INCIDENT AND COMPLAINT SUMMARIES FOR SECOND QUARTER 2016*

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

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

Incident and Complaint Summaries
2nd Quarter 2016

Table of Contents

Incidents Opened Second Quarter 2016

I - 9388 - Lost/Recovered Device Containing Radioactive Material - Marco Inspection Services - Longview, Texas

On April 13, 2016, the Agency was informed by the licensee that one of its radiography crews had lost a QSA 880 D industrial radiography camera. The camera contained a 98.7 curie iridium-192 source. The licensee reported the crew had placed the camera on the tailgate of their vehicle to survey it and forgot to place it in the transportation container. The crew drove 300 yards to the end of their road and turned on to a county highway where the camera fell off the tailgate. A member of the public saw the camera fall off the truck. The individual knew what the camera was and that the licensee had a facility in the area. The individual moved the camera out of the highway and into the ditch and called the licensee. The licensee responded immediately and retrieved the camera. The licensee inspected the camera and found it was not damaged. The licensee surveyed the camera and confirmed the source was still in the fully shielded position. The licensee's radiation safety officer (RSO) reported the camera was out of their possession approximately 13 minutes and no one received any exposure above regulatory limits. The RSO stated the radiographer received additional training on related procedures and will be required to work with a qualified radiographer for six months. The licensee was cited for two violations.

File closed.

I - 9389 - Badge Overexposure - Triumph Hospital of East Houston LP - Webster, Texas

On April 13, 2016, the Agency received notice of a badge overexposure for an x-ray technologist primarily operating portable x-ray and computed tomography devices. The employee's badge read 9985 millirem deep dose for the first quarter. An investigation by the Agency and the registrant found no unusual exposure and the worker followed protocols to minimize dose. The incident was a badge only overexposure and the dose record was amended based on calculations of workload and previous quarter averages. Staff training was held on radiation safety and protection. No violations were cited.

File closed.

I - 9390 - Lost Source of Radioactive Material - Thermo Finnigan LLC - Round Rock, Texas

On April 20, 2016, the licensee reported that an anti-static nozzle containing polonium-210 had been misplaced at his facility. The activity of the source was 10 millicuries. The source was inside the spray nozzle control which screws onto the spray gun used for electronic cleaning. The licensee was collecting the nozzles to return them to the manufacturer when it was found that one was missing. A company-wide search was conducted. The device could not be located. The device was technically leased from its manufacturer, which has been notified. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9391 - Transportation Event - Federal Express - Houston, Texas

On April 21, 2016, the Agency was contacted by the Environmental Protection Agency in response to a notice it had received regarding excessive dose rates coming from a package in shipment. The package was being carried by Federal Express (FedEx) and was located at one of its facility in Houston, Texas. The Agency contacted the radiation safety officer (RSO) for FedEx. He stated they had been informed by Customs and Border Patrol that one of their packages was reading higher than expected and they had responded. The investigation into this event produced evidence of package tampering while the package was in route from the Phillipines to US-Texas. No surveillance video or evidence has produced information to confirm the event of package tampering by any individual working for the shipping company or an employee of customs. At this point, the radioactive source has been placed in storage for disposal at the manufacture's location. No violations were cited.

File closed.

I - 9392 - Badge Overexposure - FTI Industries LP - Mansfield, Texas

On April 22, 2016, the licensee notified the Agency that one of its radiographers had dropped his dosimetry badge without noticing it and completed an exposure shot with the badge next to the industrial radiography camera. The radiographer found the badge while collecting the film. No person was overexposed--exposure was to badge only. The badge was sent for processing. The licensee's radiation safety officer (RSO) provided the dose report with a corrected dose assigned for the radiographer for the monitoring period. The RSO stated to prevent recurrence the radiographer was instructed to ensure the area was clear before leaving the camera to complete the exposure. No violations were cited.

File closed.

I -9393 - Source Leak Test Exceeds Limit, Celanese LTD, Pasadena, Texas

On April 22, 2016, the Agency was notified by the licensee's radiation safety officer (RSO) that the results of a leak test performed on a 2.72 microcurie foil type nickel -63 source, exceeded the limit. The source had been removed from a Varian Gas Chromatograph and was located in a storage cabinet at the facility. On May 25, 2016, the RSO notified the Agency the source had been delivered to a service company for disposal. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9394 - Medical Waste at Landfill - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

On April 28, 2016, a landfill reported it had received waste containing technetium-99m from the licensee's facility. The waste was in a roll off dumpster used for a construction project at the facility that was not the normal waste containers used after trash goes through radiation portal monitors at the hospital. Since the trash was from the licensed facility and it had a history of short lived radioactive material reaching the land fill, the Agency determined it was responsible for the waste leaving the facility. The licensee will start checking the roll off trash containers with a hand held meter prior to the trash leaving the facility grounds. The licensee has had two similar incidents in the past six months at this particular licensed site. The licensee's previously instituted corrective actions were ineffective in this case. One violation was cited.

File closed.

I - 9395 - Stolen Gauge - Arias & Associates, Inc. - San Antonio - Texas

On May 2, 2016, the licensee notified the Agency that one of its technician's had discovered at approximately 5:30 a.m. that a Troxler Model 3430 moisture/density gauge had been stolen out of the back of the licensee's pickup while it was parked at the technician's residence. The licensee's radiation safety officer (RSO) reported the technician had checked out the gauge on Saturday, April 30, 2016, to do a job in another town. After traveling to the job site, the job was cancelled. The gauge was left chained inside the back of the company pickup at the employee's residence. The technician told the RSO that the trigger lock was on the device. The technician told the RSO he heard noise outside his house at approximately 3-4:00 a.m. that morning and suspects that was when it was being stolen. He found the chains had been cut and the transport case and gauge were gone along with another concrete testing device. Local law enforcement was notified and the technician drove around searching the area. The RSO contacted multiple pawn shops in the area. On May 5, 2016, the licensee's RSO reported that the gauge had been found by a member of the public who knew what the gauge was and called the manufacturer's location. The manufacturer researched the serial number and called the RSO to collect the gauge from the person. The RSO had the gauge leak tested. The gauge was not damaged, although the outer carrying case was not recovered. The RSO stated the employee had not complied with company policy by taking the gauge home. The RSO provided the written policy which stated zero-tolerance on such events and all other employees were reminded by the RSO of the policy. No violations were cited.

File closed.

I - 9396 - Loss of Control of Radioactive Material - Texas DSHS - Austin, Texas

On April 31, 2016, the Agency discovered it had lost control of a smoke detector containing an 80 microcurie americium-241 source. The source was out of the Agencies control for less than an hour and was found at the back entrance of the Agency's facility. The investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2016

I - 9397 - Lost/Stolen Equipment Containing Radioactive Material - Universal Pressure Pumping, Inc. - Pleasanton, Texas

On May 4, 2016, the licensee notified the Agency that it had been unable to locate one of its Thermo Fisher Scientific Model 5192 densometers, which contains 200 millicuries of cesium-137. A search for the gauge by the licensee produced limited results. The Agency requested the manufacturer search for the gauge at its facility based on information on a leak test record in 2015. The manufacturer performed a search at its facility and located the gauge. The licensee completed required transfer records with the manufacturer. The licensee updated its inventory records, amended its license and is in the process of hiring a new radiation safety officer. No violations were cited.

File closed.

I - 9398 - Radioactive Material Found - ELG Metals, Inc. - Houston, Texas

On May 4, 2016, a scrap metal dealer notified the Agency that it had discovered a GammaMat Model S-301 industrial radiography exposure device in a load of scrap stainless steel that had come from Mexico. The radiation measurements were just under 1.5 millirem/hour on contact. Agency inspectors were dispatched and confirmed the radiation was from depleted uranium shielding in the device and no other radioactive source was present. The scrap metal dealer had also found a piece of pipe approximately 4 inches long with elevated radiation measurements in the very back of a storage bin (connex) where it keeps items contaminated with naturally occurring radioactive material (NORM) pending disposal. The inspectors checked the pipe and identified the radioisotope as radium-226 with readings close to 10 millirem/hour on contact. The scrap metal dealer had no records pertaining to receipt or origin of the pipe piece, but its investigation determined it had apparently been there many years. Based on its location in the storage area, there would not have been an exposure to any individual that would have exceeded a regulatory limit. The scrap metal dealer secured the two items until the radiography device was transferred to a licensee and the piece of pipe was properly disposed. No violations were cited.

File closed.

I - 9399 - Equipment Malfunction - Alcoa World Alumina - Point Comfort, Texas

On May 10, 2016, the Agency received notification from the licensee's radiation safety officer (RSO) that the shutter on a Thermo Fisher Scientific Model 5176-SN B2578 density gauge, containing a 500 millicurie cesium-137 source, failed to shut during an operational check. Open is the normal operation position of the gauge shutter. No licensee employee received any exposure as a result of this event. The gauge does not create an exposure hazard to the licensee's employees or a member of the general public. A service company inspected the gauge and the shutter and determined they were fully operational and worked properly. The density detector had failed, which had resulted erroneous radiation readings. The licensee incorrectly reported a shutter failure. The incident was retracted as a reportable event to the Nuclear Regulatory Commission. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9400 - Occupational Overexposure - Laredo Pain Consultants - Laredo, Texas

On May 10, 2016, a consultant reported to the Agency that he had been hired by the registrant to assess an annual occupational dose of 18,256 millirem, as reported by the registrant's dosimetry processor, to a physician for the year 2015. The consultant investigated and recommendations to the registrant included changes to the physician's position in relation to the tube and placement of his dosimetry. The consultant provided one-hour training to the physician and his staff and recommended the eight-hour online radiation safety awareness training for the physician, both specified in Agency rules. Based on the consultant's calculations, the physician was assigned a total annual dose of 5,427 millirem for 2015. One violation was cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9402 - Overexposure - Mistras Group Inc. - La Porte, Texas

On May 11, 2016, the licensee reported a potential overexposure to the Agency. The licensee reported one of its radiographers had taped the guide tube (with collimator attached) to a jig in order to perform an exposure. During the exposure, the guide tube fell. The radiographer failed to retract the source before he walked to the end of the guide tube, picked it up, and taped it back on the jig. The radiographer's dosimetry badge was sent for immediate processing. The radiographer was using a QSA 880D device with a 34.8 curie iridium-192 source. The Agency conducted an on-site investigation at the licensee's facility on May 19, 2016. The radiographer was interviewed about the event. The licensee's radiation safety officer (RSO) had the employee re-enact the event without an active source and exposure/dose estimates were calculated. The dosimetry badge results were obtained and reviewed. The radiographer had blood work completed with no unusual results at this time. The calculated dose to the hand/fingers was 467 rem. The whole body dose estimate was 937 mrem. The Agency reviewed all information and concurs with the dose estimation. The calculations used by the licensee are considered a conservative, worst case scenario for the radiographer (8 second dose to the hand, 37 second dose to the whole body). The licensee's corporate RSO sent out an alert to all company personnel as a reminder of safety precautions. The licensee terminated the radiographer's employment with the company. One violation cited to the licensee and to the radiographer.

File closed.

I - 9403 - Radiography Source Disconnect - Quality Inspection and Testing Orange County,

On May 14, 2016, the licensee notified the Agency that a radiography source disconnect had occurred at a temporary job on May 13, 2016. The licensee reported that the radiography crew had been performing radiography at a field location when upon the completion of an exposure they were unable to retract the source. The licensee’s radiation safety officer (RSO), who was authorized to perform source retrieval, responded. The RSO cut the guide tube to get access to the source and found that the connector on the drive cable had come off. The RSO recovered the source and received 1,248 millirem exposure during the retrieval. The crank out device was sent to the manufacturer for inspection. The manufacturer's report stated that the outer cable may have partially separated from the inner core reducing the diameter of the cable allowing the connector to slip off. No exposure limit was exceeded by any individual due to this event. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9404 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On May 16, 2016, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on a Ohmart Vega model SH-F2, containing a 200 millicurie cesium-137 source failed to shut during maintenance. Open is the normal operational position of the gauge shutter. No licensee employee received any exposure as a result of this event. The shutter failed to close due to excessive rust and corrosion. The licensee obtained an exception to operate the gauge until it was repaired. On September 26, 2016, the shutter was replaced and the gauge is functioning properly. No violations were cited.

File closed.

I - 9405 - Gauge Shutter Failure - Union Carbide Corporation - Sea Drift, Texas

On May 19, 2016, 2016, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on a Ohmart Vega model SHLM-BR4 gauge, containing a 5,000 millicurie cesium-137 source, failed to shut during maintenance. Open is the normal operation position of the gauge shutter. No licensee employee received any exposure as a result of this event. The licensee obtained an exception to operate the gauge until it was repaired. On October 19, 2016, the gauge was replaced and is functioning properly. No violations were cited.

File closed.

I - 9406 - Laser Injury - The University of Texas at Austin - Austin, Texas

On May 24, 2016, the registrant notified the Agency that an individual had reported that an event had occurred on May 19, 2016, during the use of a laser that caused an injury to the individual. During an alignment procedure, the individual attempted to adjust a mirror component. The mirror was mounted in such a way that its adjustment plane was diagonal across the walkway. The individual was not familiar with that mirror component and peeked under their protective eyewear to manipulate the hinges. The mirror changed position at that point and caused injury to the individual. The licensee shut down the lab in question pending a full safety audit and upgrade. The lab has implemented several improvements including new enclosures for the beam path, new policies and standard operating procedures, the purchase of new safety eyewear, and the installation of new lighting. The lab has since resumed operations. One violation was cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9407 - Leaking Source -Baker Hughes Oilfield Operations Inc. - Houston, Texas

On May 25, 2016, the licensee notified the Agency that while performing leak tests on sources it was taking out of storage for disposal it discovered that one of the sources, a 600 microcurie cesium-137 source, was leaking. Leak test results on the source were 0.018 microcuries, which exceeds the regulatory limit of 0.005 microcuries. The licensee contained the source by double-bagging it. Contamination surveys, including swipes, were performed of the source's storage location and tools used by the licensee. The results were negative. The licensee contracted with another Texas licensee to re-encapsulate the source, along with three others of the same make that were not leaking, prior to its disposal. The re-encapsulated sources are back in storage awaiting disposal. No violations were cited.

File closed.

I - 9408 - Transportation Event - Cardinal Health - Dallas, Texas

On June 1, 2016, the licensee notified the Agency that one of its shipments was involved in a transportation accident. A carrier was transporting two type “A” packages, each containing a vial of fluorine-18 (F-18) fluorodeoxyglucose, when it was involved in the accident. Emergency responders arrived at the scene and the driver of the vehicle transporting the F-18 was taken to a hospital. The emergency response personnel had the vehicle transporting the F-18 towed a local vehicle storage yard. The licensee was able to recover the F-18 five and one-half hours after the accident occurred. The licensee surveyed the packages and vehicle and did not find any contamination. No member of the general public would have received an exposure from this event. No violations were cited.

File closed.

I - 9409 - Badge Overexposure - Valley Children's Clinic PA - Harlingen, Texas

On June 6, 2016, the registrant notified the Agency that the electronic dosimeter for one of its employees indicated an dose of 5743 millirem for the month when it was read. It was determined by the registrant and the dosimetry manufacturer that the reading was due to a malfunction in the dosimeter. A dose of 0 millirem has been assigned for the period based on the employee's past dose records. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9410 - Equipment Malfunction - Exxonmobil Chemical Co Beaumont Polyethylene Plant - Beaumont, Texas

On June 7, 2016, the Agency was notified by the Licensee's consultant that on June 6, 2016, the licensee found the cable on a Berthold LB 300 model gauge that connects the operating rod to a 500 millicurie cobalt – 60 source had failed. The source is currently inserted in the in source well in the normal operating position and cannot be removed. The failure does not create any additional exposure risk to the licensee's workers or members of the General Public. The licensee stated there is no access to the vessel the source is located in during operation. Work orders have been issued to repair or replace the gauge at the next plant shutdown, which may not occur for three years. The vessel and area are barricaded and tagged no entry without approval from the radiation safety officer. The investigation into this event is on going.

File open.

I - 9411 - Damaged Device Containing Radioactive Material - Terracon Consultants Inc. - Fort Worth, Texas

On June 9, 2016, the Agency was notified by the licensee that one of its Troxler model 3440 gauges containing an 8 millicurie cesium-137 and a 40 millicurie americium-241 source had been damaged at a field site. The technician had used the gauge and was discussing something with another individual at the site. The technician was standing next to the gauge when they noted a construction vehicle was headed in their direction. The technician attempted to stop the driver from hitting the gauge, but was not able to get their attention. The licensee stated that the case for the gauge was damaged on one corner. The licensee stated the sources were shielded and the shielding components were functioning properly. Dose rates taken on the gauge were normal. The gauge was leak tested and inspected by a service provider. The result of the leak test was satisfactory and the inspection found the only damage was a crack in the housing. The housing was repaired and the gauge returned to service. No violations were cited.

File closed.

I - 9412 - Medical Waste at Landfill - Methodist Specialty and Transplant Hospital - San Antonio, Texas

On June 15, 2016, the Agency was notified by a landfill that a load of waste from a licensee hospital had caused its radiation monitor to alarm. The isotope identified was technetium-99. The Agency contacted the licensee and informed it of the event. The licensee determined the radiation monitor was turned off due to construction near the area. Training was held with hospital staff, including housekeeping, on the incident and procedures on what trash should leave the hospital. This severity level 4 violation was not cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9413 - Gauge Shutter Failure - Flint Hills Resources Longview LLC - Longview, Texas

On June 17, 2016, the Agency was notified by the licensee's radiation safety officer that the shutter on a Ohmart SH-F1 gauge would no longer close. The gauge contained a 50 millicurie (original activity) cesium-137 source. The licensee contacted a service company to repair the gauge. On June 22, 2016, the service company's representative filed away some corrosion and grease that had built up around the shutter operating mechanism and the gauge function was returned to normal. No violations were cited.

File closed.

I - 9414 - Medical Waste at Landfill - Texas Health Harris Methodist Hospital Fort Worth - Fort Worth, Texas

On June 22, 2016, the Agency was notified by a landfill that a load of waste from a hospital had caused its radiation monitor to alarm. The isotope identified was technetium-99. After the Agency contacted the hospital licensee, the licensee's investigation determined its portal monitor was turned off and trash leaving the hospital had not been monitored for contamination. The licensee put in a work order to put a lock box around the controls for the monitor. Training was held with hospital staff, including housekeeping, on the incident and procedures on what trash should leave the hospital. This severity level 4 violation was not cited.

File closed.

I -9415 - Difficulty Retracting Source - Desert NDT LLC - Abilene, Texas

On June 23, 2016, the licensee initially notified the Agency that a radiography camera had failed to lock in position after retracting the source. After further information was collected, the licensee reported the radiographers had been able to get the source locked into place but with difficulty. The licensee reported the ball stop had moved about 3/16 of an inch from its original position on the source assembly cable which prevented the locking mechanism from working properly. The camera was an 880 Delta with an iridium-192 source at 52.6 curies. The source assembly was returned to the manufacturer. The manufacturer could not determine a cause. No violations were cited.

File closed.

Incidents Opened Second Quarter 2016

I - 9416 - Response to Concern - All American Inspections Inc. - San Antonio, Texas

On June 30, 2016, the Agency was notified by the licensee that it had been denied access to the building where its radioactive material was currently stored. The licensee had not paid the rent and the building owner was attempting to lock the licensee out of the building. The building owner agreed to allow the licensee back into the building and the licensee agreed to sell off its radioactive material and vacate the building. The licensee sold all of its radioactive material on July 25, 2016, and it was removed from the building. The licensee submitted a request to terminate its license on July 27, 2016. No violations were cited.

File closed.

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

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

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

File closed.

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

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

File closed.

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

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

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

File closed.

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

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

File closed.

Complaints Opened Second Quarter 2016

C - 2692 - Laser Hair Removal - JayMed LLC dba Amerejuve MedSpa - Houston, Texas

On April 14, 2016, the Agency received a complaint alleging a technician at a laser hair removal facility burned the complainant during treatment performed in May 2015. Medical records were received from complainant on June 14, 2016, that revealed the complainant had been burned during her laser hair removal treatment. The Agency contacted the facility and discussed corrective actions. The technician had been released from employment a few months after the incident in 2015. The registrant's laser safety officer stated that new management had instituted policies to prevent reoccurrence and since that incident no other second degree burns have been reported. The registrant had failed to notify the Agency of the injury as required. The complaint was substantiated. One violation was cited.

File closed.

C - 2693 - Regulation Violations - Industrial Nuclear Co., Inc. - La Porte, Texas

On April 18, 2016, the Agency received a complaint alleging that the licensee may have had a reportable contamination event at its facility and failed to reported it to this Agency. The complaint alleged the licensee was allowing an individual who was not identified as trustworthy and reliable unescorted access to Category 2 or greater quantities of radioactive material. The complaint also alleged the licensee's security program was not fully compliant with this Agency's rules. The Agency performed an on-site inspection on May 5, 2016. The inspection was not able to substantiate the contamination event nor the unauthorized access allegations in the complaint. The inspection was able to substantiate the security related allegations in the complaint. The licensee was cited for one violation.

File closed.

C - 2694 - Regulatory Violations - Accuren Inspection Inc. - Corpus Christi, Texas

On April 13, 2016, a licensee's industrial radiography employee contacted the Agency and requested his trainee status card. He stated he had started performing industrial radiography in October 2015. Agency records showed he was not issued a trainee status card until March 30, 2016. On April 26, 2016, the Agency opened an investigation. The Agency found that the licensee submitted a request for a trainee status card for the employee on November 15, 2015. Agency rules allow trainees to work during a 30-day interim period between submission of the required documentation and receipt of a trainee status card from the Agency. Though the licensee had never received a trainee status card for the employee, it allowed the employee to continue performing radiography from December 2015 (after the 30-day interim period) to April 2015. The complaint was substantiated. One violation was cited.

File closed.

Complaints Opened Second Quarter 2016

C - 2695 - Failure to Utilize Dosimetry - Weld Spec Inc - Lumberton, Texas

On April 28, 2016, the Agency received a complaint forwarded from the Nuclear Regulatory Commission. The complaint alleged that on April 16, 2016, the licensee had allowed a radiographer trainee to work without a dosimetry badge, direct-reading dosimeter, or alarming rate meter. The Agency's investigation revealed that the licensee has recently terminated the employment of a radiographer trainee for not wearing dosimetry during radiography operations at a temporary field site. The licensee had also disciplined the radiographer trainer in charge of those operations. The complaint was substantiated. Two violations were cited to both the licensee and the radiography trainer.

File closed.

C - 2696 - Regulatory Violations - Brazoria County CT, Inc. - Angleton, Texas

On May 3, 2016, the Agency received a complaint alleging that the registrant did not have a radiation safety officer, that the x-ray table was loose and the bucky does not lock into place, and the alignment is off. On May 17, 2016, an Agency inspector performed an unannounced routine inspection and investigation. The registrant had submitted a request to change the radiation safety officer well within the time required by rule and the inspector did not find any other violations or equipment issues. Complaint was not substantiated. No violations were cited.

File closed.

C - 2697 - Radioactive Material Stored at Unauthorized Location - Outlaw Inspections - Joshua, Texas

On April 28, 2016, the Agency received an anonymous complaint that a radiography crew was storing a source at an unauthorized location. The complaint also alleged that the company was not licensed in the State of Texas. An on-site investigation on May 3, 2016, was conducted by this Agency. The inspection found the radiography company had reciprocity to work at the location the inspection was conducted. The inspection also found the source was being stored in the back of the company's truck which was equipped with the appropriate, functioning security systems. The complaint was not substantiated. The licensee and a radiographer were cited for an unrelated violation.

File closed.

Complaints Opened Second Quarter 2016

C - 2698 - Radiation Surveys Not Performed - Nondestructive & Visual Inspection LLC - Ingleside, Texas

On May 25, 2016, the Agency received a complaint alleging radiographers were not performing required surveys after each exposure. The Agency performed an on-site investigation at the location provided in the complaint on July 29, 2016. The investigation was conducted at 0400 hours and the work area did not have any lighting, so it was very dark. The investigator was not able to clearly see the radiographer's actions and there were other radiographers working in the area so it was not possible to determine who was operating a radiography device. The radiographers put out boundary cones after the investigator arrived. The investigator had indication that radiography work was being conducted based on observed dose rates, but could not determine where it was being done. When the investigator questioned the radiographers, they stated they had not performed any radiography that day. The radiographers had the required instrumentation and it was all in current calibration. There was one unrelated non-cited severity level IV violation observed that was corrected by the licensee.

File closed.

C - 2699 - Regulatory Violations - Radiological Systems Inc. - Richmond, Texas

On June 9, 2016, the Agency received an anonymous complaint reporting that a registrant who provides x-ray services is unscrupulous, violated HIPPA rules, and employs people without performing criminal background checks. On June 20, 2016, the Agency contacted the complainant and explained that HIPPA rules and criminal background checks were not covered under Agency radiation rules. After discussing the concerns of the complainant, he requested that the complaint be withdrawn. No violations were cited.

File closed.

C - 2700 - Unregistered Laser Equipment - Strereo - San Antonio, Texas

On June 10, 2016, the Agency received an allegation that a company was performing a laser show on June 11, 2016, and had not obtained the appropriate approval from this Agency. The Agency was contacted by the laser show company owner who stated they were not aware of the requirement to register their equipment. The Agency received the laser company's application for registration. No violations were cited.

File closed.

Complaints Opened Second Quarter 2016

C - 2701 - Unregistered X-ray Service - Medicatech USA - Irvine, California

On June 13, 2016, the Agency received information that a company in California was installing x-ray machines in the state of Texas and did not have a registration to do so. The complainant identified two locations. An Agency x-ray inspector had conducted a routine inspection at one of the locations on May 25, 2016, and the inspection findings confirmed the allegation at one of the locations. The Agency's investigation located papers in both of the identified registrant's files that the unregistered company had installed x-ray machines at the facilities. The Agency contacted the unregistered company. The company provided a list of four other locations in Texas it had installed computed radiography (CR) or digital radiography (DR) systems to existing x-ray machines. The Agency found that the company had installed a new x-ray machine at one of the locations and CR or DR systems at three locations, which included having registrant staff energize the x-ray machine to test the systems. The unregistered company did not perform equipment performance evaluations within 30 days of x-ray machine installations as required. The owners of the unregistered company stated during the investigation that they had been unaware of the registration requirement. The unregistered company committed to become properly registered prior to performing any more installations or service in Texas or it will contract with companies that are properly registered in Texas to perform the work. Complaint was substantiated. Two violations were cited.

File closed.

C - 2702 - Regulatory Violations - Skin Deep Laser MD LLC - Forth Worth, Texas

On June 22, 2016, the Agency received a complaint alleging the registrant's employees were not wearing proper safety glasses during laser treatments as well as other violations of the laser rules. An investigation was completed with the doctor who is the laser safety officer of the facility. Allegations were discussed and it was revealed that no patient has received an injury or any other health hazards at the facility. The doctor explained the laser treatment procedures and the use of glasses and safety equipment. The complaint had listed other issues at the facility which were discussed although did not pertain to radiation or laser usage. The technician had been released from employment for not following established protocols. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2016

C - 2703 - Regulatory Violations - Solis Mammography of Houston LLC - Houston, Texas

On June 25, 2016, the Agency received an anonymous complaint alleging that a registrant used an unqualified employee to perform mammography and used inadequate personal protective equipment. On July 5, 2016, the Agency conducted an on-site investigation. The investigation determined that an individual who did not hold the required qualification did energize the x-ray tube during a mammogram. The investigation was not able to substantiate the allegation of inadequate personal protective equipment. The registrant instructed all of its personnel on the requirements for operating x-ray machines. The registrant provided additional instructions in its procedures for actions required when holding a patient. One violation was cited.

File closed.

C - 2704 - Naturally Occurring Radioactive Material - USFS, LLC - Longview, Texas

On June 29, 2016, the Agency received a complaint that a company was conducting NORM decontamination without a license. The company advertised services for Naturally Occurring Radioactive Material (NORM) decontamination and remediation on their website. On June 30, 2016, the Agency contacted the company and determined they had submitted a request for a NORM license and they were bidding for NORM jobs. The company understood that they had to wait for a license and had not started any decontamination work. On August 1, 2016, the company was issued an Agency license. No violations were cited. The complaint was not substantiated.

File closed.

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

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 - 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 - 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.

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

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.

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

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

File closed.

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

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

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

File closed.

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

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

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

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

File closed.

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

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

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

File closed.

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

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

File closed.

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

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

File closed.

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

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

File closed.

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

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

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

File closed.

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

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

File closed.

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

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

File closed.