
# INCIDENT AND COMPLAINT SUMMARIES FOR THIRD QUARTER 2015*

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

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**Incident and Complaint Summaries**

**3rd Quarter 2015**

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## Incidents Opened Third Quarter 2015

I - 9322 - Damaged Device Containing Radioactive Material - Bryant Consultants, Inc. - Carrollton, Texas

On July 1, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that one of their moisture/density gauges had been damaged at a work site. The RSO stated the device had been placed on the tailgate of a truck for use by their technician. Before the technician could use the gauge, he was instructed to move his vehicle by a work supervisor but he failed to remove the gauge from the tailgate of the truck. As he moved the truck, the gauge fell off the tailgate and was struck by the truck's muffler which slightly bendt the source rod for the cesium source. The technician secured the area and contacted the RSO. The RSO arrived at the site within 20 minutes and performed a radiation survey of the gauge. No increase in radiation levels was detected. he source was not damaged and remained shielded. The RSO stated the source rod could be operated but it did not travel its full range. The gauge was sent to a service provider for leak test, inspection, and repair. The source leak test results were satisfactory. The licensee provided additional training to its technicians on gauge handling. No violations were cited.

File closed.

I -9323 - Medical Waste at Landfill - Methodist Healthcare System - San Antonio, Texas

On July 3, 2015, a landfill operator contacted the Agency to report it had received a load of waste containing radioactive material. The landfill operator provided a spectrum from its radioactive isotope identifier and a route sheet. The isotope was identified as iodine-131 and the waste had been picked up from the licensee's facility. The licensee has had three incidents overall in the past six months under its license and this is the second occurrence for this particular licensed site. The licensee's previously instituted corrective actions were ineffective in this case. One severity level 3 violation was cited.

File closed.

I - 9324 - Gauge Shutter Failure - Zilkha Biomass Crockett LLC - Houston, Texas

On July 7, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that the shutter on a Ronan GS-400 level gauge containing a 50 millicurie cesium-137 source was stuck in the open position. The stuck shutter was discovered during the start up of a system component. Open is the normal position for the shutter. The gauge did not pose an exposure risk to any individuals. The manufacturer replaced the gauge. Failure of the gauge was due to a buildup of resin and sawdust on the actuator shaft and in the actuator guide tube. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9325 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On July 8, 2015, the Agency was notified by the licensee's radiation safety officer that while performing routine testing of gauge shutters they found two gauges where the source could not be fully retracted. Both gauges are Ohmart Vega model SHLMBR-4 gauges, each containing a 5,000 millicurie cesium-137 source. The sources were left in the normal operating unshielded position. Repair attempts were unsuccessful, and both gauges will be replaced during a plant shutdown in 2016. The licensee has received an amended license to continue operations under these conditions. No exposures to the public are likely to result from this event. No violations were cited.

File closed.

I - 9326 - Gauge Shutter Failure - Chevron Phillips Chemical Company LP - Pasadena, Texas

On July 8, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) of a stuck shutter on an Ohmart Vega SH-F2 nuclear gauge containing a 500 millicurie cesium – 137 source. The stuck shutter was found during a routine six month inspection. The RSO determined the source would not operate due to internal corrosion seizing it in the open position. The RSO verified the radiation levels in the area of the gauge had not changed. The RSO stated the source normally operates in the open position and there are no safety issues. The RSO stated he had contacted a service provider to make repairs to the gauge. The RSO stated a replacement internal shutter mechanism equipped with a gasket will also be ordered for installation to prevent future water intrusion and corrosion. The gauge does not pose an exposure risk to the licensee's workers or to members of the general public. The gauge was repaired on August 5, 2015. The service provider stated the cause for the failure was water intrusion in the operating rod cavity. The licensee intends to replace the shutter with a new design better suited to prevent the water intrusion. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9327 - Radiography Source Disconnect - Texas QA Services, Inc. - Grand Prairie, Texas

On July 24, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that one of its crews was unable to retract a 39 curie iridium-192 source into a QSA 880 D camera. The RSO stated the radiographers had completed their first shot of the day in a shooting bay and noted the lock on the camera did not trip when the source was retracted. The RSO stated the radiographers noted the dose rate where they were standing was 30 millirem per hour. The radiographers notified the RSO of the event. The RSO responded to their location. The RSO was authorized to recover disconnected sources. The RSO stated he recovered the source by disconnecting the source guide tube and shaking the source out of the guide tube and into a shield designed for this purpose. The RSO was able to connect the source pig tail to the drive cable and retract the source into the camera. The RSO stated he received 15 millirem during the source retrieval. No member of the general public received a dose as a result of this event. The RSO's investigation into this event produced information to detail the radiographer mis-connected the source before the first shot. It was identified that the pigtail and source were in good working order, but a worn adapter was replaced to prevent recurrence of the event. The RSO retrained the radiographer in source connecting activities. No violations were cited.

File closed.

I - 9328 - Source Leak Test Exceeds Limit - DMS Health Technologies, Inc. - Garland, Texas

On July 29, 2015, the Agency was notified by the licensee's radiation safety officer that they had received notification that one of their germanium-68 calibration check sources had failed a leak test. The leak test results indicated the activity was 19.3 nanocurie. The RSO stated the source had been damaged during a routine source check of their positron emission tomography device. The RSO stated that during the test the source and rotation device got caught in a Mylar covering that surrounds the entry to the device. This caused the source rod to bend and the source to be damaged. The RSO stated they were not able to determine how the Mylar had become wrinkled enough to cause the source to get entangled. The RSO stated the source has been isolated in a lead pig and will be disposed of within the next two years. The RSO stated the area where the source was used has been surveyed for loose surface contamination. No contamination was found. The RSO stated they now require an inspection of the entry to the machine and Mylar prior to performing the daily source checks. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9329 - Damaged Moisture/Density Gauge - Raba-Kistner-Brytest Consultants, Inc. - Belton, Texas

On August 3, 2014, the licensee reported to the Agency that one of its technicians had run over and damaged a Humboldt 5001 EZ moisture/density gauge at a temporary job site in Belton, Texas. The gauge contained a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The technician had started the test and the cesium source was extended four inches into the ground. The technician decided to move his pickup and while doing so he backed over the gauge. The source rod handle broke completely off of the gauge. The licensee contacted the service company which responded and reported that the source was inside the gauge and not down in the hole. The source had apparently been pulled back into the gauge when it was run over. The service technician performed surveys and found no contamination. No member of the public or worker received any exposure as a result of this event. The gauge was disposed. The licensee counseled the employee and is conducting training with all workers on attention to detail and following procedures. No violation was cited.

File closed.

I - 9330 - Therapy Event - The University of Texas Medical Branch - League City, Texas

On August 7, 2015, the Agency was notified by the registrant that a misadministration had ocurred. A patient with a similar name received part of the wrong treatment plan in a similar area of the body (wrong treatment site). The patient received 31 centigray of a 2 gray fraction before the procedure was stopped. The patient and prescribing physician were notified. No adverse effects or changes to the patient's treatment are expected. The licensee instituted changes to its time out procedure to prevent recurrence. No violations were cited.

File closed.

I - 9331 - Radiography Source Disconnect- Element Materials Tech, Inc. - Houston, Texas

On August 10, 2015 the licensee's radiation safety officer (RSO) reported to the Agency that a source was not able to retract into a radiography camera. The RSO responded to the job site and checked the equipment and found the drive cable had broken. The RSO replaced the crank out control mechanism and retracted the source. The new crank mechanism was checked and the source was easily extended and retracted as normal. The camera was placed back into service. The camera was a QSA Delta 880 with an iridium-192 source at 44 curies. The equipment was checked by the manufacturer and it was determined that undetected damage to the drive cable was the cause. The licensee made changes to its inspection and maintenance procedures. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I -9332 - Medical Misadministration - SJ Medical Center LLC - Houston, Texas

On August 11, 2015, the licensee contacted the Agency for a follow up regarding a reportable event it had reported in February 2015. The event had been reported to the Agency's Patient Quality Care group and not reported to the Radiation Control Program. The licensee was asked to provide details of the event. The event occurred on February 25, 2015. A patient was partially treated with a different patient's plan. The therapist halted the treatment prior to completion once the mistake was realized. According to the therapist, the wrong treatment plan was loaded into the computer because of the similarity in the two patient's last names. Both of these patients had the same treatment site, radiation type, treatment energy, and prescribed daily fractional dose of 2 gray. The total daily dose was estimated to less than one percent. The dose from the partial treatment was estimated to be about 29 cGy. The patient's total administered dose was 5029 cGy (25 fractions). The prescribed dose was 5000 cGy. The patient was notified of the occurrence and no adverse effects were anticipated. The licensee's procedures were updated to prevent further misadministrations by performing a time out to verify treatment plan, patient name and birth date before starting a treatment plan. No violations were cited.

File closed.

I - 9333 - Gauge Shutter Failure - Calfrac Well Services Corporation - San Antonio, Texas

On August 11, 2015, the Agency was notified by the licensee that during a routine inspection of one of its Berthold model 8010 portable inline density gauges it found the shutter handle was bent and the shutter could not be fully operated. The gauge contains a 20 millicurie cesium-137 source. The licensee's radiation safety officer's (RSO) investigation found that while the gauge was being moved using a crane to the inspection area the gauge shutter operating arm was struck . The gauge was secured at the licensee's facility in the closed position. The RSO contacted the gauge manufacturer and the gauge was repaired on August 28, 2015. The gauge was returned to service. A leak test of the source was performed and the results were within the applicable limit. There was no significant exposure to any individual as a result of this event. Personnel involved in moving the gauge were provided additional training in handling nuclear gauges. No violations were cited.

File closed.

I-9334 - Therapy Event - Rio Grande Urology - El Paso, Texas

On August 12, 2015, the registrant notified the Agency that on August 11, 2015, a therapy event occurred when the wrong patient was treated with a linear accelerator. The error was caught and treatment was discontinued after 21 rad was delivered.
The overall percentage of extra dose to the patient after completion of the treatment will be less than 0.1% of prescribed dose, a total of 6.6 rads. The patient was informed of the error and that there was no adverse reaction to the extra dose.
The registrant has implemented changes to add a time out protocol to have two radiation therapists confirm the correct patient is being treated. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9335 - Lost Radioactive Material - Texas A&M University - College Station, Texas

On August 27, 2015, the licensee notified the Agency that a 100 millicurie cobalt-57 source had been ordered by one of its investigators and shipped to the proper address for the licensee, but the source had not been received. The licensee's radiation safety officer (RSO) reported that the investigator had checked around noon on the status of the order with the radiation safety office. The radiation safety staff learned that the investigator had ordered it without following procedure and going through their office, so they had not been aware that the source was supposed to be coming. The RSO reported that upon checking with the common carrier handling the package, the carrier showed the package had been delivered on August 21, 2015, "in College Station" (no other information documented by the driver), and the carrier provided the name of the person who signed for receipt. The carrier opened an investigation. The RSO contacted the company from whom the source was purchased and verified the shipping address was correct. A search was conducted of the building it should have been delivered to, staff was questioned if they had seen/received it or knew the person who signed for it, and the RSO searched staff and student directories and checked through the university's police department for the signer's name with negative results. At approximately 1630 hrs, the RSO made the determination the package was missing and reported to the Agency. The licensee continued its investigation and search for the package. On September 9, 2015, the source package was found intact and unopened, having been delivered to the wrong campus building. No exposure to members of the public occurred. No violations were cited.

File closed.

I - 9336 - Unable to Retract Radiography Source - Team Industrial Service, Inc. - Borger,

On September 3, 2015, the Agency received a report from the licensee that a radiography source retraction failure occurred at a temporary field site in Borger, Texas. A mount fell on and crimped the guide tube which prevented retraction. The source was retrieved according to license conditions and the damaged equipment was removed from service. The camera was a SPEC-150 and the source was 78 curies of iridium-192. No exposure to the public occurred. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9337 - Radiography Source Disconnect - Hi-Tech Testing - Longview, Texas

On September 11, 2015, the licensee notified the Agency that one of its crews had not not been able to retract a 92 curie iridium-192 source back into the QSA Delta 880D camera they were using. Source retrieval was performed by an authorized person. There were no overexposures to any individual. During his investigation, the licensee's radiation safety officer found that he was able to connect three different sets of control cables to the camera without having to first connect to the pigtail. Both the drive cables and camera passed the "go/no go" test. The camera and control cables were sent to the manufacturer for evaluation. The manufacturer found the camera failed the misconnect test. It was able to rotate the rear plate assembly ring from the "connect" to "operate" position without attaching the drive cable connector to the source assembly. After disassembling the drive cables, a measurement of the connecting plug assembly revealed excessive component wear. This condition contributed directly to the misconnect failure. The camera and drive cables were removed from service and will be disposed of accordingly. The source will be reloaded into a conforming delta 880 device. Corrective actions to prevent recurrence of the mis-connect include a company-wide inspection of all drive cable control units. All controls are routinely checked during quarterly maintenance field audits and instructions for the misconnect test are provided in all source notebooks as part of the daily inspection. No violations were cited.

File closed.

I - 9338 - Water Treatment System Leak - Water Remediation Technology LLC - San Angelo, Texas

On September 17, 2015, the Agency was notified by the licensee, as required by a license condition, that on September 15, 2015, a leak of filter media from its water treatment system had occurred. The licensee stated that approximately one cup of media "fines" had been found on the floor and that the leak had resulted from a broken fitting on the discharge recirculation line. The licensee calculated the radium activity to be approximately 120 picocuries/gram. The media was cleaned up, packaged, and will be disposed with the system's next media exchange. Surveys were performed and there was no contamination detected. No overexposures to any individual resulted from this event. Corrective actions by the licensee included repairs and installation of special support structures. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9339 - Radiography Source Disconnect - Team Industrial Services, Inc. - Pasadena, Texas

On September 18, 2015, the licensee notified the Agency that a radiography source disconnect had occurred at a temporary job site. The licensee reported that the radiography crew had been using a QSA Global model 880D exposure device that contained a 52.9 curie iridium-192 source. The device fell from a height of 30 feet and hit the floor of the vessel. The source was in the fully shielded position when the device fell. The radiographers noted the guide tube had a small kink in it and replaced the guide tube. The radiographers tested the device by cranking the source out. When they attempted to retract the source, the drive cable did not stop at the rear outlet of the camera. An individual qualified in source recovery was able to remove the source from the guide tube and place it in a source changer for storage. The licensee's radiation safety officer stated that during their inspection they found the connector on the drive cable had separated from the cable. During the licensee's investigation it was determined the radiographer held on to the drive cables while the camera fell. This created a large stress to the cable connector which caused it to part. The radiography equipment was inspected and repaired. The manufacturer agreed the source disconnect was from the drop and holding the drive cables. No personnel exceeded exposure limits during the incident and source recovery. No violations were cited.

File closed.

I - 9340 - Unable to Retract Radiography Source - JV Industrial Service Company - La Porte, Texas

On September 19, 2015, the Agency was notified by the licensee that one of its radiography crews was unable to retract a 63 curie iridium-192 source into an INC model IR-100 exposure device. The source was retrieved by a consultant licensed to do so. The equipment was removed from service and sent to the manufacturer for testing, but a cause for the retraction failure could not be determined. No overexposures resulted from the event. A complete written report was not received within 30 days. One violation was cited.

File closed.

I - 9341 - Abandoned Well Logging Source Down Hole - Halliburton Energy Services Inc. - Porte, Texas

On September 22, 2015, the Agency was notified by the licensee that it had abandoned a 1.5 curie cesium-137 source contained in a well logging tool down hole in a Ward County, Texas, well. The licensee reported a 1,600 nanocurie and a 500 nanocurie sources were also contained in the logging tool and abandoned. The licensee stated the americium-beryllium source contained in the tool was recovered from the well. The source was abandoned at a depth of 8,508 feet. A 150 foot cement plug containing red iron oxide dye ending at a depth of 8,355 feet was placed above the tool. A drill bit was placed above the cement plug to act as a kickoff device. The licensee stated they have no intention to side track the well. A plaque has been ordered for placement at the well head. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2015

I - 9346 - Badge Overexposure - Hi-Tech Testing Service, Inc. - Elderville, Texas

On September 23, 2015, the licensee notified the Agency that it had received notification from its dosimetry processor that one of its radiographers had received a dose of 4,849 millirem for the monitoring period August 1-31, 2015. The licensee's radiation safety officer investigated and determined that the dose had been to the radiographer's badge only. The radiographer had been working at a job site on August 18, 2015, and after completing the series of shots the radiographer discovered his badge in the driver's side door pocket of their vehicle. The job was re-created and calculations performed. The dose to the badge was calculated to have been 4,733 milirem. Radiation reports showed the radiographer's dose for the month to be 55 millirem. The licensee assigned a dose of 116 mrem for the August 2015 reporting period. The licensee had immediately suspended the radiographer from radiographic operations to complete the investigation. The licensee's radiation safety officer stated the suspension would remain in effect for the remainder of the year and the radiographer would work performing other non-destructive testing operations. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2015

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 - 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.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2015

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.

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, Texas

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.

## Complaints Opened Third Quarter 2015

C - 2630 - Response to Public Concern - Salvo Testing - Holliday, Texas

On July 8, 2015, the Agency received a complaint alleging that a company was allowing water containing radioactive materials to flow into residential gardens and yards. An Agency inspector conducted an on-site investigation on July 21, 2015, and found no evidence of such contamination. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2631 - Laser Injury - Clear Image Laser Studio LLC - Colleyville, Texas

On July 8, 2015, the Agency received a complaint alleging burns. The complainant did not have records of the burns. The facility is registered and has staff with proper credentials. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2633 - Regulatory Violations - Arends Inspection LLC - Houston, Texas

On July 8, 2015, the Agency received a complaint alleging the licensee did not have a radiation safety officer, it possessed a device not authorized on a registration, was storing radioactive materials in unauthorized locations, and was missing records required by this Agency. The Agency performed an on-site inspection on July 9, 2015. The inspector found some required inspections of equipment and exposure records for some individuals were missing. The inspector was able to substantiate most of the allegations. The licensee was cited for eight violations.

File closed.

C - 2634 - Regulatory Violations - Alliance Imaging Inc. - Texarkana, Texas

On July 29, 2015, one of the Agency's inspectors reported they had attempted numerous times since November 19, 2014, to make a scheduled radioactive materials license inspection at the licensee's records storage address on its license but had been unable to do so. The licensee had an address in Arlington as its records location on its license. On July 31, 2015, the licensee requested that the licensed site be moved to Texarkana which was approved by the Agency. The Radioactive Materials Group Manager requested that the complaint not be pursued and allow his group to conduct an inspection at the new site.

File closed.

## Complaints Opened Third Quarter 2015

C - 2635 - Regulatory Violations - Flexxray LLC - Arlington, Texas

On July 29, 2015, the Agency received an allegation that the registrant was not providing workers with personnel monitoring devices and that registrant was not protecting individuals from unnecessary exposure. On September 10, 2015, an on-site inspection was performed. Training and safety measures were found to be in compliance with Agency regulations. The complaint could not be substantiated. Two unrelated violations were cited.

File closed.

C - 2636 - Not Registered For Radiation Generating Device - Mr. Luis Velasco - McAllen, Texas

On August 21, 2015, the Agency received a complaint alleging an individual was in possession of a x-ray device and did not have a registration to possess the device. An Agency investigator received a call regarding the equipment prior to the receipt of the written complaint. The Agency investigator went to the location the x-ray device was stored and found the part in question was a transformer from an x-ray unit and the x-ray tube was not there. The investigator surveyed the transformer and did not find any contamination. No violations were cited.

File closed.

C - 2637 - Regulatory Violations - Maximized Living Chiropractic - Dallas, Texas

On August 25, 2015, the Agency received a complaint alleging that a chiropractic facility was taking x-rays using one setting only, the owner delegates x-ray duty to all employees and some have no training to perform x-rays, the facility should not have passed its last inspection with the state, there are no records for the x-ray unit and no quality control activities, and various other non-compliance issues. The Agency conducted an on-site investigation on August 27, 2015. The facility did have issues with finding records. Electronic records such as patients logs were being completed. There was no evidence found to support or demonstrate anyone other than the chiropractor was performing x-rays. It appeared that different settings were being used on the x-ray images. The procedures manual and other equipment performance records had to be found. The facility lacked organization although produced the required documents. The facility has established a binder to store all records regarding the x-ray unit and operating procedures. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2015

C - 2638 - Regulatory Violation - Radiological Systems, Inc. - Richmond, Texas

On August 4, 2015, the Agency received a complaint alleging the registrant was altering x-ray devices without Agency or the Food Drugs Administration (FDA) approval. Due to scheduling conflicts, the investigation could not be scheduled until October 21, 2015. On October 21, 2015, the Agency and a member of the FDA performed an on-site investigation at the registrant's office. The registrant's radiation safety officer (RSO) stated they were installing a variable resistor in the power supply to the x-ray tube on some dental machines to lower the voltage to the tube, which produced better quality images for the doctor to review. The RSO stated any machine the resistor was added to passed all required testing after the modification was made. The Agency tested four machines where the modification had been made. All machines passed the test performed. A review of manufacturer's operating instructions did not find any statement preventing this type of modification. A review of the FDA rules determined they do not prohibit this type of modification. The allegation was forwarded to the Agency's Drugs and Medical Devices Group for their review. No violations were cited.

File closed.

C - 2639 - Potential Exposure to Individual - Dental Smiles PA - Austin, Texas

On September 8, 2015, the Agency received an anonymous complaint that dental staff were conducting too many x-rays in the same location on the complainant due to an inexperienced technician. The complainant feared that she was overexposed after five x-rays were performed, using two machines, to get adequate x-rays for dental work. The Agency conducted an investigation on September 21, 2015, and discussed the additional x-rays with the dentist. The dentist stated that the patient was offered a thyroid collar and extra shielding at an additional visit. The dental office had difficulty getting a good picture of the complainant's teeth. The Agency and dentist determined there was no overexposure from the additional x-rays and that in the future the dentist would discuss the safety of extra x-rays and address any patient concerns if additional x-rays were taken. The complaint was not substantiated. No violations were cited.

File closed.

C - 2640 - Regulatory Violations - Versa Integrity Group, Inc - Houston, Texas

On September 9, 2015, the Agency received an anonymous complaint alleging that the licensee was intentionally moving its radiography cameras and trucks to alternate sites for the day of the Agency’s scheduled inspection so they would not be available for inspection and potential violations. The Agency conducted inspection and investigation activities at the licensee's two licensed sites simultaneously. There was no evidence the licensee had attempted to circumvent camera or truck inspections. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2015

C - 2641 - Regulatory Violations - Archer Wireline LLC - Wichita Falls, Texas

On September 10, 2015, the Agency received allegations that the licensee did not have a radiation safety officer(RSO) and that the licensee was in possession of a source not on its inventory. The individual contacting the Agency also alleged the source not in the licensee's inventory is not being leak tested. An on-site investigation was performed on September 24, 2015. Source inventory, leak test, and source use logs were reviewed. No discrepancies were noted. During the questioning, the RSO stated he had found a item in a bin in one of their storage areas that may have been mistaken for a source. The RSO brought the item to the investigator. The item appeared to be a dummy well logging source used for training. Dose rates taken on the item were background. The RSO stated he did not know where the dummy source came from. The dummy source did not have any marking on it indicating it was a source or a dummy source. The RSO stated they would mark the source to ensure it was not mistaken for a real source. The investigator performed a radiation survey of the licensee's property and did not find any radioactive material that was not locked in the licensee's storage area. Complaint was not substantiated. No violations were cited.

File closed.

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.

## Complaints Opened in a Previous Quarter and Closed in Third Quarter 2015

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

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

File closed.

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 - 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 in a Previous Quarter and Closed in Third 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-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.