INCIDENT AND COMPLAINT SUMMARIES FOR FOURTH 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

4th Quarter 2015

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Incidents Opened Fourth Quarter 2015

I - 9342 - Source Disconnect/Fixed Gauge - Citgo Refining and Chemical Company - Corpus Christi, Texas

On October 1, 2015, the licensee notified the Agency that a 9.5 millicurie cesium-137 source had disconnected during a routine shutter check on an Ohmart Model MDTS gauge. The gauge is mounted on the side of a vessel. The source is connected to a mylar tape which is used to raise and lower the source inside a well within the vessel. During a routine shutter check, the source disconnected from the tape and fell to the bottom of the well, which is near its normal operating position. A radiation survey was conducted in areas of general employee access. All radiation readings were at background level. There were no exposures as a result of this event. The gauge was repaired on-site by the manufacturer. According to the service report, the circuit board and power supply required repairs and the tape, which had been damaged by the device during source retraction, was replaced. No violations were cited.

File closed.

I - 9343 - Badge Overexposure - Mistras Group, Inc - Houston, Texas

On October 1, 2015, the Agency was notified by the licensee that it had received a report from its dosimetry processor indicating one of its radiographer had an exposure of 92 rem for the third quarter 2015. An investigation into the activities of the radiographer revealed that the radiographer placed the monitoring badge in a tool box located in the shooting bay before going home at the end of one of her shifts. Another crew used the tool box and completed exposure shots with the monitoring badge in the shooting bay. The radiographer did not experience any physical signs of receiving this exposure. The radiographer was assigned an exposure of 89 millirem for the exposure period based on daily exposure records. As corrective action, all employees will be required to place monitoring badges in a storage area away from the work area before leaving work. No violations were cited.

File closed.

I - 9344 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On October 1, 2015, the Agency was notified by the licensee that a labeling error had occurred on a bulk dose sent to a customer. The vial contained the correct amount of fluorine-18 activity ordered by the customer, but the vial was labeled with the incorrect activity. The licensee investigated and determined the computer software generated an incorrrect label due to an autorange error on the dose calibrator when activity units were changed from millicurie to curie. The label printed out with .51 millicuries instead of 515 millicuries. A replacement dose calibrator was ordered. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2015

I - 9345 - Gauge Shutter Failure - Tolunay-Wong Engineers, Inc - Houston, Texas

On October 9, 2015, the Agency received a report that a moisture-density gauge had been found during an Agency inspection to be stuck open due to debris in the way of the shutter. The debris was cleared and the shutter was closed. The gauge was a Troxler 3430 with a 40 millicurie americium-241 source and an 8 millicurie cesium-137 source. No overexposures are believed to have occurred due to this event. One violation for this event was included among violations cited by the inspector.

File closed.

I - 9347 - Gauge Shutter Failure - BASF Corporation - Freeport, Texas

On October 13, 2015, the licensee reported to the Agency that during routine gauge inspection and shutter checks its staff found the shutter on one of its Ronan SA-1 gauges, containing a 10 millicurie cesium-137 source, was stuck in the open position. The gauge normally operates with the shutter in the open position and there was no risk of exposure. The licensee cleaned and lubricated the gauge according to manufacturer's instructions and the shutter operated normally. The company had completed maintenance and inventory in April 2015 as required. The licensee stated that all gauges will be placed on a three month cleaning schedule to prevent future occurrences. No violations were cited.

File closed.

I - 9348 - Source Leak Test Exceeds Limit - East Texas Medical Center Pittsburg - Pittsburg, Texas.

On October 15, 2015, the Agency was notified by the licensee that a cesium-137 vial source had failed a required leak test. The leak test indicated the activity was 0.014 microcuries of removable contamination. No contamination of personnel or the public resulted from the event. The licensee stated the source was wrapped in tape and placed in storage. The licensee stated a replacement source has been ordered and the leaking source will be picked up for disposal at the same time the new source is delivered. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2015

I - 9349 - Badge Overexposure - Remon Fino MD PA - College Station, Texas

On October 19, 2015, the registrant notified the Agency that it had received a report from its dosimetry processor indicating one of its employees had received 7,071 mrem DDE on his dosimetry badge for the exposure period of calendar year 2014. During an Agency routine inspection on August 12, 2015, it was identified that individual monitoring devices were not being returned to the processor on a quarterly basis. An investigation by the Agency revealed that the registrant failed to process badges for most of 2014 and when the badges were processed the annual dose limit was exceeded for one employee. The investigation determined that the employee was wearing a lead apron and a thyroid collar with the dosimetry badge on the outside of the apron. In accordance with Agency regulations the registrant was allowed to reduce the exposure to .3 of the original amount since all exposure was from fluoroscopy. No additional violations were cited since seven violations were cited during the routine inspection.

File closed.

I - 9350 - Equipment Malfunction - Formosa Plastics Corporation Texas - Point Comfort, Texas

On October 19, 2015, the Agency was notified by the licensee's radiation safety officer (RSO) that the operating cable on a 150 millicurie cesium -137 source used in a Berthold model 21357 nuclear gauge broke during routine operation of the source. The licensee stated the source was stored in the fully shielded position. On December 15, 2015 the cable was replaced, repairing the gauge. The work was done onsite by the original manufacturer. No violations were cited.

File closed.

I - 9351 - Badge Overexposure - Team Industrial Services, Inc. - Pasadena, Texas

On October 30, 2015, the Agency was notified by a licensee's radiation safety officer that one of their radiographers had dropped their dosimetry under a pipe being examined and received a badge overexposure. The individual's badge was sent to the manufacturer for processing. The badge reading was 14.9126 rem. The licensee sent a in vetro sample to Radiation Emergency Assistance Center/Training Site in Oak Ridge, Tennessee, for analysis. The results indicated the individual had not received the exposure indicated on the badge. The licensee adjusted the exposure to the individual to 91 millirem based on the exposure received on the individual's self reading pocket dosimeter readings for the exposure period. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2015

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 Fourth Quarter 2015

I - 9354 - Abandoned Well Logging Source Down Hole - Schlumberger Technology Corporation - Hardin County, Texas

On November 5, 2015, the Agency was notified by the licensee that it had abandoned a 1.7 curie cesium-137 source contained in a well logging tool down hole in a Hardin County, Texas, well. The source was abandoned at a depth of 9,563 feet. A 200 foot cement plug containing red iron oxide dye ending at a depth of 8,680 feet was placed above the tool. Over 880 feet of irretrievable drill pipe and a Bottom Hole Assembly will serve as a mechanical deflection device. 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.

I - 9355 - Nuclear Pharmacy Error - Triad Isotopes Inc - Houston, Texas

On November 6, 2015, the Agency received notice from the licensee that an indium-111 dose containing 550 microcuries had been mislabeled. This was discovered by the customer and a correct label was sent for their records. The actual dose dispensed was verified by the customer to be the dose ordered. No violations were cited.

File closed.

I - 9356 - Damaged Moisture/Density Gauge - Terracon Consultants, Inc. - College Station, Texas

On November 10, 2015, the Agency received notice from the licensee that one of its Troxler Model 3430 moisture/density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, had been damaged at a construction site. The licensee investigated and reported its technician finished testing and placed the gauge on the concrete floor next to the last column tested, out of the way of any construction traffic. He then walked approximately 20 feet to his truck to put away his clipboard. While he was loading his truck a contractor employee lowered the bucket of a small front end loader onto the top of the gauge. The technician performed a survey of the gauge and determined the source was fully shielded inside the gauge. The licensee sent the gauge to the manufacturer for evaluation and repair. The only damage was the top shell was cracked and one of the battery packs was damaged. The licensee has discussed this incident with all of its site radiation safety officers who passed the information to its authorized gauge users. The technician involved will take a refresher training course. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2015

I - 9357 - Medical Waste at Landfill - Harris Hospital - Fort Worth, Texas

On November 3, 2015, a landfill operator notified the Agency that a load of waste had caused its radiation monitor to alarm. The isotope was identified as technetium-99. The landfill provided the waste collection information and the Agency contacted the licensee from whom the waste had been picked up. The licensee's investigation determined that the radioactive waste released from its facility had been from an outpatient and the waste was in regular trash. The licensee has decided to install radiation monitors on the regular trash outlets at the facility to reduce or eliminate outpatient trash incidents. This severity level 4 violation was not cited.

File closed.

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.

Incidents Opened Fourth Quarter 2015

I - 9359 - Lost Source of Radioactive Material - Petrochem Inspection Services, Inc. - Pasadena, Texas

On November 19, 2015, the Agency was notified by the licensee at 1630 that one of its radiographers was missing along with the company truck and a QSA 880-Delta radiography camera containing a 74 curie iridium-192 source. The radiographer's co-worker called him from the licensee's facility at approximately 0530 and the radiographer said he was coming to the licensee's facility. He did not show up and attempts to contact him were unsuccessful. The Agency contacted the licensee's radiation safety officer (RSO) at 0655 on November 20, 2015, and he stated they recovered the camera and the truck at 2355 on November 19, 2015. The RSO reported the radiographer went with a friend and the truck to a park from 1000 to 2130. The radiographer then went to his father's house at 2300. The father drove the truck with camera after midnight to the RSO's house which was only five minutes away. The licensee terminated the radiographer's employment. The licensee is holding meetings with all of its radiographers to discuss the incident and it will install GPS tracking devices on all of its trucks. The radiographer 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 - 9361 - Medical Event - Scott & White Hospital Round Rock - Round Rock, Texas

On December 1, 2015, the licensee's radiation safety officer contacted the Agency seeking guidance whether a situation that had recently occurred at the licensee's facility was a reportable event. The situation involved low activity iodine-125 seeds implanted as tumor markers (in a procedure called "Radioactive Seed Localization") into a patient. The scheduled removal of the seeds had to be postponed due to the patient's medical condition. The Agency determined this was not a reportable event. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2015

I - 9362 - Equipment Malfunction - Texas Oncology - Bedford, Texas

On December 3, 2015, the Agency was notified by the licensee that during a source exchange on a Varian high dose rate afterloader unit the manufacturer's engineer heard an unusual noise coming from the afterloader. To prevent damage to the source, the engineer removed the fuse from the drive motor to stop the retraction of the source. The source was a 10 curie iridium-192 source. The engineer contacted their office for assistance. It was decided to complete the source retraction manually and monitor the resistance on the cable as they did so. The source was fully retracted and the engineer did not feel any abnormal resistance on the cable while retracting the source. The RSO stated the manufacturer identified a problem in the controller board was causing power to the drive motor to cycle on and off causing the unusual noise the engineer heard. The control board was replaced by the manufacturer which corrected the problem. No individual received any significant exposure during this event. The source was not damaged. No 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.

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.

Incidents Opened Fourth Quarter 2015

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 - 9366 - Water Treatment System Leak - Water Remediation Technology LLC - San Angelo, Texas

On December 15, 2015, the licensee reported, as required by a license condition, that there had been a leak in one of its water treatment systems. Media containing radium that had been removed from the water had leaked out of the system. The licensee's investigation determined a PVC fitting had failed. The media was removed, packaged, and properly disposed. Surveys were performed by the licensee following the remediation that indicated all of the radium had been removed from the floor area where the media had leaked and radiation levels were indistinguishable from background. There were no overexposures to any individual as a result of this event. Corrective actions by the licensee included evaluation of the system design/installation and types of fittings used and new operating procedures. 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 Fourth Quarter 2015

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.

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

I - 9262 - Naturally Ocurring Radioactive Material - Comanche Iron & Metal - Comanche, Texas

On December 22, 2014, the Agency received notice that a property involved in bankruptcy proceedings was contaminated with naturally occurring radioactive material. It was determined that the site fell under the jurisdiction of the Railroad Commission and the Commission on Environmental Quality. These commissions have been notified and are pursuing an appropriate resolution. No violations were cited.

File closed.

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

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

File closed.

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

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

File closed.

I - 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 in a Previous Quarter and Closed in Fourth 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 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 - 9339 - Radiography Source Disconnect - Team Industrial Services, Inc. - Pasadena,

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.

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

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. La 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.

Complaints Opened Fourth Quarter 2015

C - 2643 - Radioactive Material Stored at Unauthorized Location - Henderson Inspection Services LLC - Henderson, Texas

On October 1, 2015, the Agency received an allegation that a partner in a radiography company had removed all the radiography cameras and associated sources and taken them to an unknown location. The Agency was able to contact the individual who had removed the gauges. The individual stated the company was being dissolved and the gauges had been returned to the manufacturer. The individual stated the gauges were stored in a radiography truck that met current security requirements from the time the gauges were removed from the storage location until they were shipped to the manufacturer. Copies of the shipping documents were provided to the Agency. The documents indicated all gauges possessed by the licensee were shipped. On October 9, 2015, the manufacturer reported it had received all of the gauges. The license was terminated on October 13, 2015. No violations were cited.

File closed.

C - 2644 - Mammography Regulatory Violations - The Rose-Galleria - Bellaire, Texas

On Oct 5, 2015, the Agency received a complaint, originally dated August 5, 2015, that was forwarded from the U.S. Food and Drug Administration that alleged mammography rule violations at two facilities. Specifically, the complaint alleged the offices did not have an adequate system to communicate results of mammography examinations to patients as soon as possible but no later than 30 days, as required, and the lay letters sent to the patients did not adequately report the findings of the physician. On November 19, 2015, the Agency conducted an investigation and reviewed the standard lay letters used at both facilities and reviewed two dozen actual lay letters and compared them to the examination results. The lay letters used by the facility are appropriate, accurate, and mailed on time. The example lay letters are almost exactly the same as the examples on the American College of Radiology (ACR) website. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2015

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.

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.

Complaints Opened Fourth Quarter 2015

C - 2648 - Radiation Exposure to Member of General Public - Southwest Scrap and Salvage - Venus, Texas

On October 20, 2015, the Agency received a complaint alleging that a scrapyard had radioactive material stored on its property that created a health risk to the workers. The Agency performed an on-site inspection at the facility on November 3, 2015. The inspection found that the facility manager was aware they had material contaminated with naturally occurring radioactive material and was working with a contractor to have the material disposed of properly. The site was inspected and radiation surveys indicated the exposure levels at the facility did not pose an exposure risk to any individuals. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2649 - Regulatory Violations - Versa Integrity Group, Inc. - Houston, Texas

On October 20, 2015, the Agency received an allegation that the licensee's radiographers were in violation of multiple Agency rules including working in shooting bays without alarms, not always having two radiographers, not setting boundaries, boundaries set at greater than 2 millirem in an hour, and cameras not stored properly. On December 2, 2015, the Agency conducted an on-site investigation at a temporary jobsite. Radiography was not in process but a radiography truck was parked on site. An inspection of the bay, boundary locations, and equipment were satisfactory. When the locked, alarmed truck was opened, a storage box with a radiography camera was found unlocked in violation of the licensee's operating and emergency procedures. The complaint was partially substantiated. One violation was cited.

File closed.

C - 2650 - Not Licensed For Radioactive Material - Century Wireline - Wichita Falls, Texas

On October 20, 2015, the Agency received a report that a company was in possession of radioactive material without a license. An on-site investigation on November 3, 2015, revealed that the company was operating under reciprocity while maintaining a permanent site in the state in violation of Texas rules. Company vehicles with cesium-137 and americium-241/beryllium well logging sources were parked at and dispatched from the site. The complaint was substantiated. Seven violations were cited.

File closed.

Complaints Opened Fourth Quarter 2015

C - 2651 - Regulatory Violations - Ronald Moon, DDS - Houston, Texas

On October 26, 2015, the Agency received a complaint alleging that a dentist was using a broken x-ray machine on which there is no shielding and the machine was exposing everyone close by. The complainant also indicated that the dentist does not have a certificate of registration for the machine. The Agency checked its records and could not find a registration. An Agency x-ray inspector conducted an on-site inspection and investigation. The inspector found that the dentist had not properly registered the radiation machines with the Agency when he purchased the practice in December 2012 from a registrant. The inspector found that a piece of the housing around the x-ray tube on one of the machines was missing. An investigation into this complaint is ongoing.

File open.

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

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.

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.

Complaints Opened Fourth Quarter 2015

C - 2654 - Not Licensed for Radioactive Material - Absolute Integrity Testing, LLC - Houston, Texas

On November 11, 2015, the Agency generated this complaint after it was determined that a company whose radioactive material license had been revoked for non-payment was still in possession of a moisture/density gauge. An Agency inspector had contacted the owner and was shown the where the gauge was currently being securely stored, which was at a location different from the site listed on the revoked license. The Agency conducted an investigation which resulted in the owner transferring the gauge to a licensed, authorized service provider. The owner plans to re-submit an application for a license. The service provider is storing the gauge until the company is licensed to possess the moisture/density gauge. One violation was cited during an Agency inspection.

File closed.

C - 2655 - Response to Public Concern - Bulk Transfer - Midland, Texas (Seagraves, Texas)

On November 7, 2015, the Agency received a complaint concerning radioactive material handling by the company's facility. The facility is an intermodal transfer station between carriers, transferring low specific activity containers from railcars to trucks for final delivery. Upon investigation and consultation with the licensing group, it was determined that the company was operating within Agency rules. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2656 - Regulatory Violations - Divinity Med Spa and Wellness LLC - Friendswood, Texas

On November 12, 2015, the Agency received an allegation that a laser device had been removed from the registrant's location. The investigation into this event is on going.

File open.

Complaints Opened Fourth Quarter 2015

C - 2657 - Regulatory Issues - Generation Chiropractic - San Antonio, Texas

On November 13, 2015, the Agency was notified by a concerned client that an x-ray facility would not provide shielding while taking x-rays of the person. The person asked for shielding and the chiropractor stated the x-rays are digital and no shielding is needed. The facility is correct in the reduction of x-rays by digital process however did not convey the information to the patient appropriately. The doctor was inspected in March 2015 and had three violations cited. No lead aprons are required at this type facility due to the nature of the x-rays requiring the entire spine and lower cervical area exposure for diagnosis. The doctor agreed that he did not convey the reduction in radiation dose to the patient in an appropriate manner and stated he would choose his wording better to prevent misunderstandings from any patient in the future. 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 Fourth Quarter 2015

C - 2659 - Regulatory Violations - Cypress Fairbanks Medical Center - Houston, Texas

On November 17, 2015, the Agency received a complaint alleging that a registered facility did not monitor exposure for a nurse who assisted in fluoroscopy examinations for eight weeks. On December 16, 2015, the Agency conducted an on-site investigation and determined that the nurse was never issued a dosimeter by the registrant. Dose estimates were determined by comparing the complainant's work load to other nurses who worked in fluoroscopy. The highest values for two months of work for similar workers was 53 millirem DDE. The nurse did not receive any significant exposure. The registrant generated new checklist for hired employees and updated several policies to ensure all required personnel wear dosimetry. The complaint was substantiated. One violation was cited

File closed.

C - 2660 - Regulatory Violations - Permian Nondestructive Testing Inc. - Gardendale, Texas

On November 13, 2015, the Agency received a complaint alleging that radiographers working for the licensee were not completing the required daily paper work associated with using a radiography exposure device. The complaints were addressed during the subsequent routine inspection. It was further alleged that the previous radiation safety officer (RSO) had not been removed from the license in a timely manner. It was found that the licensee had failed to notify the Agency of an RSO change within 30 days as required. The complaint was partially substantiated. One non-cited level IV violation was noted.

File closed.

C - 2661 - Regulatory Violations - Chisholm and Smith Health PLLC - Waco, Texas

On November 12, 2015, the Agency received notification from the registrant's laser safety officer that the registrant had moved its clinic on October 21, 2015, and she was no longer the laser safety officer. After processing the notification, the letter was forwarded to the radiation investigations group on November 24, 2015, for it to address alleged non-compliance issues that were included. Among non-applicable issues, the applicable allegations were that most patients were not initially consulted nor was a prescription ever written by a physician and there was no supervision by the physicians.

File open.

Complaints Opened Fourth Quarter 2015

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. No violations were cited.

File closed.

C - 2663 - Inadequate Credentialing - Center for Endoscopic Spine Surgery LLC - Richmond, Texas

On December 2, 2015, the Agency received a complaint alleging the registrant was allowing personnel without the proper credentialing to operate fluoroscopic units. The Agency performed an on-site inspection on March 17, 2016. During interviews, the doctor stated that on four occasions he had someone other than a qualified individual energize the fluoroscopic unit. He stated in every occurrence it was in response to patient safety during a procedure. He stated he was in direct supervision of the individual energizing the device. The complaint was substantiated. One violation was cited.

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 Fourth Quarter 2015

C - 2665 - Regulatory Violations - Mission Plaza Dental - San Antonio, Texas

On December 3, 2015, the Agency received a complaint referred by the Texas State Board of Dental Examiners. The complaint alleged that technicians were holding patients and x-ray equipment while taking images and that lead aprons were not provided. An on-site investigation and inspection completed on January 14, 2016, revealed that technicians were holding the device housing while performing x-rays. Furthermore, lead aprons were not provided for staff to use while holding patients. Written procedures for patient holding were not available as required. The complaint was substantiated. Eight violations were cited.

File closed.

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.

Complaints Opened Fourth Quarter 2015

C - 2667 - Unregistered Laser Facility - About Face - Waco, Texas

On December 15, 2015 the Agency received a complaint that a laser hair removal technician was offering laser hair removal services without a registered facility. An investigation into this complaint is ongoing.

File open.

C - 2668 - Regulatory Violations - Chiropractic Plus PC - Houston, Texas

On December 22, 2015, the Agency received a complaint alleging the registrant had taken an x-ray of a patient without collimating the beam. The complaint included a copy of the image which shows a 2 year old child's x-ray from the top of their head to the middle of their thigh. The image also included the hand and forearm of another individual. No gonadal shield was used. The Agency performed an on-site investigation on March 15, 2016. The investigation found that the registrant had not provided shielding to the patient or the individual holding the patient. The registrant had not restricted the beam to the area of clinical interest (collimated) on at least two x-rays and the registrant did not have a procedure for holding patients. The complaint was substantiated. The registrant was cited for four violations.

File closed.

C - 2669 - Regulatory Violations - Nondestructive & Visual Inspection LLC - Odessa, Texas

On December 17, 2015, the Agency received an anonymous complaint alleging the licensee was in violation of multiple Agency rules including: cameras not stored properly, survey meters not being used, dosimetry not being worn, truck alarms not working, and an overexposure not reported to the Agency from operations conducted out of an Odessa office. The Agency completed an investigation including an unannounced site visit to the Odessa office. The licensee had records of an overexposure claim by a radiographer who stated he received 2000 mrem in a week. However, the emergency processing of his dosimetry badge indicated an exposure of only 91 mrem for the period. The licensee terminated the radiographer's employment for falsely reporting an exposure, disrespect to management, and defamation of the licensee. The Agency monitored operations at the Odessa office and found a radiography truck parked at the office with a camera stored in the back of a truck for over 24 hours, the truck alarm turned off, and no one at the office. The office was being set up as a new site office but was not ready to store cameras in the vault. The complaint was partially substantiated. Two violations were cited.

File closed.

Complaints Opened Fourth Quarter 2015

C - 2670 - Radioactive Material Stored at Unauthorized Location - Protechnics - Midland, Texas

On December 28, 2015, the Agency received an anonymous complaint that the licensee was storing radioactive material waste in barrels in an unauthorized location and burning radioactive waste. Investigation into the allegation revealed that a trash drum containing burned debris was on the licensee's property. An on-site visit on April 6, 2016 revealed that this debris contained small amounts of several isotopes used in oilfield tracer material, and there was some contamination of the surrounding ground. The licensee is authorized for possession, use, and decay in storage of those isotopes. The licensee's representative stated that they had no knowledge of the barrel's origin and that they have no policy of burning trash or other refuse on-site. The licensee collected the barrel and debris for decay in storage in a sealed container. The surrounding area was decontaminated to below public release limits. Sufficient decontamination was confirmed by the licensee's lab and the Agency's lab. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2671 - Inadequate Credentialing - Southlake Doctors Express - Southlake, Texas

On December 29, 2015, the Agency received a complaint that alleged a Non-Certified Technician (NCT) was performing x-rays at the registrant's facility and the NCT's license expired in 2013. The complainant also alleged a lack of physician supervision of all of the NCT's performing x-rays. An investigation into this complaint is ongoing.

File open.

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.

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

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.

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.

Complaints Opened in a Previous Quarter and Closed in Fourth 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 - 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 in a Previous Quarter and Closed in Fourth 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.