INCIDENT AND COMPLAINT SUMMARIES FOR SECOND 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.

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

Incident and Complaint Summaries

2nd Quarter 2015

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Incidents Opened Second Quarter 2015

I - 9295 - Source Leak Test Exceeds Limit - Southwest Research Institute - San Antonio, Texas

On April 2, 2015, the Agency received notice that a cesium-137 source, one of a collection of sources from the Department of Energy Orphan Source Recovery Program slated for disposal, may be leaking. The sources were contained in a hot cell with proper filtration. No contamination of personnel or the public resulted from the event. No attempt to identify the particular source in the collection that was leaking has been made. The collection of sources was placed into a new sealed container and are slated for later disposal at an undetermined future date. No violations were cited.

File closed.

I - 9269 - Badge Overexposure – Phoenix Non Destructive Testing, Co - Channelview, Texas

On April 3, 2015, the licensee notified the Agency that it had received a report from its dosimetry processor indicating one of its radiographers had received 7.7 rem on his dosimetry badge for the exposure period of February 1-28, 2015. The licensee's radiation safety officer (RSO) conducted an investigation and determined that the exposure had been to the badge only. The radiographer had placed his equipment bag into one of their vehicles in preparation for going out to work at a job site. However, the radiographer was unable to report for work and another radiographer, who had been scheduled to work in the shop that day, was sent out in his place. The replacment didn't have his equipment with him so he used some of the equipment from the radiographer's bag. He did not realize the radiographer's dosimetry badge was also in the bag. During the day's work, he left the bag near the camera. The RSO assigned a dose of 96 millirem for the month based on the radiographer's pocket dosimeter readings recorded for the month. No violations were cited.

File closed.

I - 9297 - Gauge Shutter Failure - Alcoa World Alumina Atlantic- Point Comfort, Texas

On April 6, 2015, the licensee radiation safety officer reported that one of its density measuring devices, a ThermoFisher Scientific model 5201 containing a 100 millicurie cesium -137 source, had a broken shutter. The shutter block disconnected from the arm. A manufacturer's service technician was contacted and scheduled to repair the gauge at the site. The area was secured and there was no exposure hazard to any individual. The licensee requested permission from the Agency to continue to operate with the broken shutter due to manufacturer being unable to repair gauge in a timely manner. Exemption was granted and the device was repaired in June 2015. The cause of the device failure was determined to be age and effects of the vibration of the vessel it was mounted on. The gauge was repaired, checked, then placed back into operation. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9298 - Gauge Shutter Failure - Bayer Material Science, LLC - Baytown, Texas

On April 7, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that during a routine maintenance check, they were unable to close the shutter on a Berthold model LB 300 IRL Type I source holder containing four cobalt-60 sources. The RSO stated only three of the sources would not rotate back to the shielded position. The RSO stated they had contacted the manufacturer for assistance. The RSO stated their was no increased risk of exposure to members of the general public or the employees at the facility. The manufacturer arrived on site on April 10, 2015, and found that polymer had overflowed from a stand pipe and onto the gauge. The manufacturer removed the polymer and lubricated the gauge's shutter operating mechanism. The gauge was returned to service. The RSO stated the possibility of the event repeating was very remote therefore no additional actions would be taken at this time. No violations were cited.

File closed.

I - 9299 - Radiography Source Disconnect - Mistras Group, Inc. - Charco, Texas

On April 8, 2015, the licensee notified the Agency that a radiography source disconnect had occurred at a temporary job site. The radiation safety officer (RSO) stated a crew had contacted him at about 0830 hours and informed him that after the first exposure using a 62.2 curie iridium-192 source, they could not retract the source back into a QSA 880D exposure device. The RSO, who is authorized on the license for source retrieval, was able to return the source to the fully shielded position in the camera. The manufacturer evaluated the equipment and reported that significant wear on the connecting plug assembly may have caused a misconnect. An investigation by the RSO indicated the radiographer may not have challenged the pig tail connection to ensure it was fully connected. Both radiographers were given 8 hours of hands-on training. No personnel exceeded exposure limits during the incident and source recovery. No violations were cited.

File closed.

I - 9300 - Medical Waste at Landfill - Methodist Healthcare System - Methodist Hospital - San Antonio, Texas

On April 10, 2015, the licensee's radiation safety officer (RSO) reported to the Agency that a load of waste from their facility had caused the radiation monitors at the landfill to alarm. The radiation safety officer went to the landfill and identified the isotope as thallium-201, which had been recently used in a cardiology study. The RSO stated he went to the facility to check the radiation monitors and found the system was not working properly. A thunderstorm had caused the monitors to malfunction and he had to reset them manually. Due to the malfunction, the radioactive material had not been detected when the waste passed through the facility's monitors. To prevent recurrence, surge protectors were installed on the monitoring system at the hospital. The licensee instituted corrective actions and no violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9301- Regulatory Violation - New Lifecare Hospitals of North Texas LLC - Fort Worth,

On April 10, 2015, a registrant self-reported that an individual was exposed to radiation without authorization from a licensed practitioner of the healing arts. Specifically, a medical radiologic technologist (MRT) allowed a radiologic technology student to perform a computed tomography (CT) scan of the MRT's head for training. The registrant's and Agency's investigations confirmed this occurred and the MRT admitted she had gotten engrossed in the teaching process and had the student take the scan while she was giving instructions on what to do to. Two other scans were performed on phantoms. The registrant's corrective actions include additional training to staff on proper use of radiological equipment, additional education and training for staff who have direct teaching contact with students, and routine audit process to identify unauthorized exams. One violation was cited.

File closed.

I - 9302 - Ruptured Source - Thermo Process Instruments LP - Sugar Land, Texas

On April 15, 2015, the licensee notified the Agency that on April 14, 2015, one of its technicians was removing a cesium-137 source, with a current activity of 694 millicuries, from an Ohmart SHLG-1 nuclear gauge. When he attempted to remove from the source sleeve, his alarming rate meter alarmed. The technician surveyed his work area and found the area and portions of his body were contaminated. The technician was immediately decontaminated by the licensee's radiation safety officer (RSO). The licensee swabbed the technician's nasal passages and found contamination. The licensee has sent the technician's dosimetry for immediate processing and is in the process of determining the internal dose estimate. Surveys confirmed that no contamination was carried outside the work room. Access to the building was restricted to only those individuals responding to this event. The licensee has secured the services of several contactors to assist in the recovery form this event. The licensee has surveyed all of its employees and the homes and vehicles of any employee who were found to have any contamination on them or their clothing. The licensee is currently decontamination all homes and vehicles found contaminated. The licensee continues to investigate the event and perform surveys as new information is obtained. The investigation into this event is ongoing.

File open. NEED TO UPDATE THIS SUMMARY!

Incidents Opened Second Quarter 2015

I - 9303 - Radioactive Material Found - Ditch/Easement - City of Houston - Houston, Texas

On April 13, 2015, the Agency was notified by a landfill operator that a load of waste had caused its radiation monitor to alarm. The operator provided a spectrum and the radioisotope was identified as cesium-137. An on-site investigation confirmed the material to be dirt/mud contaminated with cesium. Further investigation was initiated to find the source of the material. Using the waste collection vehicle's route sheets and the Agency's radiation detection equipment, the Agency identified the area where the mud had originated in a drainage ditch along the side of a street, which was within the city's easement. The waste material was isolated and a cost estimate was obtained for a contractor to remediate the area. The initial surface readings obtained in the ditch ranged from 430 ur/hr to 16 mr/hr. During remediation the readings ranged up to 1 rem/hr and the depth of the material to be removed was within a few inches beneath the soil to a max depth of 14 feet in the most concentrated area. Site remediation was completed by the end of July 2015. The property was released for unrestricted use on September 1, 2015 after final soil samples were analyzed. The highest concentration of contamination, point of origin, was identified at a depth of approximately 14 feet below the ground surface. Ownership of the source of the radioactive material could not be determined. No violations were cited.

File closed.

I - 9304 - Damaged Moisture/Density Gauge - Rone Engineering Services, Ltd. - McKinney,Texas

On April 16, 2015, the licensee notified the Agency that one of its Troxler 3430 moisture/density gauges had been damaged while one of its technicians was performing a compaction test at a temporary job site. The gauge contained an 8 millicurie cesium-137 source and a 40 millicurie americium 241/beryllium source. The technician had seen the roller approaching but thought it was in the next lane. When he realized it was in the same lane, he attempted to move the gauge out of the way. The roller's tire caught the edge of the gauge and damaged the casing and electronics. The sources were in the shielded position at the time of the incident. There was no leakage of the source and no exposure to any individual as a result of this incident. The gauge will be returned to the manufacturer for disposal. A safety meeting was held with all technicians to prevent reoccurrence. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9305 - Transportation Event - Midwest Inspection Services - Andrews, Texas

On April 21, 2015, the Agency was notified by the licensee of a traffic accident involving one of its radiography trucks that was carrying an INC exposure device containing approximately 26 curies of iridium-192. The driver of the vehicle and the passenger were killed in the accident. Local emergency response personnel at the scene had a survey performed and were told the dose rates ten feet from the truck were 15 millirem per hour. The emergency response personnel treated the survivors of the accident and evacuated the immediate area until the licensee's radiation safety officer (RSO) could arrive at the scene and perform a radiation survey. The RSO arrived and located the camera still inside the transport container. The camera did not appear to be damaged. The RSO determined dose rates at and around the camera were normal. The RSO returned the camera to the licensee's storage facility. The RSO stated the actual curie content of the source was 16 curies. The licensee sent the exposure device to the manufacturer for inspection and repairs. The manufacturer reported it replaced a few parts on the exposure device and returned the device to the licensee for use. No member of the general public received any exposure due to this event. No violations were cited.

File closed.

I - 9306 - Gauge Shutter Failure - City Public Service - San Antonio, Texas

On April 23, 2015, the Agency received notification from the licensee's radiation safety officer (RSO) that a Kay-Ray 7062BP gauge, containing a 25 millicurie cesium-137 source, had a broken bracket used to keep the shutter in the open position. The gauge was a spare that was kept in storage and had never been placed in operation. The broken component was found when the licensee was conducting a required leak test. The gauge shutter was in the closed position during the test and inspection. The licensee is returning the gauge to the manufacturer for disposal. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9307 - Lost Equipment Containing Radioactive Material - RRC Power and Energy LLC - Ft. Worth, Texas

On April 23, 2015, the licensee reported to the Agency that one of its InstroTek model 3500 moisture/density gauges, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was lost by a technician at a job site. The technician had placed the gauge on the back of his pickup truck and then drove off the job site with the tailgate down. When he got to his next job site he discovered the gauge was missing. The licensee's search for the gauge was unproductive. On April 24, 2015, the licensee notified the Agency that it had recovered the gauge from another contractor working at the job site. The contractor had found it the day before and had taken it to their storage area. The source rod was locked during the event. The gauge was leak tested and the technician found the electronics on the gauge were damaged. The gauge was sent to the manufacturer for repair. The licensee has implemented a new procedure to place cones in front of and behind the vehicle as a process for technicians to ensure equipment security before removing the cones and driving off a site. Two violations were cited.

File closed.

I - 9308 - Medical Waste at Landfill - Texas Health Harris Methodist Hospital - Ft. Worth, Texas

On April 27, 2015, the Agency was notified by a landfill operator that a load of waste from the licensee's facility had cause its radiation monitor to alarm. The radioisotope was identified as iodine-131. The Agency contacted the licensee and learned the radiation safety officer (RSO) was already aware of the situation. The RSO reported that employees at the hospital were made aware of the situation and staff were retrained. The facility also ordered a digital entrance/exit scinillation detector to be installed at the main loading dock to scan all waste that leaves the building. This is the second occurrence within six months at this facility. One violation was cited.

File closed.

I - 9309 - Stolen Moisture/Density Gauge -Terracon Consultants, Inc - San Antonio, Texas

On May 01, 2015, the licensee notified the Agency that a Troxler 4640 moisture/density gauge had been stolen along with a company vehicle. The gauge contained an 8 millicurie cesium-137 source. The truck was stolen at a gas station and local police were immediately called by the driver/technician. The truck had a tracking device installed so the truck and gauge were located within 5 minutes by the local police. The gauge was still properly secured in the back of the pickup truck. The licensee recovered the gauge 30 minutes later. Training was conducted with all technicians on the security and transportation of gauges. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I -9310 - Medical Seed Ruptured - Scott & White Memorial Hospital - Temple, Texas

On May 4, 2015, licensee's radiation safety officer (RSO) reported to the Agency that he had been notified that on Thursday, April 30, 2015, a physician had ruptured an iodine-125 seed, used for localization, during removal from a patient. The seed had been identified as leaking after the removal and when it was in a container in the pathology department. Per procedure, the physician had screened the patient with a radiation detector following the removal and no radioactivity was found. No overexposure to the patient or doctor occurred. After detailed information from the licensee was reviewed, the Agency determined that this was not a reportable event. No violations were cited.

File closed.

I - 9311 - Lost Equipment Containing Radioactive Material - Rock Engineering and Testing Laboratories - San Antonio, Texas

On May 4, 2015, the licensee's radiation safety officer (RSO) reported that one of licensee's technicians had notified him that the Troxler model 3400 moisture/density gauge he had been using at a temporary job site was missing. The source rod was locked and there was unlikely potential for public exposure. The technician had placed the gauge into the back of what he thought was his work truck so it would be out of harm's way at the busy work site while he performed other duties. The truck was, in fact, a supervisor's truck and the supervisor had moved the vehicle away from the technician's immediate area for a short time. The technician returned to his own truck, thought the gauge was missing, and notified the RSO. The supervisor returned and the technician saw the gauge in the back of his truck and realized his mistake. The gauge had been found within an hour and had never left the work site. During the RSO's reporting of the event to the Agency, the technician contacted him and reported he had found the gauge and the source rod was still locked. The RSO stated he disciplined the technician and retrained the technician on safety protocols and procedures in handling the gauge. No violations were cited.

File closed.

I - 9312 - Lost Equipment Containing Radioactive Material - DAE & Associates, Ltd - Houston, Texas

On May 7, 2015, the licensee reported to the Agency that during an inventory check it could not locate one of its moisture density gauges. The licensee's radiation safety officer (RSO) checked the facility and called the technicians. No one had seen the gauge or knew where it was located. The RSO contacted company who performs the leak tests and service for the licensee. The company had not serviced the gauge. The last calibration of the gauge was April 2014. The licensee determined that the gauge was lost and possibly stolen and reported the event to the local law enforcement on April 20, 2015. No report was made to the Agency until May 7, 2015. The gauge was a Troxler model 3430, and contained an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. Three violations cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9313 - Medical Waste Released Above Background -Methodist Healthcare System - San Antonio, Texas

On May 14, 2015, the licensee notified the Agency that a sharps container from its facility had caused the radiation monitors at its recycler's facility to alarm. The licensee's radiation safety officer investigated and found that no patient had been treated at the licensee's facility within the last week with the identified isotope of iodine-131. The sharps container had been located in the clinic laboratory where blood and urine samples are collected. The waste was generated from an outpatient who was seen for further urine and blood testing. The individual had been released as a nuclear medicine patient and therefore body fluids were exempt from regulations. The sharps container was not surveyed and bypassed the radiation monitors since it had not come from the nuclear medicine department. The individual did not inform anyone of the recent treatment thus no one knew to screen the sharps or urine cup. The licensee is considering ordering more radiation monitors to scan all trash that leaves its facility. No violations were cited.

File closed.

I - 9314 - Therapy Event - Sugar Land Cancer Center - Sugar Land, Texas

On May 21, 2015, the registrant notified the Agency that it had discovered that a patient prescribed to receive total therapy dose of 6600 rad over 33 fractions actually received 9577 rad, which was a 45% increase over the prescribed dose. Adjustments to each fraction were made after the first 11 treatments due to nanodot (dosimeter) measurements on the patient which indicated readings below the prescribed dose. A second physicist reviewed the prescribed change after all treatments were completed and noted that an incorrect calibration factor was used for the placement of the nanodots resulting in the patient getting much larger doses per fraction which caused the overexposure. The patient was notified on May 22, 2015 and is being monitored for any potential adverse affects. New procedures have been implemented for placement of nanodots. Additionally, changes to approved treatment plans will be reviewed by two independent physicist. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9315 - Badge Overexposure - Mistras Group, Inc. - Deer Park, Texas

On May 21, 2015, the licensee's radiation safety officer (RSO) reported to the Agency that he had received a report from the licensee's dosimetry badge processor that indicated a radiographer's badge had received 37,542 millirem for the February 2015 monitoring period. The RSO conducted an investigation. He reviewed the radiographer's work records and daily radiation reports and conducted interviews. The RSO made the determination that the exposure had been only to the badge. The radiographer had taken the badge with him to another state to do work during February and upon his return in mid-March he left it in an equipment bag stored near the exposure device in one of the truck's dark room. He did not perform radiography again until April, at which time he received a new badge. His February badge was found in the truck on May 4, 2015 and sent for processing. The RSO assigned a dose of 11 millirem for the monitoring period based on the radiographer's self-reading dosimeter record and supporting investigation. The RSO implemented new procedures to ensure badges are returned for processing in a timely manner. One severity level IV violation was noted.

File closed.

I - 9316 - Contamination Event - Tracerco - Pasadena, Texas

On May 27, 2015, the licensee reported to the Agency that while performing a routine survey of its source storage area, it discovered that a barium-137 generator, originally containing 50 millicuries of cesium-137, had leaked. The area where the generator was stored is a restricted area (security). Access was further restricted for greater than 24 hours due to the contamination. The licensee investigated and found cesium contamination in its office area and some of its work vehicles and equipment. Employees' vehicles were surveyed and seven employee's residences were surveyed. Small amounts of contamination was identified in several of these. Remediation has been completed of all identified contamination except the storage room, which is in progress. In August 2015, the licensee's investigation revealed the release of cesium from the generator originated from activities at a temporary job site in Oklahoma, which resulted in the contamination described as well as contamination at the temporary job site. The contamination at the temporary job site was under the State of Oklahoma's jurisdiction and was processed as a separate incident in their state. An investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2015

I - 9317 - Lost Source of Radioactive Material - Longview Regional Medical Center - Longview, Texas

On May 29, 2015, a licensee notified the Agency that it was unable to locate a package containing approximately 41.2 millicuries of iodine-125 seeds. The package had been received at the licensee's facility on May 26, 2015, and per the licensee's procedures it was delivered to the nuclear medicine department and left in the designated area. However, the staff in the nuclear medicine department had been allowed to leave due to a slow schedule. On May 27, 2015, when staff returned they were unable to locate the package. The licensee conducted a facility wide search. The materials management employee that placed the package in the nuclear medicine department and the housekeeping employee that cleaned the department the previous night were interviewed. The housekeeper reported she had not removed any boxes from the department. The licensee was unable to identify anyone else had entered the department. The faculty's waste container had been picked up and taken to the landfill earlier that morning. The licensee checked with the landfill and learned it does have a radiation monitor but the container from the hospital had not set it off. The contents of the container had already been covered over in the landfill. The patient's procedure was canceled and re-scheduled. The licensee has changed its procedures for radioactive material package delivery by the facility's materials management to the nuclear medicine department to prevent reoccurrence. The licensee is continuing its search for the package. The facility lost possession of the material. One violation was cited.

File closed.

I - 9318 - Gauge Shutters - BASF Corporation - Freeport, Texas

On June 4, 2015, the licensee notified the Agency that on June 3, 2015, it was performing routine shutter checks on fixed nuclear gauges at its facility and found the shutters on four of the gauges would not close. All four gauges were Ronan Model SA-1. The licensee lubricated the shutter mechanisms on all four gauges and let them sit overnight. Two of the gauges closed the next morning with no problem. The other two shutters still would not close. The licensee contacted an outside service group and it recommended using a different lubricant. The licensee followed the suggestion and both became operable. These gauges normally operate with the shutter in the open position. There were no radiation exposures or increased risk of exposure as a result of this event. The licensee provided additional training on gauge maintenance to its workers and consulted with the gauge manufacturer on the proper lubrication of the gauge shutters. No violations were cited.

File closed.

Incidents Opened Second Quarter 2015

I - 9319 - Damaged Device Containing Radioactive Material - Hunter Well Science, Inc. - Arlington, Texas

On June 10, 2015, a licensee contacted the Agency reporting that an Agency inspector was at the site inspecting the facility. The inspector informed the licensee that an event that occurred on March 5, 2015, should have been reported to the Agency. During the repair of a pulsed neutron generator tool, two work countertops and the housing of the tool became contaminated with hydrogen-3 (tritium) from a leak of a sealed tritium tube. An investigation by the Agency determined that this was not a reportable event. The device leaked a small amount of tritium which did not exceed any regulatory limits. The licensee remediated the contamination and the tool was repaired. No violations were cited.

File closed.

I - 9320 - Radioactive Material Identified at Landfill - El Paso County Hospital District - El Paso, Texas

On June 20, 2015, the Agency received notice that a load of waste from the licensee's facility that was sent to a landfill had been identified as containing radioactive material. The material was dumped two days later as it had decayed beyond detectable levels. The licensee was notified and stated that all waste goes through portal monitors installed at the facility's loading dock, including non-medical waste. No detections occurred at the loading dock during the time frame of the event. The origin of the material is unknown. One non-cited severity IV violation was noted.

File closed.

I - 9321 - Medical Waste at Landfill - Texas Health Harris Methodist Hospital - Ft. Worth,

On June 25, 2015, the Agency was notified by a landfill operator that a load of waste from an Agency licensee's facility had caused its radiation monitor to alarm. The radioisotope was identified as technetium-99. The licensee has since installed radiation portal monitors at both loading docks through which waste exits the facility. One violation was cited.

File closed.

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

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

On January 16, 2015, the Agency received a report that an x-ray fluoresence 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 - 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.

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

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.

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.

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

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.

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.

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.

Complaints Opened Second Quarter 2015

C - 2623 - Potential Exposure to Individual - Shared Imaging, LLC - Houston, Texas

On May 19, 2015, the Agency was notified by the registrant's previous radiation safety officer that individuals receiving scans with a positron emission tomography /computerized tomography unit were potentially receiving excessive doses. The person stated he had completed calibration of the unit and it was not responding correctly for diagnostic practices. He stated the unit is being used on patients. The Agency performed an inspection at the facility on July 9, 2015. The inspector was not able to substantiate the allegations. No violations were cited.

File closed.

C - 2624 - Regulatory Violations - Furmanite America, Inc. - Corpus Christi, Texas

On May 22, 2015, the Agency received information that alleged the licensee had dispatched two industrial radiographer trainees to a temporary job site without a trainer and upon notification of this information, the site radiation safety officer (SRSO) called them back to the office and cancelled the job. The Agency conducted an investigation and determined that the event occurred in May 2014 and involved a qualified radiographer and a trainee. They loaded the truck but were stopped before they left the office. The licensee terminated the SRSO's employment because of multiple violations discovered by an internal audit led by the corporate radiation safety officer in late 2014. In May 2015, the Agency conducted an inspection and found 6 violations related to maintenance and records that had been maintained by the SRSO. The violations have been corrected by the licensee. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2625 - Unregistered Technician - Beauty Med Spa - Irving, Texas

On May 22, 2015, the Agency received a complaint that the facility may be using unregistered technicians for laser hair removal services. Investigation revealed that the facility is registered and has several registered technicians. An individual named in the complaint does not currently work at the facility. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2015

C - 2626 - Regulatory Violations - MedX Imaging - Southlake, Texas

On June 8, 2015, the Agency received a complaint alleging a physician was performing mammography studies and using a credentialed technologist's initials when the technologist was not at the facility. On June 10, 2015, the Agency received a second allegation from a different complainant who alleged the physician was performing mammograms and using another credentialed technologist's initials. An on-site investigation was conducted at the facility. Records and computer images were reviewed and employees were interviewed. The complaint was substantiated. The complaint was referred to the Medical Review Board for further investigation. Six violations were cited.

File closed.

C - 2627 - Transfer of Radioactive Material - Go Frac LLC - Weatherford, Texas

On June 11, 2015, the Agency received information that a company had purchased two trucks equipped with density gauges containing radioactive material at an auction. Investigation revealed that a general license acknowledgement holder had transferred the devices in violation of rule. The gauges, Thermo Fisher Scientific models 5192 and 5190, each contained 200 millicuries of cesium-137. The new owner has obtained a general license acknowledgement. The complaint was substantiated. One violation was cited.

File closed.

C - 2628 - Regulatory Violations - Universal Pressure Pumping, Inc. - Midland, Texas

On June 18, 2015, the Agency received a complaint alleging the licensee was not carrying shipping papers when transporting sources used in well fracturing. The complaint also alleged the paper work that is produced is incomplete. The Agency performed inspections at three of the licensee's locations. The inspectors reviewed the shipping records at each of the three facilities and did not find any discrepancies. The inspectors were unable to substantiate the allegations. One unrelated violation was cited for one location.

File closed.

Complaints Opened Second Quarter 2015

C - 2629 - Unregistered Laser Hair Removal Facility - Purely You Spa - Katy, Texas

On June 30, 2015, the Agency received a complaint that a laser hair removal (LHR) facility is not registered with the Agency and does not have a medical director. An Agency investigation was conducted and determined the facility and technicians were not registered to conduct LHR, nor did the facility have a medical director. The owner was unaware of state LHR regulations and agreed to cease all LHR. The owner was cooperative and said she may consider getting registered later in the year. The complaint was substantiated. No violations were cited.

File closed.

C-2632 - Potential Exposure to Individuals - Iofina Plant - Crowley, Texas

On June 11, 2015, the Agency received an anonymous complaint referred by the Nuclear Regulatory Commission that stated that workers at facility were concerned about their safety due to high radiation levels. Specifically, the plant extracted iodine and concentrated naturally occurring radioactive material to levels as high as 5000 microR/hr. On June 30, 2015, the Agency conducted an on-site investigation and found that the plant was shut down and being decommissioned. Twenty barrels of sludge with radiation levels of 5 to 11 milliR/hr were found roped off with a "caution radioactive material" sign. The company no longer operated the facility and no contractors that were cleaning up the site were present. Further investigation determined a licensed decontamination company was cleaning up the site. The complaint was not substantiated. No violations were cited.

File closed.

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

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 - 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.

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.