INCIDENT AND COMPLAINT SUMMARIES FOR FOURTH 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
4th Quarter 2016

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Incidents Opened Fourth Quarter 2016

I - 9430 - Lost Source of Radioactive Material - Fugro Consultants Inc. - San Antonio, Texas

On October 7, 2016, the Agency was contacted by the Federal Bureau of Investigation (FBI) which reported that a Troxler model 3430 moisture/density gauge had been dropped off at a San Antonio, Texas, fire department by a member of the general public (MGP). The MGP had found the gauge on the side of a road and recognized it contained radioactive material, thus decided to bring it to the fire department. The FBI Agent was able to open the gauge case and provided the gauge and a source serial number to the Agency. The Agency contacted the gauge manufacturer who was able to trace the gauge back to the licensee. The Agency contacted the licensee. The licensee retrieved the gauge. The licensee's radiation safety officer stated the source rod was locked in the shielded position and the locks were on the case when it was found. The licensee's investigation discovered one of its technicians had picked up the gauge from the storage area and placed it in a vehicle at that time the technician realized he had left his wallet at home. He did not secure the gauge properly in the bed of the truck. He drove home to retrieve his wallet. On his way back to the office, he noticed in his rear view mirror the gauge was missing. He returned to his home searching the route, but did not find the gauge. The technician thought to himself if he indeed picked up the gauge or not. He did not report the incident, returned to the office, signed out another gauge and continued his work day. The technician completed his assigned job, returned and signed in the second gauge, and went home. The licensee has removed the technician from the gauge users list and secured his keys to the company truck and the gauge access. The licensee conducted radiation safety meetings and reviewed the event with all its technicians. The licensee also has added its contact information on the transport cases for the gauges. Three violations were cited.

File closed.

I - 9431 - Transportation Violation - Professional Service Industries, Inc. - Houston, Texas

On October 17, 2016, the Agency received information that first responders in Houston had responded to a location after local law enforcement had observed a container fall off of the back of a truck onto the road. The responders found the container was an empty moisture/density gauge transport case. The driver of the truck returned to the scene. The moisture/density gauge was in the cab of the vehicle and was not properly blocked and braced. Following its investigation, the licensee reported that the technician had been re-charging the gauge in the cab of the truck while on a job site. He got in a rush to go to the next job and failed to secure the gauge in its case in the rear of the truck prior to traveling to the next job site. The licensee's corrective actions included discipline, re-training, and increased auditing for the technician. Gauge security and control was covered in the licensee's Houston facility's monthly meeting, and a sticker with the wording "Secure the Gauge" was affixed inside the driver's compartment of each of the licensee's gauge transport vehicles in Houston. Three violations were cited.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9432 - Overexposure - Central Texas Medical Center Foundation - San Marcos, Texas

On October 20, 2016, the Agency was notified by the registrant that one worker had exceeded the annual deep dose equivalent (DDE) exposure limit for the year 2015. The worker was an interventional cardiologist with a DDE of 7.615 rem. Corrective actions included fluoroscopic guidance training and radiation protection instruction for the physician and other staff. Two violations were cited.

File closed.

I - 9433 - Unable to Retract Radiography Source - Acuren Inspection Inc. - Beaumont, Texas

On October 21, 2016, the Agency was notified by the licensee that one of its radiography crews were unable to retract a 71 curie iridium 192 source into a QSA 880D radiographic device. The radiographers had placed the guide tube stand on a wooden box to complete an exposure when during the exposure the stand fell off the box and landed on the guide tube crimping the guide tube enough that the source could not be retracted. The radiographers contacted the licensee's radiation safety officer who sent a team of authorized individuals to recover the source. The recovery team placed lead shielding over the source and was able to remove the crimp enough to retract the source back into the exposure device. No one involved in the event received an exposure that exceeded any limit. No member of the general public was exposed due to this event. The licensee provided additional training for all of its radiographers at that site. The exposure device was returned to the manufacturer for inspection and the guide tube was taken out of service. No violations were cited.

File closed.

I - 9434 - Gauge Shutter Failure - Albemarle Catalysts Inc. - Pasadena, Texas

On October 25, 2016, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on an Ohmart Vega model SH-F1 gauge, containing a 60 millicurie cesium-137 source, failed to shut during a leak test. Open is the normal operation position of the gauge shutter. No licensee employee received any exposure as a result of this event. The licensee received a license amendment to continue operating with the gauge for 30 days. On November 22, 2016 the gauge was repaired by a service company and is fully operational. The cause of the failure was product dust getting into the shutter mechanism preventing it from fully closing. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9435 - Gauge Shutter Failure - International Paper Company - Queen City, Texas

On October 27, 2016, the Agency was notified by the licensee's radiation safety officer (RSO) that the shutter on a Berthold model LB7440-D-CR gauge containing a 10 millicurie (original activity) cesium - 137 source would not close. The licensee obtained authorization from the Agency to temporarily continue operations with the gauge stuck in the open position. On December 13, 2016, the gauge was repaired by the manufacturer. No violations were cited.

File closed.

I -9436 - Lost Radioactive Material - DuPont - LaPorte, Texas

On October 26, 2016, the Agency received a notice that two exit signs containing tritium were found to be missing. Each sign contained 0.426 terabequerels of tritium. Further investigation revealed one sign to have been sent back to the original manufacturer. The other was likely disposed of along with other construction debris in early 2016. Any exposure to members of the general public is unlikely. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9437 - Intertek Asset Integrity Management INC - Longview - Texas

On November 3, 2016, the Agency was contacted by the licensee's radiation safety officer (RSO). The RSO was reporting that two radiographers had experienced a radiation dose causing pocket dosimeters to go off scale. The crew were working at a temp job site on a power plant. The camera had a 36 curie Ir-192 source. The crew had not been using the survey meter as required, when one of the radiographers noticed that the source was protruding from the camera about six inches when he removed the guide tube to reposition the camera after he thought he had cranked the source into the device. The area was noisy and the crew could not hear the alarming rate meters alerting them to the source being out of the shielded position. Both radiographers were interviewed by the RSO and then suspended until monitoring results were received. The RSO calculated the dose to be 1593mrem for the one radiographers hand dose. The monitoring badges were sent for processing with results of 317 and 309 mrem doses. The annual dose for both radiographers was below the 5 rem limit. The calculations for the extremity dose (hand, foot, and knee) were below the 50 rem overexposure limit. The annual dose for both radiographers was provided with results of 2053 mrem and 2761 mrem. The November badges had been worn for two days when the incident occurred. A re-enactment investigation was conducted on November 29, 2016 due to limited details on the report provided by the RSO and the calculations appeared to be short in dose. The dose to the hand, foot, gonads, knee and whole body were recalculated and it was determined that the radiographers had received a slightly higher dose but still under the limits for an overexposure. We had calculated the dose to the hand to be approximately 29 rem instead of 15.9 rem reported by the RSO. The distance of the hand dose was provided by the RSO at 4 inches, during the re-enactment a smaller distance of ½ inch during the time the radiographer removed the guide tube was more accurate. His hand passed directly over the source when he pulled the guide tube over the source when it was extended from the camera. The shorter distance increased the dose, however, was still under the 50 rem limit for an overexposure. The radiographer has not experienced any redness, blisters or soreness to his hand. He has been viewing them daily to relieve his own mind that he has not experienced a radiation burn or injury. During the investigation his hands were viewed and no noticeable damage was seen (26 days after the incident). The cause of the incident was not retracting the source completely into the shielded position and not using a survey meter to ensure the source was shielded. The two radiographers had changed positions during this job. One usually worked the crank and the other collected the film. Both radiographers commented during the investigation, that they weren't using the meter like they should and it was their fault for not doing the required survey. One violation cited to the company and each radiographer.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9439 - Lost/Found Source of Radioactive Material - NRC Electronic Technologies LLC - Conroe, Texas

On November 7, 2016, the Agency was notified by an inspector that the licensee's office appeared vacant and the doors were locked. The license possessed four Americium-241 sources each at a maximum activity of .02 microcuries used for calibration on a well logging tool. The Agency conducted an investigation and determined that the sources were transferred to another licensee in Texas. The licensee stopped operations in early 2015 and failed to renew its Agency license. The Agency contacted the second licensee on December 12, 2016, conducted an onsite investigation and located the sources. The second licensee planned to commence operations in January 2017 and will add the four sources to its license. The licensee was already in enforcement for payment due in arrears. No additional violations were cited.

File closed.

I - 9440 - Damaged Device Containing Radioactive Material - ECS-Texas LLC - Frisco, Texas

On November 9, 2016, the Agency received a report that a moisture/density gauge had been damaged. The gauge contained 10 milicuries of cesium-137 and 40 milicuries of americium-241. The gauge was damaged when a bulldozer blade was lowered onto it, pushing it into the mud and damaging the keypad area. The sources were locked in the shielded position. The shielding was not compromised and no exposure to the general public is likely. The gauge only requires replacement of its shell and keypad. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9441 - Gauge Shutter Failure - INEOS USA LLC -

On November 17, 2016, the licensee notified the Agency that during its semi-annual fixed nuclear gauge inspection on November 16, 2016, it had discovered that the shutter mechanism on an Ohmart Model SHLM-BR-2, which contains 1,000 millicuries of cesium-137, had become inoperable. An investigation into this event is ongoing.

File open.

I - 9442 - Device Leaked Radioactive Material - Westrock Texas LP - Silsbee, Texas

On December 23, 2016, leak confirmed. On November 17, 2016 the Agency received notice from a service company that it had a gauge which appeared to have leaked the radioactive material. The gauge potentially leaked Krypton-85 gas because the device failed to operate normally. The device activity did not produce acceptable measurements and was removed from service/operation. The device was removed from service by the service company and set into a storage area and labeled to prevent movement. The licensee made arrangements for the manufacturer to service the gauge stating to the Agency that it would take the manufacturer three weeks before it could schedule a visit to the plant site. The manufacturer must confirm that Kr-85 indeed did leak from the gauge. Device information provided included by the licensee: Manufacturer – Valmet/Metso, Gauge model - BMW2, Gauge S/N – 50048138, Isotope - KR-85, Activity – 400mCi, Source S/N – QA00168. On December 23, 2016, the licensee verbally confirmed the device had leaked the Kr-85 gas. The manufacturer will be providing a service description and details of how the device was checked and or repaired. Awaiting the service report from the manufacture. Update will be provided in accordance with SA300 guidelines.

File open.

Incidents Opened Fourth Quarter 2016

I - 9443 - Radiography Source Disconnect - Nondestructive and Visual Inspection LLC - Mentone,Texas

On November 21, 2016, the Agency was notified by the licensee that on November 19, 2016, one of its radiography crews was unable to retract a 66 curie iridium-192 source back into a Spec 150 radiography exposure device (camera). Following their third exposure on a pipeline inspection at a temporary job site, one of the radiographers retracted the source and went to the camera to disconnect the guide tube. The 6-foot guide tube was laying over the top of the pipe and the collimator was on the opposite side from the radiographer. When the radiographer disconnected the guide tube he pulled collimator to the top of the pipe. The radiographer's alarming rate meter sounded and his survey meter went off scale. He left the area, verified the two millirem per hour boundary and called the site radiation safety officer (SRSO). The SRSO who is on the license to perform retrievals, responded and retrieved the source. The control cable was found to be broken approximately one inch from the drive cable connector. The device and control assembly was sent to the manufacturer for evaluation and repair. The radiographer's and the SRSO's dosimetry was sent for processing. No individual received an exposure that exceeded a limit. The manufacturers report stated the failure of the drive cable was due to poor maintenance of the drive cable. The manufacturer stated the cable had become embrittled and packed with dirt. The licensee inspected all the crank out units in its inventory, provided additional training to the two radiographers involved, and placed the two radiographers on an increases oversite schedule. One non-cited severity IV violation was noted.

File closed.

I - 9444 - Unregistered X-ray Machine - Dr Andy Lam DDS - Garland, Texas

On November 28, 2016, the Agency determined that a Dental Office who submitted a complaint about a service company installation of x-ray equipment in November 2011 never registered with the Agency. The dentist thought that after the installation of two x-ray machines, the service company would file paperwork with the U.S. Food and Drug Administration and this was the required method of registration. During a meeting with a new service company on September 21, 2016, the dentist was told he was required to register his x-ray equipment with the Agency. The dentist submitted a registration application to the Agency on October 2, 2016. The facility operated two x-ray machines from November 2011 to 2016 without being registered. One violation was cited.

File closed.

I - 9445 - Orphaned Source - Surefire Industries LLC - Houston, Texas

On December 1, 2016, the Agency received a report from a realty company that a previous tenant had vacated the property leaving behind a 200 millicurie (original activity) cesium - 137 source. The source was mounted on a short piece of pipe and did not appear to have been installed into a system. Agency attempts to contact the owner of the radioactive material were unsuccessful. On January 12, 2017, the Agency took possession of the material and placed it in storage for disposal. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2016

I - 9446 - Medical Waste at Landfill - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

On December 8, 2016, the Agency received notice from a landfill operator that waste coming from the licensee's facility had set off their radiation detectors. This was determined to be gallium-67, a medical isotope. This is a repeat violation within six months for this site. One violation was cited.

File closed.

I - 9447 - Damaged Device Containing Radioactive Material - Accuren Inspection Inc. - Beaumont, Texas

On December 10, 2016, the Agency was notified that on December 9, 2016, the licensee was required to perform a source retrieval of a 74.9 curie iridium -192 source. The exposure device associated with the source is a QSA 880 exposure device. They licensee reported the exposure device fell on the guide tube and crimped it to a point where the source could not pass by. The radiographers verified the boundaries and contacted the radiation safety officer. The licensee sent a qualified recovery team to the location. The recovery team cut the guide tube and was able to retract the source. No individual received an exposure that exceeded any limits. No member of the general public was exposed as a result of this event. The licensee stated the camera would be sent to the manufacturer for inspection. The maximum exposure dose for the recovery team was 609 mrem and 500 mrem. The radiographer who tried to retract the source received 1462 mrem during the event. The radiographer was removed the radiation program in his employment. No violations were cited.

File closed.

I - 9448 - Medical Waste At Landfill - Methodist Healthcare System of San Antoino - San Antonio, Texas

On December 15, 2016, the Agency was notified by a landfill operator that a load waste from one of the licensee's location had caused a radiation monitor alarm. The waste was surveyed and the radionuclide was identified as technetium -99m a medical isotope. The landfill operator was allowed to dispose of the waste. The licensee stated the hospital has a major construction project in progress and may have prevented someone from using the monitor. The licensee provided additional training on disposal of the waste to its employees. This is the first event at this location. One non-cited severity IV violation was noted.

File closed.

I - 9449 - Damaged Moisture/Density Gauge - CMJ Engineering and Testing Inc. - Colleyville, Texas

On December 15, 2016, the licensee's radiation safety officer reported to the Agency that one of its Humboldt 5001-EZ moisture/density gauges containing a 40 millicurie americium-241/Beryllium source and a 10 millicurie cesium-137 source had been run over by a pneumatic roller at a temporary job site. The upper casing on the gauge was damaged but there was no damage to the source rod or shielding. The gauge was given to a service company to install a new plastic cover and electronic display. A safety stand-down was held for all employees to watch the surrounding work area while operating the gauge. No violations were cited.
File closed.

Incidents Opened Fourth Quarter 2016

I - 9450 - Radiography Source Disconnect - US NDI LLC - Abilene, Texas

On December 15, 2016, the Agency received notice that the licensee had retrieved a source disconnected via a broken drive cable. The camera was an 880 Delta with a 135 curie iridium-192 source. An investigation into this event is ongoing.

File open.

I - 9451 - Increased Control Violation - Spectral Oil & Gas Corporation - Humble, Texas

On December, 14, 2016, the Agency was conducting an investigation on the transfer of radioactive material from a licensee A to licensee B. Licensee B failed to add the transferred radioactive material to their license. Additionally, licensee B failed to pay for renewal of their license in 2015 and the Agency had issued a violation for payment in arrears. The licensee reported that they stopped working in early 2015 due to two floods in the Humble area and that they intended to pay their licensee fee in the next 30 days and start up operations. The Agency requested to check the storage of a 19 curie americium-241/beryllium source used for well logging. The source had adequate locks however the alarm system was shutdown and nonfunctional. An investigation into the incident is ongoing.

File open.

I - 9452 - Radioactive Material Involved In A Fire - Eagle NDT LLC - Poth, Texas

On December 20, 2016, the Agency was notified by the licensee's corporate radiation safety officer (CRSO) that a fire had occurred at their Poth, Texas location causing extensive damage to the building. The fire caused the roof to collapse onto the storage location for the licensees exposure devices. Once the licensee gained access to the storage location all ten exposure devices were removed from the storage location. The licensee inspected the devices and found on two of them the carrying handles had been melted. Radiation surveys of the devices indicated the shielding had not been damaged. The devices were sent to the manufacturer for inspection. The state Fire Marshal determined the fire was an electrical short at a plug. The investigation into this event is ongoing.

File open.

Incidents Opened Fourth Quarter 2016

I - 9453 - Nuclear Pharmacy Error - GE Healthcare - Waco, Texas

On December 13, 2016, the Agency was notified by the licensee that on November 8, 2016, they had sent the wrong activity of technetium - 99m (Tc) to a customer. The licensee's investigation found that the dose calibrator used to measure the dispensed dose was set for indium - 111 instead of Tc-99m. The customer discovered the error and contacted the licensee. The customer adjusted the dose and the patient received the correct dose. The employee who made the error was re-trained by the licensee on setting the dose calibrator. No violations were cited.

File closed.

I - 9454 - Nuclear Pharmacy Error - GE Healthcare - Temple Texas

On December 13, 2016, the Agency was notified by the licensee that two customers had been delivered unit doses' where the particle range was outside the manufacturers recommendations. The licensee's investigation determined the procedure in use did not define acceptable particle range. The procedure was changed to specify the acceptable particle range and all staff was trained on the change. No violations were cited.

File closed.

I - 9455 - Lost Radiation Generating Device - All American Inspection - San Antonio, Texas

On December 29, 2016, the Agency generated an investigation regarding unaccounted-for x-ray industrial radiography devices previously in the registrant's possession. An investigation into this event is ongoing.

File open.

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

I - 9276 - Unlicensed Radioactive Material - R T Precision Machinery - Cypress, Texas

On February 9, 2015, the Agency was provided information by Harris County Sheriff's Deputies that they suspected a radiation source (gauge) was present in a pipe inspection trailer that had been parked approximately 14 years at a storage facility. The Agency contacted the owner of the trailer who stated this was one of two trailers he purchased at an auction approximately 14-15 years prior. He sold one trailer (see I-9278) and stored this trailer at the facility without ever using it. He did not have any of the purchase paperwork. The owner was not aware he was required to be licensed to possess the radioactive material in the gauge. The Agency conducted an on-site investigation and determined a cesium-137 source was present but the radiation levels did not pose a health risk. The trailer owner responded promptly and contracted with a licensed company who, on March 4, 2015, removed and took possession of the source for proper disposal. The Agency's investigation to identify the original owner of the gauge/source was unsuccessful. No violation was cited.

File closed.

I - 9291 - Overexposure - Mistras Group, Inc. - Texas City, Texas

On March 25, 2015, the licensee notified the Agency that on March 15, 2015, one of its radiographer trainees had experienced an exposure to an extremity that may have exceeded the regulatory limit that required reporting. The licensee's radiation safety officer (RSO) conducted an investigation and the Agency conducted an on-site investigation on March 30, 2015, that included re-enactment. Information from both investigations revealed that the QSA 880D camera was up on a deck and the radiographer trainee had cranked in the source from below. He went up on the deck to disconnect the source guide tube while the radiographer trainer stayed below and was checking the images on the computer. The radiographer trainee reported he surveyed the camera and hadn't gotten any readings, but he failed to recognize there might be an issue. He then tried to disconnect the guide tube but he couldn't get the outlet port cover to rotate. He checked the back of the camera to ensure the selector was in the right position and then tried again. Unsuccessful, he looked again at the back of the camera and saw the slide bar of the lock was showing red, indicating the source was not locked in the fully shielded position. He climbed down, told the trainer, and the trainer cranked out about 1/4 turn and forcefully retracted it to its locked and shielded position. They checked the survey meter and found it wasn't working properly. They opened it, adjusted the terminals, and it worked properly. The trainee said he did not hear his alarming rate meter, which was working, due to the noise level at the site. The radiographer trainee's dosimetry badge had a reading of 384 millirem. Following re-enactments, the RSO calculated and assigned a dose of 23 rem to the trainee's hands and 450 millirem to his left knee. The RSO sent the camera and associated equipment to the manufacturer for evaluation. There were no deficiencies identified. One violation each was cited for the licensee and the radiographer trainer.

File closed.

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

I - 9301- Regulatory Violation - New Lifecare Hospitals of North Texas LLC - Fort Worth,

On April 10, 2015, a registrant self-reported that an individual was exposed to radiation without authorization from a licensed practitioner of the healing arts. Specifically, a medical radiologic technologist (MRT) allowed a radiologic technology student to perform a computed tomography (CT) scan of the MRT's head for training. The registrant's and Agency's investigations confirmed this occurred and the MRT admitted she had gotten engrossed in the teaching process and had the student take the scan while she was giving instructions on what to do to. Two other scans were performed on phantoms. The registrant's corrective actions include additional training to staff on proper use of radiological equipment, additional education and training for staff who have direct teaching contact with students, and routine audit process to identify unauthorized exams. One violation was 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 - 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 in a Previous Quarter and Closed in Fourth Quarter 2016

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 - 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 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.

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.

Complaints Opened Fourth Quarter 2016

C - 2715 - Regulatory Violations - Phoenix Mechanical Integrity Services - Houston, Texas

On October 10, 2016, the Agency received a complaint alleging that a radiography company was storing radioactive material in a location not authorized on their license. The complaint also alleges the radiographers working at the same location were not using their radiation detection instruments while performing radiography and the licensee was falsifying records to indicate the source was being returned to storage each night. An on-site investigation on October 27, 2016 revealed a radiation source, determined to be a radiography camera, stored in a locked structure with no company personnel on location. A subsequent site visit on November 10, 2016, and an inspection at the licensee's licensed facility confirmed that the structure did not meet security requirements including two independent barriers and monitoring requirements. The checkout logs do not show a camera checked out on October 27, 2016, but do show cameras checked out to the temporary job location on other days. The licensee is slated for a future field inspection. The complaint was partially substantiated. Two violations were cited.

File closed.

C - 2716 - Not Registered - Vandelay Education LLC - Various Cities in Texas

On October 12, 2016, the Agency received a complaint alleging a new dental assistant school in Tyler, Texas, may be providing training on the use of dental x-ray equipment without being properly registered with this Agency. The Agency's investigation revealed that the company who owns the school has a total of 26 dental assistant schools throughout the state and only three are properly registered. The company/registrant immediately submitted applications to add the 23 unregistered locations to one of its existing certificates of registration. The registrant stated the two staff members who held responsibility each thought the other was managing the registrations. The registrant stated the responsibility for additions and terminations of locations to its registration has been assigned to one staff member and the process for updating its certificate of registration has been included in its internal procedures for opening or closing schools. The complaint was substantiated. Violations were cited.

File closed.

Complaints Opened Fourth Quarter 2016

C - 2717 - Regulatory Violations -Industrial Nuclear Company INC - La Porte - Texas

On October 13, 2016, the Agency received a complaint regarding source problems in radiography cameras becoming stuck or breaking off at the pigtail. The complainant alleged that competitor's sources were becoming a safety problem in the radiography projectors in which the complainant was associated or provided to the general industry. The complainant based this allegation on one reportable event (listed in June 2016) caused by the competitor's source in the complainant's projection device. The complainant wanted an investigation into the other company and information on the number of times this type incident occurred. A search of state and national information showed only the one incident of this nature. The complainant stated more information would be provided for further investigation although no additional information was provided. The complaint was not substantiated. No violations cited.

File closed.

C - 2718 - Radioactive Material Found at Scrap Yard -

On October 12, 2016, the Agency received an email from the State of Arkansas stating an individual in Arkansas had bought pipe from two locations in Texas and the pipe was determined to be contaminated when the scrapyard that ended up with the pipe tried to sell to a steel mill. The investigation into this event is ongoing.

File open.

C - 2719 - Regulatory Violations - Ultimate Image Skin Care - Plano, Texas

On October 17, 2016, the Agency received a complaint about a Laser Hair Removal Facility (LHR) reporting multiple violations including the use of cracked and incorrect type of safety glasses. On October 26, 2016 an onsite investigation was completed. The spa was registered for LHR however, a second location was not registered in accordance with Agency rules on laser services and usage. Multiple violations were found at the inspected facility including a lack of key control, cracked safety glasses, missing operating procedures, and no warning signs posted on two rooms with class 4 lasers. The complaint was substantiated. Five violations were cited.

File closed.

Complaints Opened Fourth Quarter 2016

C - 2720 - Radiofrequency Interference - Houston, Texas

On October 18, 2016, the Agency received a complaint referred from the Environmental Protection Agency. Upon contacting the complainant, it was discovered that the complaint involved radiofrequency interference. Radiofrequency interference is the mandate of the Federal Communications Commission. The complainant was referred to the FCC complaint process. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2721 - Regulatory Violation - Weslaco Advanced Medical Imaging LLC - Weslaco, Texas

On October 19, 2016, the Agency received a complaint alleging the registrant was not providing prior mammograms within 30 days of the request for the records as required. The complainant alleged it had received requested records for two patients but receipt exceeded 30 days from request and alleged it had requested records for four patients over 30 days prior and had not yet received the records. The Agency conducted an investigation that included an on-site visit to the registrant's facility. The registrant provided documentation that the two patients' records had been provided at 30 days from the request. The registrant stated it had not received requests/signed releases for the other four patients and the complainant could not provide evidence to the contrary. The Agency randomly selected and reviewed 29 other patient requests received by the registrant between February and October 2016 and found all had met the 30-day requirement. The Agency offered suggestions to the complainant and registrant for better tracking of requests and communications. The complaint was not substantiated. No violations were cited.

File closed.

C - 2722 - Unregistered Laser/Laser Injury - La Vraie Beaute Aesthetic Clinic - San Antonio, Texas

On October 19, 2016 the Agency received a referral complaint from the Texas Board of Nursing. A facility was conducting laser services without registration or a certified technologist. The investigation revealed that the technologist was not certified nor was the facility registered. The facility hired a lawyer to handle all investigations of this facility and has recurrently provided a registration form for the facility in December 2016. The form was missing information and returned for corrections. The lawyer contacted the Agency on January 6, 2017 stating he is currently gathering information to complete the registration. Awaiting on documents. File will remain open until registration is complete.

File open.

Complaints Opened Fourth Quarter 2016

C - 2723 Not registered Laser Hair Removal Facility - Capture the Beauty - Austin, Texas

On October 26, 2016 the complainant contacted our Agency to inquire and report and unlicensed facility. The business phone number was called numerous times with no reply or response. The location was visited revealing the laser removal service was being operated from an apartment complex. The person had vacated the apartment due to leasing agreement which did not allow business operations. The business has deceased at the location and no contact information was available to pursue another location of operation. The complaint could not be substantiated.

File closed.

C - 2724 - Naturally Occurring Radioactive Material - Various - Midland, Texas

On October 31, 2016, the Agency received an allegation referred from the Environmental Protection Agency stating that an individual was concerned with workers being exposed to radiation from pipe in the oil industry. The complainant was contacted by this Agency on November 1, 2016. The individual stated they had recently delivered a load of piping to an oil/gas pipe service company and the owner surveyed the load for radiation. He stated the owner informed him that all pipe is surveyed at the entrance to the facility ensuring it did not exceed the regulatory limit. He stated that in his experience of transporting pipe from the oil wells he has never seen a survey done on the pipe. The person was informed that the Railroad Commission (RRC) has specific authority for this issue and that this Agency would forward the information to the RRC. The information was referred on November 1, 2016. No violations were cited.

File closed.

C - 2725 - Unregistered X-ray Service Company - Tri County Dental Supply - San Bernardino, California

On November 29, 2016, the Agency received a complaint from a Dental Office that X-ray equipment installed in November 2011 by a service company was not installed in accordance with Food and Drug Administration regulations, specifically not registered. The Agency determined that the out of state service provider was not registered in Texas to install x-ray equipment. According to information provided, the equipment was purchased from the company, and that an employee of the company installed the x-ray equipment and demonstrated its effectiveness by taking an image of his own teeth. The complaint was substantiated. Two violations were cited.

File closed.

Complaints Opened Fourth Quarter 2016

C - 2726 - Regulatory Violations - Gateway Diagnostic Imaging LLC - Richardson, Texas

On November 29, 2016, the Agency received a complaint alleging there was no field light on the registrant's x-ray machine, no detent to prevent the tube from moving/drifting, and posted techniques were incorrect and resulted in under-penetration. The complainant also alleged he had not been made aware of, or required to read, any operating and safety procedures at the registrant's facility and he had been asked, but refused, to perform x-ray(s) without a physician's order. The Agency conducted a routine, unannounced inspection of the facility on December 5, 2016, and telephonic interview with a facility manager. The equipment was found to be operating properly and the techniques appeared to be appropriate. Records were provided that showed the complainant had signed that he had read the operating and safety procedures. There was no way of confirming or refuting that there had been any request to image without a physician's order. The complaint was not substantiated. Violations cited as a result of the inspection were not related to the allegations.

File closed.

C - 2728 - Regulatory Violations - Texas Pain & Spine Institute PLLC - Amarillo, Texas

On December 12, 2016, the Agency received an anonymous complaint about the movement of a registered fluoro x-ray machine. He was concerned about the location of use, calibration, and proper registration of the machine. An investigation into the event is ongoing.

File open.

C - 2729 - Regulatory Violations - Unknown Craigslist Posting - Garland, Texas

On December 19, 2016, the Agency was contacted by the Federal Bureau of Investigation reporting a craigslist posting of an individual wanting depleted uranium cut into sample sizes. The Agency attempted to contact the person who posted the advertisement by personal and state email and received no response. The Agency contacted Craigslist and had posting removed. The Agency monitored Craigslist for two additional weeks looking for a repost of the advertisement but it was not reposted. The Agency did not pursue any further action due to the low radiation risk from depleted uranium. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2016

C - 2730 - Inadequate Credentialing - Etre Belle - Dallas, Texas

On December 29, 2016, the Agency received a complaint about the registrant. The complaint included allegations of laser hair removal procedures being performed by uncredentailed individuals and by individuals in training without adequate supervision. Additionally, the complaint alleged burns and adverse reactions not referred to a contracted physician. An investigation into these events is ongoing.

File open.

C - 2731 - Regulatory Violations - Garden Oaks Veterinary Clinic PA - Houston, Texas

On December 30, 2016, the Agency received a complaint alleging that during the time the complainant was employed by the registrant and helped with x-ray procedures, the registrant only provided a protective vest/apron and failed to provide gloves or thyoid shield and failed to monitor the complainant's exposure to radiation. An investigation into this complaint is ongoing.

File open.

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

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

On November 12, 2015, the Agency received an allegation that a laser device had been removed from the registrant's location by one of the co-owners. The Agency conducted an on-site visit on December 2, 2015, and confirmed the laser was not at the facility. The co-owners had been directed by the Agency that the laser, per rule, must be located at the registered location. The co-owner in possession corrected the non-compliance and returned the laser device to the facility on December 3, 2015. A follow-up investigation was opened to monitor other potential non-compliance issues that were brought to attention in the original investigation. The facility closed in April 2016 and registration is being terminated. No violations were cited. Complaint substantiated.

File closed.

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

On December 15, 2015, the Agency received a complaint that a laser hair removal technician was offering laser hair removal services without a laser hair removal facility registration. The Agency's investigation revealed that the technician had previously worked under a laser registration held by a physician at a spa facility. The physician ended his association with the spa and opened a clinic. The technician opened her own business in the same building as the clinic, and assumed she could still work under the physician's registration. When the technician was advised the arrangement did not comply with Agency's rules, she immediately ceased performing laser/laser hair removal procedures and agreed to resume only after she obtained proper registration. Complaint was substantiated. No violation was cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth 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 - 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 in a Previous Quarter and Closed in Fourth 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 - 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, I conducted an unannounced inspection of Renew Med Spa. The facility was not registered to conduct LHR and had just hired a LHR Apprentice. There was no indication that a client had been burned. The Agency explained that the facility needed to get registered immediately if they wanted to conduct LHR. The facility continued to conduct LHR including using a 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.