INCIDENT AND COMPLAINT SUMMARIES FOR THIRD 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.

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Incident and Complaint Summaries
3rd Quarter 2016

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Incidents Opened Third Quarter 2016

I - 9417 - Damaged Device Containing Radioactive Material - Raba-Kistner Consultants Inc. - Robstown, Texas

On July 6, 2016, the licensee reported to the Agency that one of its moisture/density gauges had been run over and damaged. The gauge involved was a Troxler Model 3430 containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The technician had extended the cesium source into the ground and started a test. He was prepping the next test location about 30 feet from the gauge when he saw a step-up grader coming fast toward the test area. He waved and yelled but was unsuccessful in getting the operator's attention. The grader hit the gauge and drug it about 10 feet. The source rod was bent and the technician could not retract the source. The technician set a boundary around the gauge, notified his radiation safety officer (RSO), and maintained surveillance of the gauge. The site foreman moved the road crew down the highway to avoid the gauge. The RSO contacted a service company who responded to the site, collected the gauge, and transported it to its facility for repair/disposal. No member of the public or worker received any exposure as a result of this event. No violations were cited.

File closed.

I - 9418 - Radiation Exposure To Member Of General Public - BASF Corporation - Freeport, Texas

On July 6, 2016, the licensee reported that on June 5 and 6 of 2016, several contractor employees were exposed to levels of radiation that exceeded the 2 millirem in an hour limit. The licensee's report indicated that none of these individuals exceeded 100 millirem total exposure. Workers were in the process of preparing to remove a small vessel that was equipped with a Ronan Model SA-15 holder containing two 50 millicurie cesium-137 sources that are used for level interface measurements. At the time the incident occurred, the vessel had been cleared and emptied of process contents, but the radiation source had not been retracted into the source holder and locked out. The radiation safety officer discovered the problem on June 6, 2016, and all workers were cleared from the area and the sources were secured in the source holder and locked. The licensee and contractor conducted interviews of all individuals to determine their time in the area. The licensee conducted dose rate studies in the work area and it was determined that 22 individuals exceeded the 2 millirem in an hour limit, but none would have received more than 100 millirem while working in the area. The licensee changed the procedures for working around nuclear gauges and provided additional training to personnel who work around these devices. One violation was cited.

File closed.

Incidents Opened Third Quarter 2016

I - 9419 - Lost/Recovered Moisture/Density Gauge - RRC Power and Energy LLC - Mentone, Texas

On July 9, 2016, the licensee reported to the Agency that on July 8, 2016, one of its technicians had failed to secure an InstroTek Model 3500 Xplorer moisture/density gauge before driving away from a temporary job. The technician failed to close the case lid, secure the case in the vehicle, or close the tailgate before leaving the job site. When he got to the main road, he realized his error and discovered that the gauge was missing. He retraced his route and checked at the job site, but his search was unsuccessful. The gauge source rod was locked. Local law enforcement was notified. The lost gauge was located by a different company when a technician found the gauge on the side of the road and took it with him to a company office in Odessa, Texas. The company called the licensee on October 14, 2016 to pickup and return the gauge. The gauge had slight damage to the case but was operable and the leak test was satisfactory. Safety and security training was conducted with all staff and procedures were changed to increase technician's awareness to the when the gauges were being used. Two violations were cited.

File closed.

I - 9420 - Diagnostic Nuclear Medicine Error - Cardinal Health - Houston, Texas

On July 12, 2016, the Agency received notice from the licensee that several patients had received diagnostic bone imaging studies involving technitium-99m that produced unexpected images. Investigations were performed by the radiopharmacy and the kit manufacturer. It is suspected by the manufacturer that a defective vial allowed for oxygen infiltration and chemical breakdown of the kit. No further testing can be completed. The kit in question was discarded. No other anomalous readings have been reported from the same lot. No violations were cited.

File closed.

I - 9421 - Medical Waste Released Prior to Decay - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

On July 29, 2016, a landfill operator notified the Agency that it received radioactive waste in a 30 yard compactor from a known facility. An investigation by the facility produced information acknowledging the waste (Tc-99m) had bypassed the monitoring system by a housekeeping employee. The licensee trained the new employee about the monitoring system. A non-cited category IV violation was listed in the licensee's file for this occurrence. No violations cited.

File closed.

Incidents Opened Third Quarter 2016

I - 9422 - Occupational Overexposure - General Inspection Services, Inc. - Hempstead, Texas

On August 4, 2016, the Agency found in a July 25, 2015 report that an employee of a radiography company had received an occupational dose over the 5 rem limit for the year. The company was contacted to clarify the statement on the inspector's report. The Agency determined that the radiographer did receive an annual dose of 5,496 millirem. An investigation revealed that the radiographer did receive large doses of radiation on several of the monthly badge reports for the 2015 year. It was also discovered that the radiographer had dropped his badge next to the camera during an exposure shot. He found the badge when he was collecting the film after the shot. The record showed no significant difference in the badge reading when the badge was said to have been dropped compared to the other monthly readings. The reports suggest the radiographer received an annual radiation dose over the limit. The radiographer had been placed on administrative leave and suspension for a month due to his not correcting instructions to back further away from the camera during exposure shots. The radiation safety officer did not realize he had to report the occupational dose. The company RSO is aware of the reporting criteria and has added new policy to the operating procedures to prevent recurrence of exposure event. Two violations cited under inspector's report.

File closed.

I - 9423 - Lost/Recovered Moisture/Density Gauge - Fugro Consultants Inc - Dallas, Texas

On August 6, 2016, the Agency was contacted by the licensee's radiation safety officer (RSO) who reported one of their crews had lost a Troxler model 3430 moisture density gauge. The gauge contained an 8 millicurie cesium-137 and a 40 millicurie americium-241 source. The crew had completed their work and returned to the office when they realized they had left the gauge on the tailgate of the truck and it was no longer there. The RSO was notified and both the crew and the RSO drove the 20 mile route used by the technicians returning to the office in an attempt to find the gauge, but the gauge was not located. The RSO stated the cesium source was in the fully shielded position, however the operating rod was not locked. Local Law Enforcement was notified about the lost gauge. On August 10, 2016, the licensee found the gauge listed for sale on a internet web site. The licensee contacted the seller and recovered the gauge. There was no evidence of tampering with the gauge. The gauge was inspected and leak tested by a service provider. The inspection did not find the gauge damaged and the sources were not leaking. The licensee provided additional training on the proper use and transport of nuclear gauges for all of their technicians. The licensee was cited for three violations.

File closed.

Incidents Opened Third Quarter 2016

I - 9424 - Gauge Shutter Failure - Arlanxeo USA LLC - Orange, Texas

On August 10, 2016, The Agency was notified by the licensee that during a daily inspection, the shutter on an Ohmart Vega SH-F1 nuclear gauge could not be operated. The gauge contains a 10 millicurie (original activity) source. The shutter is operated by an pneumatic operator. The operating mechanism is located inside a steel box to help prevent foreign material from interfering with the shutters operation. It appears that over time, moisture was being trapped in the box causing the operating rod connecting pin to rust and break. The shutter cannot be moved. It is in the open position which is the normal operating position for the shutter. The investigation into this event is on going.

File open.

I- 9425 - Gauge Shutter Failure - Arlanxeo USA LLC - Orange, Texas

On August 11, 2016, the Agency was notified by the licensee's radiation safety officer (RSO) that during a daily inspection, the shutter on an Ohmart Vega SH-F1 nuclear gauge could not be operated. The gauge contains a 50 millicurie (original activity) cesium -137 source. The gauge shutter was found in the open position which is the normal operating position for the shutter. The gauge is mounted on the top of a tall vessel and did not present an exposure hazard to the licensee's workers or members of the general public. On September 23, 2016, the RSO informed the Agency the gauge had been repaired by a service company. The inspection of the gauge found that corrosion and debris had built up in the gauge and prevented the operating arm from rotating the shutter. The RSO stated the top cover seal on the gauge was replaced to prevent any additional water intrusion into the area of the shutter operating mechanism. No violations were cited.

File closed..

I - 9426 - Overexposure - Mistras Group Inc - Deer Park, Texas

On August 24, 2016, the Agency received a report from the licensee regarding an overexposure of an employee. The licensee reported that one of its radiographers had received 5.5 rem on the July monthly monitoring report resulting in a total dose of 6.4 rem for the year. The radiation safety officer (RSO) investigated the cause of the overexposure and determined that the radiographer had not been following procedures. The RSO stated that the radiographer was working in an enclosed area and not distancing himself from the source as required when the source was exposed. Subsequent interviews with the licensee and radiographers involved indicated that the daily survey sheets had been falsified and that the radiographers had taken extra exposure in order to produce the work more quickly. Both radiographers were terminated from employment. Five violations were cited to each radiographer and to the licensee.

File closed.

Incidents Opened Third Quarter 2016

I - 9427 - Medical Waste at Landfill - Cooks Children Hospital - Fort Worth, Texas

On August 31, 2016, a landfill operator notified the Agency that it received radioactive waste in a compactor from a known facility. An investigation by the facility produced information acknowledging the waste had bypassed the monitoring system. The licensee retrained staff about the monitoring system and survey techniques. A non-cited category IV violation was listed in the licensee's file for this occurrence. No violations cited.

File closed.

I - 9428 - Gauge Shutter Failure in storage/inventory - Non-Reportable - Universal Pressure Pumping Inc. - Cleburne, Texas

On August 31, 2016, the Agency was notified by the licensee of a stuck shutter on a gauge. The gauge was in storage and an inventory was being completed. The gauge was leak checked and found that the shutter would not open or close. The incident was non-reportable however the gauge was tracked through the process of disposal by the company and the transfer record dated October 12, 2016 was placed in the incident and facility file. No violations were cited.

File closed.

I - 9429 - Lost Source of Radioactive Material - Chevron - Houston, Texas

On September 15, 2016, the Agency was notified by an Operation Specialist (OS) of a general licensee stating that during an inventory of a waste storage room in its building on August 15, 2016, discovered an exit sign containing 7 curies of tritium (original activity) was missing. The sign was manufactured by Isolite in October, 2002. The OS stated the building was searched and all personnel who had access to the room were interviewed. It is believed the sign may have been inadvertently disposed of in the trash. Procedures were modified to control access and all personnel received training on the control of radioactive material. No violations were cited.

File closed.

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

I - 9271 - Radiography Source Disconnect - Fox NDE, LLC - Odessa, Texas

On January 26, 2015, the licensee reported to the Agency that on January 25, 2015, one of its radiography crews had experienced a source disconnect at a temporary job site. The radiography crew had been unable to retract an iridium-192 source into its QSA Delta 880 exposure device. An authorized person performed the source retrieval. The source retriever received 206 millirem whole body, per dosimetry badge report, and was assigned a calculated dose of 37 rem to his hands. The licensee attempted to replicate a disconnect and misconnect but could not. The camera and crank assembly were sent to the manufacturer for evaluation. The manufacturer could not replicate a disconnect or misconnect either. The manufacturer's evaluation indicated the condition of the controls may have contributed to the incident. The licensee removed the controls from service. One severity level 4 violation was noted.

File closed.

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

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

File closed.

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

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

File closed.

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

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

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

File closed.

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

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

File closed.

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

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

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

File closed.

I - 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.

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

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 (conex) 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.

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

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

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.

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 - 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 in a Previous Quarter and Closed in Third Quarter 2016

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 a 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.

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.

Incidents Opened in a Previous Quarter and Closed in Third 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.

Complaints Opened Third Quarter 2016

C - 2705 - Not Registered for Radiation Generating Device - Cancer Treatment Institute at Physicians Hospital - El Paso, Texas

On July 8, 2016, the Agency was notified by a registrant that her medical practice, which included a linear accelerator, was placed in receivership by court order. The registrant is concerned because the receiver is not registered to operate a linear accelerator. The Agency conducted an investigation and discussed the registration requirements with the legal representative of the receiver. They have no plans to take over the facility from the registrant and use the linear accelerator. The Agency discussed the alternatives with the registrant to terminate or sell the practice. Currently, three other registered facilities have expressed interest in buying the facility and linear accelerator. The complaint was not substantiated. No violations were cited.

File closed.

C - 2706 - No Physician Supervision For Laser Treatment - Skinny Sculpt Med Spa - Freindswood, Texas

On July 27, 2016, the Agency received a complaint alleging laser treatments were being completed by a med spa without supervision of a licensed practitioner of the healing arts. The owner of the med spa was contacted and he stated they did not perform laser treatments. He stated they contracted a registered laser company to come to their office and conduct any laser treatments they needed. The Agency contacted the laser company the owner who stated they did conduct laser treatments at the med spa. I contacted the medical director listed on the registration and he confirmed he was the medical director for the company providing the laser services. The complaint was not substantiated. No violations were cited.

File closed.

C - 2709 - Regulatory Violations - Shawcor - Fort Worth, Texas

On September 2, 2016, the Agency received a complaint alleging that the licensee had conducted multiple regulatory violations at the site office and at temporary job sites. Allegations included non qualified personnel transporting a radiography camera out of the site and radiographers removing cameras from the vault without following check out procedures. An investigation was conducted on September 6, 2016 at the site office. The vault was inspected and all cameras that were out were checked out properly. A review of cameras shipped to and from the office had proper shipping papers and qualified personnel transported the cameras. The site had 25 radiographers and only 2 were trainees. The trustworthy and reliability program was reviewed to ensure radiographers were authorized to handle the radiography cameras. No regulatory violations were noted. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2016

C - 2710 - Regulatory Violations - Simplicity Laser - Austin, Texas

On September 14, 2016, the Agency received a complaint that the registrant may have allowed its registration to lapse and that signatures on training procedures completed by its personnel may have been forged. A renewal request was received by the Agency on September 9, 2016, though the previous registration had expired on August 31, 2016. Subsequent investigation showed that the alleged forged name did not appear on any of the paperwork in question. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2711 - Unregistered Laser Facility - Black Diamond Spa - San Antonio, Texas

On September 19, 2016, the Agency received a complaint alleging that a laser hair removal facility was operating without registration. Investigation revealed that the facility and a related facility with a different address were offering laser services without registration. Laser facility registration paperwork and related fees have been submitted for each facility. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2712 - Unregistered Laser Facility - Glo Salon Spa/ Shantham INC - Houston - Texas

On September 19, 2016, the Agency received a complaint that a laser hair removal facility was operating without registration. Several attempts were made to contact this facility. The ownership of the business has changed and the current owner has sent in a registration form on January 4, 2017. The registration form was accepted with payment in the licensing section. Registration is in process. Complaint was substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2016

C - 2714 - Unregistered Laser Facility - Renew Med Spa - Georgetown - Texas

On September 28, 2016, the Agency was notified by complainant alleging a facility is not registered to conduct Laser Hair Removal (LHR) and maybe causing injury to clients. On October 20, 2016, an unannounced inspection confirmed the facility was not registered to conduct LHR and had just hired a LHR Apprentice. There was no documentation nor indication that a client had been burned. It was explained to the owner that the facility needed to be registered. The facility continued operating without registering using the LHR Apprentice from late October 2016 to early December 2016 with no supervision. As of December 29, 2016, the facility still has not submitted an application and fees to register. The complaint was substantiated. Three violations were cited.

File closed.

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

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

File closed.

C - 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 ratemeter. 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.

Complaints Opened Third Quarter 2016

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.

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

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 in a Previous Quarter and Closed in Third 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.