseled the radiographer concerning the importance of wearing the dosimetry and maintaining it from loss. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2016

I - 9368 - Potential Overexposure to Individual - Southwest Research Institute - San Antonio, Texas

On December 28, 2015, the Agency was notified by the licensee that one of its workers may have received a radiation exposure that exceeded a regulatory limit. The licensee's radiation safety office (RSO) stated a worker was removing a source from a shield when the source stuck in the shield. The RSO stated about one-half of the source was unshielded. The worker was able to return the source to the shielded position. The worker's radiation monitoring devices were sent for processing. On December 30, 2015, the RSO reported the dosimeter worn by the worker the day of the event read 52 millirem which brought the worker's total for the year to 1.976 rem. The RSO stated they have change the procedure for this work to prevent a complete withdrawal of the source until the shield is placed in the hot cell. No overexposure occurred. No violations were cited.

File closed

Complaints Opened First Quarter 2016

C - 2673 - Regulatory Violations - Viascan of Los Colinas - Irving, Texas

On January 7, 2016, the Agency received an allegation that the registrant was performing computed tomography (CT) without orders from a licensed practitioner of the healing arts. On March 15, 2016 the Agency performed an on-site investigation at the registrants facility. The investigation determined the registrant had performed a CT a study of one patient without orders from a licensed practitioner of the healing arts. The complaint was substantiated. One violation was cited.

File closed.

C - 2674 - Regulatory Violations - Christus Santa Rosa Health Care Corporation - San Antonio, Texas

On January 15, 2016, the Agency received a complaint alleging multiple staff members were near a patient when a radiologic technologist (RT) made several exposures using a portable C-arm machine without warning. This resulted in radiation exposure to staff. On February 3, 2016, the Agency conducted an on-site visit and determined that the RT took an x-ray in accordance with the operating physician's orders, announced the x-ray, but the RT did not see a medical technician on the other side of the patient and drape. The hospital conducted an investigation and made policy changes including announcing all x-rays in a loud manner, taking a timeout, and documenting the timeout in the x-ray software system. A medical physicist calculated the total dose to the technician was 1 mrem. The complaint was substantiated. One non-cited severity level IV violation was noted.

File closed.

C - 2675 - Regulatory Violations - Sealed Air - Iowa Park, Texas

On January 20, 2016, the Agency received an anonymous complaint regarding maintenance and test practices at the licensee's facility. An on-site inspection and investigation was conducted on February 29, 2016. Investigation revealed that an update notification had not been sent to the Agency regarding a change in operating and safety procedures. Furthermore, an internal certification list specified in the procedures was not being maintained. The complaint was partially substantiated. Two violations were cited.

Complaints Opened First Quarter 2016

C -2676 - Regulatory Violations - Ben Taub Hospital - Houston - Texas

On January 21, 2016 a complaint was received by the Agency alleging an inspector missed increased control violations at a facility during the routine inspection. The complaintant wants to understand why violations were not cited against the facility for non-compliance of regulations. Investigation open.

File open.

C - 2678 - Regulatory Violation - VHS San Antonio Imaging Partners LP - San Antonio, Texas

On January 28, 2016, the Agency received an anonymous complaint that mammography studies were being reviewed using an inappropriate monitor. An Agency inspector obtained the records needed to determine what monitors where being used to interpret the images. The records indicated only one monitor was being used and it was in compliance. Since the complaint was sent from an anonymous source, no additional information to help in the investigation could be obtained. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2679 - Unregistered Laser Hair Removal Facilities - BotoxRN Med Spa - San Antonio, Texas

On February 2, 2016, the Agency received a complaint that two laser hair removal (LHR) facilities in San Antonio were not registered with the Agency. An investigation by the Agency determined that a physician who owned three laser hair removal facilities in Houston purchased the two facilities. All five facilities were not registered to use lasers because a partner in Houston believed since the facilities were owned and directed by a physician they were not required to register the facilities with the Agency. After determining that all facilities were using class 3B lasers and multiple discussions with the Agency's laser registration staff, the company understood that they were required to register all facilities. On April 7, 2016, the laser registration staff reported that a complete application and required fees were submitted for all five facilities. The complaint was substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2016

C - 2680 - Regulatory Violations - SGS North America - Deer Park, Texas

On February 9, 2016, the Agency received a referred complaint from the Nuclear Regulatory Commission regarding regulatory violations at various temporary work sites. The complaint included allegations that dosimetry and survey meters were not used. An on-site investigation was conducted on February 18, 2016, in conjuction with investigation I-9372. Dosimetry records for all employees for several years were reviewed without indication that dosimetry had not been worn. The division the complainant had worked in had been shut down in mid-2015. Other previous employees were contacted and described wearing dosimetry, proper use of the radioactive material, and use of survey meters. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2681 - Regulatory Violations - Integrity Solutions NDE - Old Ocean, Texas

On February 16, 2016, the Agency received an anonymous complaint that an industrial radiography company working at a job site in Old Ocean, Texas, had unsafe work practices and specifically stated they were not using survey meters, rate alarms, or film badges. There are other workers in the vicinity. An investigation into this complaint is ongoing.

File open.

C - 2683 - Regulatory Violation - Dorsa Family Dentistry PLLC - Corpus Christi, Texas

On February 23, 2016, the Agency was sent a referral from the Texas State Board of Dental Examiners regarding a complaint it had received. The complaint stated the registrant was allowing individuals to hold the x-ray head of a x-ray unit during operation of the device. An on-site investigation was conducted by the Agency on March 31, 2016. The investigation found there was no computer, monitor, or key pad attached to the unit referenced in the complaint. The radiation safety officer stated the device had not been used since they discovered the head was drifting. The complaint could not be substantiated. No violation was issued.

File closed.

Complaints Opened First Quarter 2016

C - 2684 - Naturally Occurring Radioactive Material - The Dow Chemical Company Texas Operations - Freeport, Texas

On February 25, 2016, the Agency received a complaint alleging that a company using naturally occurring radioactive material (NORM) as a catalyst lost control of some of the material and it may have been released into the environment. The licensee was identified based on a search for authorized companies that use NORM as a catalyst and site visits to several licensees. The Agency determined that the licensee removed some packing downstream of a chemical reactor in September 2015 that used thorium-232 as a catalyst. The licensee found unexpected contamination and six roll off boxes of waste were generated with contaminated stainless steel packing. The licensee had contained, covered, and labeled the material properly. The highest levels of exposure was 200 ur/hr on the exterior of the roll off boxes. The licensee acknowledged that laboratory analysis needed to be conducted to determine the concentration of thorium in the material to ensure proper disposal of the material. The complainant gave inadequate information to further investigate the complaint. No violations were cited. The complaint was not substantiated.

File closed.

C - 2685 - Potential Exposure to Members of General Public - Desert NDT - Abilene, Texas

On February 29, 2016, the Agency received a complaint that the licensee may have exposed non-radiation worker employees to radiation in excess of regulatory limits. Other procedural violations were also alleged. An on-site investigation was conducted on March 22, 2016. Interviews and examination of dosimetry records revealed no evidence of tampering with area monitors as alleged. The licensee could not produce documentation of surveys and other required safety activities radiographic operations performed on February 10, 2016. It is unlikely that any members of the public were exposed beyond limits set forth in rule. The complaint could not be substantiated. Four unrelated violations were cited.

File closed.

C - 2686 - Monitoring Not Provided - MobileX USA - Plano, Texas

On March 3, 2016, the Agency received a complaint alleging the registrant had not provided occupational dose monitoring devices to the complainant during the monitoring period January through February 2016. Records provided by the registrant and its dosimetry processor demonstrated the company did provide monitoring devices to the complainant and other employees. The complainant had a monitoring record in the documents. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2016

C - 2687 - Monitoring Not Provided - Advanced Diagnostic Healthcare - San Antonio, Texas

On March 3, 2016, the Agency received a complaint alleging the registrant had not provided occupational dose monitoring devices to the complainant from June through December 2015. Records provided by the registrant and its dosimetry processor demonstrated the company did provide monitoring devices to the complainant and other employees. The complainant had a monitoring record in the documents. The complaint was not substaniated. No violations were cited.

File closed.

C - 2688 - Inadequate Credentialing - Kalin Kelso MD PA - Austin, Texas

On March 10, 2016, the Agency received an anonymous complaint alleging uncredentialed technologists were performing x-rays at the registrant's facility. An on-site investigation was conducted on March 31, 2016. No evidence of non-credentialed technologists performing radiographic exams could be found. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2689 - Regulatory Violations - Accelerator Service and Parts LLC - Phoenix, Arizona

On March 23, 2016, the Agency received a complaint from a registrant reporting that an out of state service provider who worked on a linear accelerator around December 2013 conducted faulty maintenance and did not rectify problems with the accelerator. A new service provider repaired the accelerator in March 2014 and reported to the registrant that previous work resulted in bypassing safety interlocks. The Agency conducted an investigation and could not substantiat the complaint. However, the Agency determined that the service company from Arizona repaired or conducted maintenance on the machine over ten times from October 2011 to January 2014 and was not registered with the Agency to perform work in Texas. The complaint was not substantiated. One violation was cited.

File closed.

Complaints Opened First Quarter 2016

C - 2690 - Unregistered Laser - Ideal You Med Spa - Corpus Christi, Texas

On March 24, 2016, the Agency received a complaint alleging a company was performing laser operations without registration to do so. The complaint also alleged several individuals had been burned during laser treatments. An on-site investigation was conducted by the Agency on March 31, 2016. The facility is a medical facility and not required to register under laser hair removal. The doctor stated when she took ownership of the spa she was unaware of the requirement to register under 25 TAC 289. 301, but had submitted the application as soon as she was made aware of the requirement. A search of Agency records found the company had filed an application for laser use entered on March 3, 2016. The doctor stated there was a case where an individual did have a burn in a small spot that could have been classified as a second degree burn, but did not believe it was severe enough to meet the reporting criteria. The doctor stated they intended to stop using the lasers at the end of April. On May 10, 2016, the Agency contacted the spa and was informed they were no longer using the lasers. No violations were cited.

File closed.

C - 2691 - Laser Injury - Texas Aesthetics Training Academy LLC - Austin, Texas

On March 25, 2016, the Agency received a complaint alleging multiple violations including laser burns. The complaint was referred to the Agency's Drugs and Medical Devices group. A joint on-site investigation was completed on April 5, 2016. It was found that consulting physician audits were conducted at proper intervals and all required registrations were held by the facility. Three violations were cited by the Drugs and Medical Devices inspector. No violations of the laser-related regulations under the Radiation Control Program were identified. The complaint could not be substantiated. No additional violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2016

C - 2642 - Regulatory Violations - Turner Specialty Services - Pasadena, Texas

On September 11, 2015, the Agency received a complaint alleging one of the licensee's radiographers does not wear his dosimetry and has told other radiographers to hide their dosimetry and not wear it. The complainant also alleged the radiographer does not use the collimators, establish required barriers, and he often does not use a survey meter but keeps it handy in case the supervisor comes around to check on the crew. The Agency made several unsuccessful attempts to locate the radiographer working at a temporary job site. An on-site investigation was conducted at the licensee's facility on January 11, 2016. The licensee's radiation safety officer and the radiographer named in the complaint were interviewed and records were reviewed. The dosimetry reports demonstrated that the radiographer had similar or higher monitoring badge results compared to the other radiographers. The daily logs and utilization documents displayed results to conclude that dosimetry equipment was being used. It could not be verified if the person was instructing others to not wear monitoring devices. The radiation safety officer stated he would ensure radiation safety was reviewed by all employees. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2645 - Naturally Occurring Radioactive Material - Hydrozonix - Barnhart, Texas

On October 13, 2015, the Agency received an allegation that a company was concentrating naturally occurring radioactive material (NORM) as part of their routine cleaning of oilfield equipment and may not be disposing of it properly. The company is a provider of water pumping services for the oil industry and services its own equipment at a site in Barnhart, Texas. Over time, low level NORM contamination had occurred on the property and inside the pumping equipment. The company contracted with licensed decontamination service providers and has completed remediation of the site and equipment. Training has been conducted with employees on surveying equipment as it returns from the field prior to servicing. Relationships are in place to remediate equipment as needed. No license is required for the company's activities. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2016

C - 2647 - Regulatory Violations - RSI Inspection - Abilene, Texas

On October 19, 2015, the Agency received a complaint alleging the licensee had instructed its employees not to wear their dosimetry when they expected high doses and one employee's exposure was not monitored at all during December 2014 even though they worked with radiography equipment. The complainant also alleged field audits and certifications were conducted via radio between the field and main office. The Agency made several attempts to conduct unannounced investigations of the licensee's radiographers in operation at temporary job sites but was unsuccessful. On January 26, 2016, the Agency conducted an investigation at the licensee's main office. The review of documents at the office did not produce evidence that employees were not wearing the dosimetry. The employee who was not monitored during December 2014 did not show up on daily reports or the utilization log and the licensee's radiation safety officer (RSO) stated the employee did work with any radiography equipment during that month. There was no evidence indicating audits/certifications were completed via radio and the RSO stated that was not the company's practice. The records checked appeared to be completed correctly. The complaint was not substantiated. No violations were cited.

File closed.

C - 2652 - Regulatory Violations - Houston Associates of Cardiovascular Medicine - Houston,

On October 27, 2015 the Agency was notified that a licensee who has had its license revoked/suspended maybe using or is in possession of radioactive material. Several attempts to contact the facility produce no results in locating the sources. On January 12, 2016 an on-site investigation produced the transfer record for the sources on September 24, 2010 and the company that received the transferred sources also produced disposal records for the sources to the manufacture. The records were appropriate to identify the source location. The company also has been granted a new license and will not be using sources of this nature in the future. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2016

C - 2653 - Naturally Occurring Radioactive Material Disposal - Property in Midland, Texas

On November 2, 2015, the Agency received a complaint from the Midland, Texas, fire department stating an individual was burying radioactive pipes on property they did not own. On January 25, 2016, Agency inspectors went to the location provided in the complaint. The inspectors did not find any pipe at the location. The inspectors contacted the owner of the company accused of leaving the pipe and he agreed to meet them at that location. The owner stated the pipe had been removed and transferred to a company licensed in the State of Texas to dispose of the material. The inspectors performed radiation surveys over the area the pipe had been laying. The inspectors did not find any readings above background. The owner stated he did not know the pipe was contaminated until the fire department showed him the readings they were getting. The owner stated the pipe was never buried. No violations were cited.

File closed.

C - 2658 - Unauthorized Disposal - Enviroklean Product Development, Inc. - Midland, Texas

On November 16, 2015, the Agency received a complaint alleging the licensee failed to provide written notification to the Agency, per its license condition, prior to performing decontamination activities at a customer's site. The complainant further alleged the licensee disposed of the NORM (naturally occurring radioactive material) waste collected from a job the week before the complaint date by putting it into a hole in the ground at its facility in Midland, Texas. The Agency performed an on-site inspection of the facility on January 26, 2016. The fences rounding the licensee's location was locked and there were no usable access doors to the facility from outside the fence. The inspector knocked on a door that had been sealed shut; no one answered. A radiation survey around the fence and accessible sections of the building was performed and dose rates observed were equal to background. An area described as the pit was found and a dose rate survey was performed near the opening to what appeared to be the pit. The dose rate was equal to background. A search of the area did not find any material that looked like pipe scale. The licensee's radiation safety officer (RSO) was contacted and asked if any NORM decon work had been performed out of that office in the last year. The RSO stated only one job had been performed out of that office in the last year and it was a chemical decon job and did not produce any NORM. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2016

C - 2662 - Uncredentialed Technologist - Midland Imaging Center - Midland, Texas

On November 30, 2015, the Agency received a complaint alleging a nuclear medicine technologist was performing computerized tomography (CT) scans on patients. The complainant stated that the individual does not have the credentials to perform CT or x-rays. During its investigation, the Agency found the individual has a general medical radiologic technologist license which was issued in 2012 and expires in 2017. During an on-site investigation at the registrant's facility on January 26, 2016, records and computer systems were reviewed. The Agency found the technologist was performing CT exams under supervision of the doctor and another technologist certified to perform CT. The complaint was also forwarded to the Texas Medical Board. Complaint not substantiated.

File closed.

C - 2664 - Regulatory Violations - Advanced Nuclear Consultants - Houston, Texas

On December 14, 2015, the Agency received a complaint alleging the licensee had taken possession of radioactive material not authorized on its license for purpose of disposal of the material. An investigation into the complaint determined that the licensee took possession and properly transferred two cobalt-57 flood sources from a facility that went out of business in January 2010. The licensee used the flood sources for functional testing and calibration of nuclear medicine imaging systems. This use was authorized on its license. The licensee then shipped the sources back to the manufacturer on January 23, 2016, for disposal. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2016

C - 2666 - Regulation Violations - Envision Imaging - Fort Worth, Texas

On December 14, 2015, the Agency received an anonymous complaint that alleged one of the registrant's technologists had over-radiated pediatric patients by using an extremely high setting on the x-ray machine. The complainant further alleged that management had been advised but the technologist was still performing x-rays of pediatric and adult patients. Lastly, the complainant alleged that during evening hours paramedics were allowed to energize the machine while the technologist held pediatric patients for the exam. The Agency's investigation revealed that a radiologic technologist had failed to use appropriate technique settings in two instances while x-raying pediatric patients. In one instance, an issue with default technique settings programmed in the machine when an exam was changed to table top and the technologist's failure to check technique settings prior to energizing the machine resulted in an entrance exposure that exceeded regulatory limits. The technologist also got a non-radiation worker to assist the parent in holding the patient for the exam and failed to provide the individual with a protective device (apron). The investigation also revealed that on one occasion another technologist had set up an exam on the machine and then got a paramedic who was working at the facility to push the button to energize the machine while the technologist held the patient. During the investigation it was discovered that a Non-certified Technician had been performing exams that were not within the scope of her credentials. The registrant's investigation also came to the same conclusions. The registrant took the following corrective actions: technologists were counseled and provided additional training, a service company corrected the default settings issue (lowered them) on this machine and the same model machines at the registrant's other locations, operating and safety procedures were reviewed with all technical staff, and additional updates and training will be provided to non-technical staff on radiation protection. The complaint was substantiated. Five violations were cited.

File closed.

C - 2672 - Transportation Violation - Troxler Electronic Laboratories - Arlington, Texas

On December 17, 2015, the Agency received an allegation that the licensee was transporting radioactive material without utilizing the required blocking and bracing. On January 13, 2016, the Agency conducted an on-site investigation at the licensee's facility. The radiation safety officer (RSO) stated they had transported nuclear gauges twice as a new service for customers. The RSO stated on one occasion they had picked up six gauges using an employee's van and the gauges were packed so tight they could not move. They could not remember how tight they were in the van on the second occasion. The Agency investigator reviewed the rules for blocking and bracing while transporting radioactive material with the RSO. The complaint could not be substantiated. No violations were cited.

File closed.