INCIDENT AND COMPLAINT SUMMARIES FOR SECOND QUARTER 2017*

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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 2017

Table of Contents

Incidents Opened in Second Quarter 2017……...3

Incidents Opened in a Previous Quarter and Closed Second Quarter 2017……..…...12

Complaints Opened in Second Quarter 2017……..…...15

Complaints Opened in a Previous Quarter and Closed Second Quarter 2017……...19

Incidents Opened Second Quarter 2017

I - 9476 - Not Licensed For Radioactive Material - Python Pressure Pumping - Graham, Texas

On April 5, 2017, the Agency received a call from Customs and Border Protection stating it had stopped an individual driving a closed truck who had a nuclear gauge containing cesium -137 at the Del Rio Texas check point. The individual did not have a copy of a license or shipping documents. A search of our records indicated the company did not have a license for radioactive material. The Agency contacted the company and discussed the issue. A company manager stated it had attempted to get a license, but the individual's name submitted to be the radiation safety officer was not accepted by our Agency and application process failed. The company obtained a General License Acknowledgment on April 13, 2017. One non-cited violation was identified during the investigation of this event.

File closed.

I - 9477 - Radiation Exposure To Member Of General Public - Chevron Phillips Chemical Company- Pasadena, Texas

On April 5, 2017 the Agency received a phone call from a doctor who stated he had just treated a patient who claimed he had been exposed to cesium -137 while working at a licensee's plant. The doctor stated bioassay samples were sent to a laboratory and indicated the presents of cesium - 137. The laboratory was contacted and the method of analysis used could determine the element, but not the specific radionuclide. The licensee's radiation safety officer (RSO) was contacted and stated they were aware of the event. The licensee obtained a bioassay sample from two individuals who had worked at the facility and sent them for radionuclide analysis. Both samples were found not to contain any radionuclides. During the investigation the licensee informed the Agency that three individuals were exposed to radiation levels that exceeded 2 millirem in any hour. The individuals were removing insulation from a vessel and had removed the signs and hand guards on two nuclear gauges. The RSO stated two individuals had reached between the source and the vessel while removing the coating on the vessel. The Agency performed an on-site investigation and concurred with the dose estimate of 2.8 millirem in an hour for one worker. The licensee has changed the training program offered to contractors on its site to include information on nuclear sources and change the design of the guards to prevent the event from occurring in the future. One violation was cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9478 - Unable to Retract Radiography Source - Desert NDT - Kermit, Texas

On April, 9 2017, the Agency was notified by the licensee's radiation safety officer (RSO) that on April 8,2017, one of his crew was unable to retract a 95 curie iridium - 192 source into a Spec 150 exposure device. The radiographers began cranking the source out for an exposure when the guide tube disconnected from the front of the exposure device. The radiographers attempted to retract the source, but could not. The radiographers contacted the site RSO and set new 2 millirem per hour boundaries. The licensee's retrieval team was able to retract the source to the fully shielded position by pulling on the crank-out device, thereby aligning the exposure device and drive cable (with the source attached), allowing the source to be retracted into the exposure device. No member of the general public nor any of the licensee's employees received an exposure that exceeded any limit. The licensee's investigation found that sand had built up in the connection of the guide tube and the exposure device preventing the guide tube from fully locking in place. The event was discussed with the licensee's personnel and additional training was provided on equipment inspection. No violations were cited.

File closed.

I -9479 - Potential Overexposure - Medical Facility - Lufkin, Texas

On April 10, 2017, the Agency received a notice from a registrant that two individuals may have received an annual exposure exceeding the allowable limit for 2016 due to fluoroscopy operations. The Agency conducted an investigation and determined that total dose to the two individuals was interpreted incorrectly for fluoroscopy operations, specifically one individual had a collar and waist badge and the other had a collar badge outside protective lead apron. The Radiation Safety Officer did not understand the use of Shallow-Dose Equivalent (SDE) for whole body dose instead of Deep-Dose Equivalent (DDE) for fluoroscopy operations. No dose limits were exceeded. No violations were cited.

File closed.

I - 9480 - Gauge Shutter Failure – Equistar Chemicals LP, Pasadena, Texas

On April 25, 2017, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on a Ohmart model SH-F1A gauge, containing a 50 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 was repaired by the manufacturer's representative on May 4, 2017. Bolts attaching the shutter actuation handle had sheared. The bolts were replaced and the gauge returned to normal operation. No violations were cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9481 - Gauge Shutter Failure - Blanchard Refining Company LLC - Texas City, Texas

On April 27, 2017 the Agency was notified by the licensee that the shutter on one of its Vega SHLG fixed nuclear gauges was stuck in the open position, which is the gauge's normal operating position. Investigation revealed that during the last three routine inspections, including shutter operation, the shutters on three SHLG gauges were sticky. The most recent inspection was performed January 2017. When the stuck shutter was discovered the licensee's operations were stopped for a turnaround and the licensee had taken advantage of the opportunity to have its service company to come check and lubricate the three gauges to try and prevent a shutter failure. The licensee requested and received authorization to continue operating and scheduled the gauges for repair by the manufacturer during the next facility shutdown. Due to the location of the gauge, there is no risk of exposure to any individual. A non-cited severity level four violation for failing to submit a written report within 30 days was noted.

This event will remain open in inactive status until scheduled repairs are completed.

I - 9482 -Overexposure - Versa Integrity - Houston, Texas

On April 29, 2017, the Agency was notified by the licensee that on April 28, 2017, one of its radiographer trainees had reported their self-reading dosimeter had gone off scale. The licensee stopped all work and sent the trainee's OSL dosimeter to be processed. The licensee received verbal report form the processor on April 29, 2017, and the dose was reported as 5.392 rem. The licensee did not know if the dose was static or dynamic. The licensee stated the trainee had not operated the exposure device and did not know how the trainee could have received the exposure. The exposure device was a QSA 880D camera containing a 51 curie iridium-192 source. The radiographer was a trainee and did not operate the camera. He did collect the film and during the collection process he remained near the camera for about 20 minutes not knowing the source was not fully retracted. He received 5.39 rem whole body and a calculated dose of 10 rem to his hand when he tried to disconnect the cable. On-site investigation was completed on June 7, 2017 after limited information was received from the radiation safety officer. The company had stand down briefings and disciplined employees. The individual exposed was released from service. The root cause of this incident was no post exposure survey to confirm source was retracted into shielded position. Company and radiography trainers will receive citations. Three violations were cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9483 - Unable to Retract Radiography Source - JANX - Midland, Texas

On April 30, 2017, the Agency was notified by the licensee's radiation safety officer (RSO) that a radiography crew working at a temporary field site was unable to retract a 101 curie iridium-192 source into a SPEC 150 exposure device. The failure occurred after the radiography crew had moved the camera from one location to another at the same job site. The radiography crew notified the licensee of the event. The licensee sent an individual to the site to retrieve the source. The individual found that the guide tube had disconnected from the front of the camera and the flex in the cable was causing the connector to hang up on the camera inlet port. The recovery individual straightened the cable by pulling on the crank out cables and was able to fully retract the source. The RSO stated no over exposures occurred from this event. The RSO stated sand had gotten into the connection between the guide tube and camera preventing the guide tube from fully latching on the camera outlet connection. The RSO stated the event would be reviewed with all radiographers during their annual meeting. No violations were cited.

File closed.

I - 9484 - Abandoned Well Logging Source Down Hole – Weatherford International LLC - Brazoria, Texas

On May 9, 2017, the Agency was notified by the licensee that after nine days of trying to retrieve a logging tool in a Brazos County, Texas well, they had decided to abandon the tool and sources downhole. The tool contained a 5 curie americium-241/beryllium source, a 1.5 curie cesium - 137 source, and three smaller sources. The licensee stated the sources were abandoned at a depth of 5,775 feet. Fifteen hundred feet of cement and 50 feet of red dye cement were placed above the tool to prevent intrusion. Additionally, a stuck drill bit and 200 feet of drill collars and heavy drill pipe are acting as a deflection device. A plaque was ordered to be placed at the well head. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 9485 - Nuclear Pharmacy Error - GE Healthcare - Dallas, Texas.

On May 3, 2017, the Agency received a report from the licensee stating on March 28, 2017, a customer reported it had received two unit doses that did not contain the activity requested. The radiation safety officer (RSO) stated his investigation determined the probable cause for the error was the technician who prepared the dosages withdrew several doses out of the saline vial without equalizing the pressure in the vial creating a negative pressure in that vial. This could cause some of the technetium to have been sucked out of the unit dose in the syringe requiring additional saline to be withdrawn to get the correct volume in the syringe diluting the activity. The technician received additional training on proper sample preparations. No violations were cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9486 - Gauge Shutter Failure - Keane Frac LP - Odessa, Texas

On May 10, 2017, the Agency was notified by the licensee that during routine testing it found the shutters on two Berthold model LB8010 nuclear gauges that were in storage inoperable. The shutters were in the closed position. Each gauge contains a 20 millicuire cesium - 137 source. One source handle was reported as missing and the other handle rotates around the shutters operating shaft, but does not turn the shaft. The licensee has contacted the manufacture to inspect and repair or replace the gauges. The gauges are not an exposure risk to members of the general public or the licensee's work force. The gauges were repaired by the manufacturer on May 23, 2017. The licensee was unable to determine the cause for the failures. No violations were cited.

File closed.

I - 9487 - Nuclear Pharmacy Error - GE Healthcare - Dallas, Texas

On May 1, 2017, the Agency was notified by the licensee that a customer reported a patient's unit dose was received without a syringe label indicating what was in the syringe. The customer did not administer the dose and the licensee sent a replacement dose to the customer. The licensee's investigation determined the root cause was an employee, who was confused about two different process for drawing flood point sources verses patient doses. The confusion resulted in the inadvertent release of the patient dose without labeling the syringe. The licensee has revised the procedures for completing the two processes to prevent the event from occurring in the future. No violation was cited.

File closed.

I - 9488 - Unable to Retract Radiography Source - Team Industrial Services - Corpus Christie, Texas

On June 2, 2017, the Agency was notified by the licensee that one of its radiography crews was unable to retract 92.5 curie iridium – 192 source into a QSA 880D exposure device. To perform the radiography needed, one end of a flexible guide tube was connected to the exposure device and the other end was connected to a stiff guide tube. After completing the forth exposure, the source hung up in the stiff guide tube and would not retract into the exposure device. The radiographers contacted their management who responded to the site. The stiff guide tube was examined and was found to have several indentations in it that appeared to be preventing the source from passing through the tube. The recovery team straightened the guide tubes and were able to retract the source into the fully shielded position. The licensee stated the guide tube was not damaged on this date and did not know when the damage to the guide tube had occurred. The licensee has removed the stiff guide tube from service. The RSO stated additional training on equipment inspection was provided to all radiographers. No violations were cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9489 - Radioactive Material At Landfill - Medical Facility- Dallas, Texas

On June 2, 2017 the landfill operator reported to our Agency that it received a radioactive waste load from a local medical facility. The load was rejected by the landfill. The spectrum was not available for isotope identification. The medical facility was contacted by our Agency to find the material in the load and hold it for decay. The radiation safety officer completed an investigation of the incident. The material was found in the load, collected and stored until decayed to background. The isotope was gallium-67 and was released through housekeeping trash. To prevent recurrence another radiation monitor was ordered to be placed on the regular trash exit. Personnel were trained on the monitor to check all trash leaving the facility. This is a category four violations which was not cited due to previous compliance history. No violations cited.

File closed.

I - 9490 - Stolen Radioactive Material - Hercules Engineering & Testing Services - Houston, Texas

On July 25, 1997, the Agency was notified that a moisture density gauge had been stolen from the back of a pickup truck. The event was tracked under incident number I-7173. The gauge was not located and the file was never closed. On May 18, 2017, the Agency was contacted by the Federal Bureau of Investigation (FBI) reporting the gauge had been found in Houston, Texas at the address which the gauge had been reported stolen. The FBI stated the land lord was conducting an inspection of an apartment when they discovered the gauge. The licensee that owned the gauge is no longer in business, so the manufacture was contacted about the gauge. The manufacturer took possession of the gauge. The FBI requested and was provided additional information regarding the initial investigation of the stolen gauge. No violations were cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9491 - Lost Equipment Containing Radioactive Material - Humboldt Scientific - Laredo, Texas

On October 16, 1998, the Agency was notified that a Humboldt model 5001 moisture/density gauge containing a 10 millicurie cesium - 137 and a 40 millicurie americium - 241 source was lost during transport from San Antonio to Laredo, Texas. A search of the transportation company's warehouses and delivery locations along the transportation route did not locate the gauge. The investigation was placed in "Inactive" status. On May 17, 2017, the Agency received an email string indicating a moisture/density gauge was for sale on eBay. A search of the eBay site found that the gauge serial number matched the serial number of the gauge reported missing in 1998. The Federal Bureau of Investigation (FBI) was contacted to assist in gathering information on the seller. Using the information gathered by the Agency and the FBI, the Agency was able to contact the seller and inform him that he could not possess or sell the gauge without a license issued by this Agency. The seller could not remember how they came into the possession of the gauge. The seller routinely buys material in warehouses going out of business and stores the items in his warehouse until he decides to sell them. The gauge was just recently found in the warehouse while they were relocating all the items to a new warehouse. On May 24, 2017, the seller surrendered the gauge to The Texas Department of Transportation (TXDOT). TXDOT worked with the manufacturer to return the gauge to the manufacturer. A leak test was performed on the sources and the results were satisfactory. No violations were cited.

File closed.

I - 9492 Radioactive waste released prior to decay - Medical Facility - Texas

On June 10, 2017 our Agency received notification from a landfill that it received radioactive waste in a compactor. The route sheet was provided and the facility radiation safety officer performed an investigation. The waste was collected by housekeeping and placed in regular trash instead of routing it to nuclear pharmacy to decay in storage before release. Personnel were retrained on procedures. The category four violation was not cited since the last incident for this facility was over two years ago. No violation cited.

File closed.

I - 9493 - Medical Waste Released Above Background - Christus Santa Rosa Health Care - San Antonio, Texas

On June 14, 2017, the Agency was notified that a container of waste set off the radiation monitor a landfill. The radionuclide was identified as technetium - 99m and the landfill was allowed to dispose of the material. The licensee's radiation safety officer (RSO) stated his investigation determined that their normal trash compactor was out of service for repairs and an open top container was being used to dispose of their trash. The RSO stated the bag containing radioactive material was carried to the new container without passing through the radiation monitor. The RSO stated the process for disposing of the trash containing radioactive material was reviewed with the appropriate personnel. The severity level 4 violation was not cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9494 - Increased Controls Violations Suspicious Activity - NSSI - Houston, Texas

On June 22, 2017, the Agency completed a review of material related to suspicious activity at a Licensee and determined it was a reportable incident. Specifically, on May 3, 2017 the licensee determined that on April 27, 2017 a Trustworthy and Reliable employee copies a large amount of security information including radioactive material inventories and classified material to a portable hard drive. The employee was terminated on May 3, 2017. On May 5, 2017, the portable hard drive was returned to the licensee. The licensee reported the information to local law enforcement and the Federal Bureau of Investigation. On June 28, 2017, the Agency conducted an onsite investigation. The Agency determined that all material was accounted for based on a facility inventory of all radioactive material on June 1, 2017. Additionally, based on security badge reading records, the terminated employee was not physically alone in radioactive material storage areas for the preceding six months. The Agency investigation determined that the employee wanted copies of all procedures in order to start his own company. The FBI documented and evaluated the incident and determined that no further investigative activity was warranted. The Information Technology (IT) department changed the computer network to stop any future downloads of material to a flash drive or portable hard drive. No violations were cited.

File closed.

I - 9495 - Gauge Shutter Failure - Atlas Roofing Corporation - Dangerfield, Texas

On June 20, 2017, the Agency was notified by the licensee that the shutter on a Thermo Fisher model SUP-1C gauge containing a 100 millicure source would not close. The gauge is located in a remote location at the facility and does not create an exposure risk to any individual. The manufacturer was contacted and was on site that day, June 20, 2017, to repair the gauge. There have been no other problems with the gauge since. No violations were cited.

File closed.

I - 9496 - Unauthorized Radiography Source Retrieval - Shawcor - Orla, Texas

On June 23, 2017, the Agency was notified by the licensee's radiation safety officer (RSO) that an event had occurred involving one of its radiography crews. The RSO stated while performing radiography operations at a field site, a radiographer had approached a SPEC 150 exposure device (camera) containing an 81 curie iridium – 192 source to disconnect the guide tube. After reaching down to disconnect the guide tube, the radiographer noticed the guide tube was not completely attached to the camera and the survey device (ND 2000 dose rate meter) was pegged high on the times ten scale. The source was then fully retracted to the fully shielded position. The radiographer stated his hand was in close proximity to the guide for about 10 seconds. The radiographer stated his self-reading dosimeter was reading 52 millirem after the event. Rush processing of the radiographer's badge found 198 millirem deep dose equivalent for the monitoring period. Calculations indicate 2.655 rem to the hand. No overexposure is likely to have occurred. The radiographer was not listed on the license for source retrieval. One violation was cited.

File closed.

Incidents Opened Second Quarter 2017

I - 9498 - Nuclear Pharmacy Error - GE Healthcare - Dallas, Texas

On June 29, 2017, the Agency was notified by the licensee that a dispensing error had occurred on June 2, 2017. The error occurred when the licensee shipped three unit doses of technetium-99m in the wrong form. The customer notified the pharmacy of the error. The customer was able to use the unit doses. The licensee's investigation determined that the technicians preparing the doses failed to follow company policy and double check a shipment prior to sending it to the customer. The licensee provided additional training for those involved in this event. No violations were cited.

File closed

I - 9499 - Unable to Retract Radiography Source - Accuren Inspection Inc. - Houston, Texas

On June 29, 2017, the Agency was notified by a licensee's radiation safety officer (RSO) that one of its radiography crews experienced an incident. The radiographers were testing a 24 inch pipe and the shots required the use of an extension on the guide tube and the use of a stand. While retracting the 56 curie iridium-192 source back to the QSA 880D camera, the stand fell on the guide tube extension crimping it which prevented the source from being retracted. The radiographers set up new boundaries and contacted the RSO. The RSO stated the source was driven to the end of the guide tube and shielding was placed over the source. The guide tube extension was removed from the camera and disconnected from the guide tube. The crank out assemble was dismantled and the drive cable was pulled through the camera and guide tube extension. The cable was inserted through the camera and the source retracted into the exposure device. The individual who recovered the source received 310 millirem based on his Landauer badge reading. The equipment was delivered to the manufacturer for inspection and repair or disposal. The individual was counseled on checking the stand for stability. A lessons learned was written and distributed throughout the company. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2017

I - 9196 - Regulatory Violations - Global X-ray & Testing Corporation - Portland, Texas

On May 19, 2014, the Agency received a complaint alleging multiple rule violations had been committed by an industrial radiographer working for the licensee. On May 27, 2014, during the complaint investigation, the licensee's site radiation safety officer (SRSO) stated that on April 25, 2014, the radiographer had taken one of the licensee's radiography trucks which contained a SPEC 150 exposure device with a 23 curie iridium-192 source following completion of a job in San Antonio, Texas. The radiographer had possession of the truck and exposure device with its source until April 30, 2014. The licensee's SRSO stated they attempted during that time to contact the radiographer, but they were unsuccessful. The radiographer provided text massages that showed sporadic communications between the RSO and the radiographer. The licensee located the truck at a recreational vehicle park in Portland, Texas, and took the truck and exposure device on April 30, 2014. During a records review on June 13, 2017, it was discovered this file had not been closed. It was also determined that the radiographer no longer held qualifications and the licensee's license had been terminated at the request of the licensee. Since neither party still holds a license, no violations were cited.

File closed.

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

On February 23, 2016, the Agency was notified by a registrant that a physician who performed fluoroscopy at its facility had exceeded the annual occupational exposure limit of 5,000 millirem for 2015. The assigned annual exposure was 5,686 millirem. While performing a record review on June 13, 2017, it was discovered that this file had not been completed. A review of the file indicated the registrant had made several changes to its program to lower exposures to its personnel. The changes included more observations of the doctors while they are performing fluoroscopic studies. The registrant was asked to provide the 2016 annual dose record for the individual who had previously received the over exposure. The exposure received by the individual was 601 for the year 2016 millirem indicating the registrant's corrective actions were effective. No violation was cited.

File closed.

I - 9470 - Gauge Shutter Failure - Ticona Polymers - Bishop, Texas

On March 7, 2017, the Agency received notice that a fixed gauge shutter had been found to be inoperable the following day during a routine check. The shutter was stuck in the normal operating position. The gauge is a Berthold model LB7442D with 30 millicuries of cesium-137. The licensee obtained an exception to operate with the shutter stuck in the operating position. On March 16, 2017, the gauge was repaired and normal function was restored to the shutter mechanism. The cause of the failure was believed to be corrosion of the control rod, which has been replaced. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2017

I - 9471 - Lost Source - Raytheon - Dallas, Texas

On March 15, 2017, the Agency received notice that a general licensee had lost an air ionization anti-static device with an as-manufactured activity of 10 milicuries of polonium-210. The licensee discovered the missing source in February 2017. Additionally, a previously-lost similar source had been found by the general licensee and returned to the manufacturer/owner. The licensee has since implemented a more frequent inventory and additional accounting at workstation checklists. The device has not been found. No violations were cited.

File closed.

I - 9472 - Stolen Moisture Density Gauge - Ranger Excavating Lp - Austin, Texas

On March 18, 2017, the licensee notified the Agency that a Troxler model 3440 moisture/density gauge had been stolen from the back of one of its trucks parked overnight at a worker residence. The gauge contained an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The source which was locked had two independent locks cut and the gauge with case was stolen out of the truck. The employee had kept the gauge in the back of his truck at his residence overnight. Local and federal law enforcement were notified for ongoing search of the gauge. The employee was reprimanded and policies reviewed with all employees. No violations were cited.

File closed.

I - 9474 - Contaminated Package - Medical Facility -Houston, Texas

On March 23, 2017, the Agency received a report from a licensee of external contamination on a package received at the medical facility. The Radiation Safety Officer (RSO) stated a package received from a transport company contained a Germania-Gallium generator. The device was intact and not leaking although the outside of the package had removable contamination. The highest level of contamination was 466 dpm/cm2 on the bottom of the box. There was some spread of contamination into portions of the transport vehicle, the driver's hands and shoes, the dolly used to remove the package from the vehicle, and the cart used to move the package in the medical facility. The level of contamination was below regulatory limits except for the bottom of the box. The contamination appeared to be a low energy beta emitter, with a short half-life in the three hour range. The radionuclide could not be identified due to lack of gamma or x-ray spectrum. The radiation could not be detected by a GM or scintillation probe, but only by a liquid scintillation counter. The contamination decayed by the next day. The route of the package started from a manufacturer in Germany, to an overseas transport company, to a commercial airline, to a United States transport company and finally ended with the licensee. An Agency investigation was unable to determine the source of the radioactive material. No health risk to the public occurred due to the low risk from a short lived beta emitter. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2017

I - 9475 - Stolen Radioactive Material - Fugro Consultants - Fort Worth, Texas

On March 28, 2017, the Agency was notified by the licensee that a Troxler Model 3411 moisture/density gauge was stolen from one of its trucks. The gauge contains a 40 millicurie americium - 241 source and an eight millicurie cesium - 137 source. The gauge had been used at a job site the day before by a technician and taken to their home for the night, stored (locked) in the bed of the truck. Since the operating rod for the cesium source was locked in the shielded position and the case was also locked, the licensee does not believe a member of the general public would receive any significant exposure. Local law enforcement was notified. The gauge has not been recovered. No violations were cited.

File closed.

Complaints Opened Second Quarter 2017

C - 2746 - Unregistered Laser/Facility - Clariday Aesthetics - Webster, Texas

On April 5, 2017, the Agency received a complaint alleging that a facility was performing laser hair removal and other laser procedures and it was not registered to do so. The complaint also alleged that the aesthetician that was performing the procedures was not registered to perform laser hair removal and had never had any certification training. The Agency's investigation found that the facility was exempt from the laser hair facility rules and registration requirement, but the registrant had failed to add this, and one other, site to its laser registration. The registrant had also failed to submit a change of its laser safety officer within 30 days as required. Both of the individuals named by the complainant as performing laser procedures have received training on the laser provided by the manufacturer and the individual who primarily performs procedures is registered with the Agency as a Laser Hair Removal Senior Technician.

File open.

C - 2747 - Regulatory Issues - Laser Hair Removal - Eye Spa &Skin Laser Center Pllc - El Paso, Texas

On April 12, 2017, the Agency received a complaint against a laser hair facility stating the laser safety officer was released from service and the registrant was operating inappropriately. An investigation revealed the LSO was no longer employed and another person was completing paperwork to become the LSO. Licensing section acknowledged amendment paperwork and are assisting the registrant in completing the update to the registration. The completed was substantiated. No violations were cited.

File closed.

C -2748 - Regulatory Violations Radiography Crew- Texas Gamma Systems- Houston, Texas

A complaint was received on April 27, 2017, that a radiography company was performing work without completing required boundaries, not seen performing surveys, and possibly causing a radiation hazard to individuals walking through and around the imaging site. Several attempts to conduct an inspection were unsuccessful at finding the crew working at the facility. Most of the work is completed at night. An on-site inspection was completed on August 21, 2017 from 8pm to 11pm. There were no items of non-compliance found. Complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2017

C - 2749 - Regulatory Violations - Medical Facility - Sunnyvale, Texas

On May 5, 2017, the Agency received an anonymous complaint reporting concerns about the radiation safety program at a facility. Specifically, the complainant stated he had worked at the facility and never received a film badge to monitor his exposure. The complainant mentioned that some staff reported overexposures occurred at the facility and were not reported to the Agency. On May 25, the Agency conducted an onsite investigation. All dosimetry records were reviewed as well as staff interviewed. No overexposure was identified and no one reported an incident of overexposure. The staff had no complaint that someone could not get a film badge. The facility does exceed local ALARA levels set and does not document these instances with employees per X-ray Operating and Safety guidelines. The complaint could not be substantiated. One non-cited severity IV violation was noted.

File closed.

C- 2750 - Laser Injury - Brad and Laurie Enterprises LLC - New Braunfels, Texas

On May 9, 2017, the Agency received a letter complaint stating that second degree burns to both lower legs had been suffered after a laser hair removal treatment on April 12, 2017. The complaint included pictures and urgent care discharge papers confirming the diagnosis of second degree burns. An on-site investigation was conducted on May 10, 2017. The consulting physician had not been notified of the potential injury, and had therefore not made a determination on reportability nor an evaluation of medical necessity. The complaint was partially substantiated. Four violations were cited.

File closed.

C - 2751 - Radiation Concerns - Neighbors - Tomball, Texas

On May 15, 2017, the Agency received an anonymous complaint alleging individuals were using various forms of electromagnetic energy against the complainant. There was insufficient information to conduct an investigation.

File closed.

C - 2752 - Regulatory Violations - Diamond G Inspections - Karnes City, Texas

On May 17, 2017, the Agency received an anonymous complaint stating that a radiographer working at a temporary job site was not following safety procedures and practices. An on-site investigation performed on May 18, 2017, revealed that one radiographer may have made exposures while the batteries in their alarming rate meter were not powered. Additionally, no disabling device was available for the vehicle, which was being parked outside of a hotel overnight. The complaint was partially substantiated. One violation was cited.

File closed.

Complaints Opened Second Quarter 2017

C - 2753 - Inadequate Credentialing - Simplicity Laser of Austin LLC - Austin, Texas

On June 2, 2017, the Agency received a complaint alleging the registrant was using untrained technicians to perform laser procedures. The Agency had received a complaint earlier this year on this registrant and the complainant stated they continued to use the untrained personnel after the previous investigation was done. The previous complaint was from an anonymous source and the information was generic in nature. The complaint could not be substantiated. This time the complainant provided information that allowed the Agency to identify the patients treated by the uncredentialed individual. A review of the registrants records for the patients identified indicated an individual who did not have trainee credentials was allowed to perform laser hair removal treatments on individuals. One violation was cited.

File closed.

C - 2754 - Public Exposure - Fugro Consultants - Houston, Texas

On June 5, 2017, a complaint was received from a company who had a gamma and x-ray detection system for testing when they noticed oscillating spikes that they believed were coming from a nearby radiography licensee. The complainant is concerned about the elevated radiation levels and the potential health risk to employees. On June 20, 2017, the Agency conducted an onsite investigation. A radiography licensee was located over 400 feet from the concerned company building. Several radiation exposures were monitored from the complainant location resulting in an increase of radiation levels of three to four times background for periods of five to twenty seconds. The elevated levels did not appreciably increase the total dose near the building and do not pose a health risk to the public. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2755 - Response to Public Concern - Oilpatch NDT LLC - Seabrook, Texas

On June 14, 2017, the Agency received a call from a concerned individual regarding an industrial radiography licensee that had recently opened a storage location near the individual's home. An inspection of the facility had been completed on March 1, 2017, and the facility had no violations cited. Additional discussions with Agency investigators of the nature of industrial radiography and the requirements for a storage location have answered the concerns of the individual. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2017

C - 2756 - Unregistered Laser Hair Removal Facility - Laser Booking Contouring Center - Houston, Texas

On June 29, 2017, the Agency received a complaint from an employee about a Laser Hair Removal Facility. The complainant reported multiple violations including no protocols for the laser and four pair of cracked glasses. Investigation revealed that the facility was not registered. The facility was able to produce an inventory of lasers and safety eyewear, including pictures. The facility was directed to licensing and subsequently submitted an application. The complaint was partially substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2017

C - 2581 - Laser Regulatory Violations - Eternal Afterhours - Dallas, Texas

On July 14, 2014, the Agency received an anonymous complaint from a technician who works in the laser entertainment business. The complainant alleged that, based on a friend's personal account and pictures posted on the internet, Class 3B or 4 lasers were being pointed into the public's faces and eyes at an entertainment establishment. The Agency's investigation found the establishment was not registered for laser use and contacted the establishment's management. The establishment stated it had been using laser lights and agreed to cease using them. It agreed to use non-regulated light show equipment while it attempted to obtain documentation from the U.S. Food and Drug Administration for a variance and then it would submit an application to the Agency for a certificate of registration prior to using the laser lights in the future. The complaint was substantiated. No violations were cited.

File closed.

C - 2646 - Trailer with Radioactive Material Placard - Private Individual - Brownsboro, Texas

On October 16, 2016, an individual called the Agency to report they had recently purchased property and found a commercial trailer labeled with "radioactive material" and they were concerned there might be radioactive material present. An Agency inspector responded to the location and found a trailer that had apparently been parked for some time as it was surrounded by overgrowth including small trees and other brush. The inspector performed a survey of the trailer and surrounding area. No measurements exceeded background and the trailer was basically empty with no indication of it having had a source of radiation. The inspector observed an old "Radioactive" and a "Dangerous" placard on the side of the trailer. The individual was satisfied with the inspector's report of his findings that there was no radioactive material present. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2017

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. The dentist responded to the Notice of Violation and submitted an application for registration, had equipment performance evaluations performed during which no leakage was found, and made contact with the manufacturer to determine recommended course of action for repair to the housing. The complaint was substantiated. Four 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. The complainant was advised that due to recent changes brought about through the Texas Legislature, that NCT's are now under the jurisdiction of the Texas Medical Board (TMB). Since the original complaint to the Agency did not contain complete information, it could not be forwarded to the TMB. The complainant was instructed to file their complaint with the TMB and links to the TMB website and complaint form were provided. Complainant was referred to proper authority--no investigation conducted by this Agency.

File closed.

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

On January 21, 2016 a complaint was received by the Agency alleging an inspector missed violations at a facility during the routine inspection. The complainant wanted to understand why violations were not cited against the facility for non-compliance of regulations. During the Agency's investigation, the inspector's report was reviewed and the inspector interviewed. The inspector had not noted any violations. The complainant was advised that the areas of their concern had been addressed by the inspector and he had not found any violations. The complainant confirmed that they were not aware of or alleging any issues that affected patient safety. The complainant also stated they wished to withdraw the complaint and not pursue it any further. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2017

C - 2734 - Inadequate Credentialing - Simplicity Laser of Austin LLC - Austin, Texas

On January 13, 2017, the Agency received a complaint alleging the registrant was using untrained technicians to perform laser procedures. The complaint also alleged supervision of a laser hair removal trainee was being performed by an individual who was not qualified as a Laser Hair Professional. The Agency performed an on-site investigation on March 10, 2017. The investigation found that an individual who had completed the requirements for Laser Hair R\Professional and submitted the required information to the Agency for certification, but had not received their certification was providing supervision for a trainee performing laser hair removal. The investigation was not able to substantiate the allegation that laser hair removal procedures were performed by individuals who did not have the appropriate credentials. One non-cited violation was identified

File closed.