# INCIDENT AND COMPLAINT SUMMARIES FOR THIRD QUARTER 2017*

Prepared by:
Art Tucker, Chris Moore, Karen Blanchard, Gentry Hearn, Irene Casares

Texas Department of State Health Services
Regulatory Services Division
Inspections Unit
Radiation Branch

* 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**
**3rd Quarter 2017**

## Table of Contents

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

Incidents Opened in a Previous Quarter and Closed Third Quarter 2017……………………………………………………………………………………..8

Complaints Opened in Third Quarter 2017…………………………………………………………………...………11

Complaints Opened in a Previous Quarter and Closed Third Quarter 2017 ………………………………………………………………………………………...15

## Incidents Opened Third Quarter 2017

I - 9500 - Potential Overexposure - Desert NDT LLC - San Antonio, TX

On July 19, 2017, the licensee's Radiation Safety Officer (RSO) reported to the Agency that two of its industrial radiographers may have experienced an overexposure. The two had been performing radiography on tanks and when they checked their pocket dosimeters, found the dosimeters off-scale. The radiographers were stopped from performing any more radiography and their dosimetry badges were sent for immediate processing. The RSO performed an investigation of the work practices for the site. No exposures in excess of limits were discovered. It was believed the workers were too close to the device during exposures due to the site setup. No violations were cited.

File closed.

I – 9501 – Device Location – Arends Inspection LLC - Houston, TX

On July 12, 2017, the Incident Investigation Program was contacted and asked to locate eight radiography exposure devices owned by a company whose license had been revoked on January 25, 2017. An inspection done by the Agency on July 28, 2016, indicated the devices were still locked up in storage at the licensee's address. The investigation into this event is ongoing.

File open.

I - 9502 - Lost Equipment Containing Radioactive Material - Henley-Johnston & Associates Inc. - Dallas, Texas

On August 4, 2017, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that on July 28, 2017, one of their technicians lost a moisture/density gauge, which they later recovered. The technician was using a Humboldt Scientific moisture density gauge containing a 10 millicurie cesium - 137 source and a 40 millicure americium - 241 source. The technician locked the operating arm on the cesium source and locked the case, but failed to secure the case in the truck bed. The technician drove to a nearby convenience store to purchase some items. When the technician drove away from the store, the case with the gauge fell out of the truck onto the road way. The local fire department was contacted and took custody of the gauge. The fire department contacted the manufacturer and obtained the name of the gauge owner. The licensee was contacted and retrieved the gauge from the fire department. No individual of the general public received any significant exposure as a result of this event. The technician involved received disciplinary actions from the licensee. One violation was cited.

File closed.

## Incidents Opened Third Quarter 2017

I - 9503 - Stuck Shutter - Pasadena Refining INC - Pasadena Texas

On August 10, 2017, the licensee's Radiation Safety Officer notified the Agency that a fixed gauge (Ohmart Vega, SHLG-2, SN 8551CM, 3000 millicuries, Cs-137) had a stuck shutter. A repair company was called and the technician completed repairs on the gauge within one day. Shutter failure was from water intrusion in the slide channel causing the shutter to rust and reduce movement. The gauge was cleaned and lubricated. A monthly maintenance procedure will be placed in effect to reduce or eliminate this issue. No violations were cited.

File closed.

I - 9504 - Medical Waste Released Above Background - Baptist Health System - San Antonio, Texas

On August 16, 2017, the Agency was notified that a container of waste set off the radiation monitor a landfill. The radionuclide was identified as technetium - 99m and the landfill was allowed to dispose of the material. The licensee's Director of Environmental Services stated her investigation determined that the detectors were operating properly at both hospital exits but they suspect the sensitivity of the landfill detector was far more sensitive than their detector. She stated the process for disposing of the trash containing radioactive material was reviewed with the appropriate staff including conducting a more thorough monitoring of waste. This is a category four violation which was not cited due to previous compliance history. No violations cited.

File closed.

I - 9505 - Radioactive Material Found - Protechnics Division of Core Laboratories LP - Alice, Texas

On August 12, 2017, the Agency was contacted by Customs and Boarder Protection (CBP) in Freer, Texas, who reported they had found a piece of radioactive material (RAM) in the back of a pickup truck owned by the licensee. The RAM was a short piece of rubber hose and the dose rate from the hose was 68 microrems per hour. The driver of the truck was unaware of the material and did not have the required paperwork to transport RAM. The licensee sent a qualified individual with the appropriate paperwork to the location and they retrieved the material. The licensee's Radiation Safety Officer stated the truck had not been used in any activity involving RAM since July 5, 2017. The licensee's investigation was unable to determine how the material got into the truck. Two violations were cited.

File closed.

## Incidents Opened Third Quarter 2017

I - 9506 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On August 17, 2017, the Agency was notified by the licensee that an irregularity on unit dose prescription labels provided to several customers had occurred. Four patients were administered the unit doses, but only one of the patient's results were altered by the error. The licensee's investigation determined that a pharmacist was making doses for multiple customers. During this process one of the customers canceled their order. The pharmacist placed the unit doses for the canceled order back into inventory and they were later sent to the customer where they were used. The licensee stated no adverse effects will be experienced by the patients involved. The licensee stated the pharmacist involved in the event received counseling on pharmacy procedures. The licensee has changed its policies and requires doses from canceled orders to be immediately disposed of. No violations were cited.

File closed.

I - 9507 - Failure to Terminate License - Eagle Inspections LLC - Nederland, Texas

On September 5, 2017, the Agency was unable to contact a licensee that possessed three radiography devices. The Agency contacted the Operations Manager for the licensee and was informed the licensee had ceased operation in January 2017. The Agency searched the National Source Tracking System and found that a service provider had reported receiving the sources. The Agency contacted the service provider and verified it had received the sources. No violations were cited.

File closed.

I - 9508 - Unable to Retract Radiography Source - IRISNDT Inc. - Houston, Texas

On September 8, 2017, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that one of their crews had experienced a source disconnect on September 7, 2017, at a field site. The crew was using a SPEC 150 exposure device containing a 92 curie iridium – 192 source. The radiographers had completed an exposure and attempted to retract the source. The RSO stated the radiographers could not get the lock on the camera to trip. As they approached the camera the radiographers noted the dose rate reading on their dose rate meter was pegged so, they retreated to the area where they operated the crank out device and called the RSO. The RSO drove to the location and performed the source recovery. The RSO placed shielding over the source, which was located in the collimator, and removed the guide tube from the camera. The RSO found the drive cable sticking through the front of the camera. He disconnected the crank out device from the rear of the camera and found the drive cable had gone completely through the camera. The RSO found that the drive cable broken in two inside the drive cable housing about 18 feet from the source. The RSO manually retracted the source into the camera by pulling on the drive cable. The source was returned to its fully shielded position. The licensee sent the drive cable assembly to the manufacturer for inspection. No over exposure or exposure to a member of the general public occurred as a result of this event. The manufacturer was unable to determine the cause for the failure. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2017

I - 9509 - Gauge Shutter Failure - BASF Corporation - Bishop, Texas

On September 12, 2017, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that during routine inspections, three Berthold nuclear gauges were found with shutters stuck in the open position. On September 19, 2017, the service company repaired all three gauges. They were able to exercise shutters on all three devices by applying lubricant in appropriate areas and allowing it to sit for a period of time to free up the shutter on/off mechanism, locking latch as well as keying mechanism. All gauges were returned to service. No violations were cited.

File closed.

I - 9510 - Potential Theft of Radioactive Material - American Piping Inspection - Midland, Texas

On September 15, 2017, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that an event involving two radiography crews had occurred. The two crews left field sites in west Texas with the intention of driving to their home site office in La Porte, Texas, turning in their trucks and cameras, and quitting their jobs. The Midland office directed the two crews to turn in their trucks to the Midland office. However, the radiographers decided to continue to drive the trucks to La Porte. The licensee notified local law enforcement which resulted in stopping the trucks and arresting one radiographer. An investigation by the Agency and the licensee's RSO determined that the radiographers had no intention of stealing the two radioactive iridium-192 sources in the cameras or the trucks. The radiographers intended to quit their job due to dissatisfaction in pay and were all four terminated that day by the licensee. No violations were cited.

File closed.

I - 9511 - Gauge Shutter Failure - Solvay Specialty Polymers USA LLC - Orange, Texas

On September 22, 2017, the Agency was notified by the licensee that the shutter on a Ronan SA1-F37 gauge containing a 500 millicuire (original activity) cesium - 137 source would not open. The investigation into this event is ongoing.

File open.

## Incidents Opened Third Quarter 2017

I - 9512 - Regulatory Violation -Security Issues - Diamond G Inspection, Houston - Texas

On September 22, 1017, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that an unusual event had occurred at their facility. The RSO stated that while he was working on his computer, he noted that the display for 16 security cameras went blank. The RSO determined that their computer system had been hacked. Onsite investigation completed on October 4, 2017 confirmed the system was breached from the video surveillance company and down linked into the radiography company's video feed communication line. The breach was directly targeted to the company supplying the video surveillance. The vault security system has a separate communication system and the security plan is not stored on the computer system. Upgrades in firewalls and alerting system have been completed as well as password changes to prevent a recurrence. The security system has back up power from batteries and a generator. There was no breach in the camera security system. No violations were cited.

File closed.

I - 9513 - Improper Disposal - Southwest Research Institute - San Antonio, Texas

On September 25, 2017, the licensee Radiation Safety Officer (RSO) reported to the Agency that the contents of four 55-gallon barrels of engine oil that contained low levels of cobalt-60 contamination had been collected by regular oil recycler during its pickup of non-contaminated oil. The licensee routinely disposes of the contaminated oil it generates through a licensed radioactive material disposal company. The licensee is still conducting its investigation of this event. An investigation is ongoing.

File open.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2017

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

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

File closed.

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

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

File closed.

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

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

File closed.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2017

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

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

File closed.

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

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

File closed.

I - 9497 - Therapy Event - Harris County Hospital District - Houston, Texas

On June 27, 2017, the Agency was notified by the registrant that a patient was treated with the wrong treatment plan. Two patients were in the treatment area and the treatments were very similar, with only a slight difference in the field shape. The resulting error in total dose to this patient was less than two percent. The physician was notified of the event, but since the patient had left the country after the treatment the physician decided to wait until the patient returns home. The registrant reported the error was due to the technicians failing to perform a proper timeout protocol prior to the procedure. The technicians involved in the event were terminated and the remaining technicians received additional training in the registrants' timeout protocols. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2017

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

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

File closed.

## Complaints Opened Third Quarter 2017

C -2757 - Regulatory Violations - Medical Facility - Sugarland, Texas

On July 19, 2017, the Agency received an anonymous complaint alleging that a new Nuclear Medicine Department Lead Tech (appointed 12/15/16) had violated rules for leak testing of Xe-133 equipment. She left door to room open, and has ignored employee's attempts to make her aware of violations. Complainant also alleged that Lead Tech falsified QC records that were overlooked. Also alleges that Lead Tech does not perform room surveys of rooms after patient injections completed. RAM waste returned to pharmacy was not being surveyed properly, and when survey meter was sent for calibration, no replacement was received. The lead and /or other techs falsified survey and calibration numbers. An onsite investigation was completed August 24, 2017. The above allegations were all checked with no evidence resulting in violations. The administration was unpleased to hear the allegations and will be completing an interval review of the department. Complaint could not be substantiated at this time, no violations cited.

File closed.

C - 2758 - Regulatory Violation - Libertytown USA 2 Inc. - Houston, Texas

On August 7, 2017, an Agency regional inspector received a complaint alleging that employees of the licensee were performing actions that were in violation of Agency rules. On August 11, 2017, a regional inspector investigated the allegations. The inspector found that all exposure devices had been transferred to other locations and the licensee was no longer performing radiography operations out of this office. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2759 - Monitoring Not Provided - Community Portable X-ray LLC - Plano, Texas

On August 8, 2017, the Agency received a complaint that the registrant was not providing personnel monitoring and that x-ray equipment was in disrepair. Prior to an onsite investigation the complainant reported that the equipment had been repaired and he had received dosimetry. On September 26, 2017, the Agency conducted an onsite investigation. Dosimetry records were reviewed and it was determined that the complainant conducted x-rays for over 5 months without dosimetry. The Agency recommended that the facility keep extra badges so they are assigned as soon as an employee starts. The complaint was substantiated. One violation was cited.

File closed.

## Complaints Opened Third Quarter 2017

C - 2760 - Unregistered Laser Facility - Mind Body and Soul - San Antonio, Texas

On August 16, 2017, the Agency received a complaint regarding an unregistered laser facility. An onsite investigation was conducted on September 13, 2017. The facility was found to be unregistered, but did have operating and safety procedures and a consulting physician. The complaint was substantiated. One violation was cited.

File closed.

C _- 2761 - Potential Overexposure - Gulfside Dental - Galveston, Texas

On August 18, 2017, the Agency received a complaint alleging a pregnant worker at the registrant's facility may be receiving too much exposure by taking x-rays of children. The complaint additionally alleged that pregnant workers were made to take excess exposure to the fetus and without monitoring. An onsite investigation was conducted on September 20, 2017. The dental assistants and Radiation Safety Officer were interviewed, and no evidence of the above allegations were found. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2762 - Radiation Exposure to Cancer Patients – Medical Facility – Woodlands, Texas

On August 21, 2017, the Agency received a complaint from a physician alleging they had treated six patients for wounds that would not heal after treatments for skin cancer. The investigation into this event is ongoing.

File open.

C - 2763 - Transportation Violation - QSA Global - Houston, Texas

On August 22, 2017, the Agency received an allegation from the State of Washington's Office of Radiation Protection stating that two Texas licensees had shipped sources to licensee’s in its state and the shipping documents did not include a no-later-than date and time. Due to Hurricane Harvey, the Agency delayed its investigations at both licensee’s locations until September 27, 2017. The investigation at the first licensee location found that the licensee had already been investigated in another of it locations outside of the State of Texas and had corrected the issue. The investigation at the second licensee’s location found that it was not including the information on the shipping documents as required. On September 29, 2017, the licensee provided the Agency with a copy of the new template for its shipping document which, showed the information added to the document. One violation was cited.

File closed.

## Complaints Opened Third Quarter 2017

C - 2764 - Potential Regulatory Violations - LB Foster - Channelview, Texas

On August 31, 2017, the Agency received a complaint alleging various regulatory violations. The allegations were based and transfer, receipt, storage and disposal of radioactive sources. An on-site investigation on September 20, 2017, revealed that three cesium-137 sources from spinning pipe thickness gauges were left in the possession of the licensee. All other sources of this type had been properly disposed. The licensee was able to produce transport, transfer, and disposal receipts for all sources. The previous locations of those sources was not found to have been a potential source of public exposure. On September 26, 2017, the licensee disposed of the last three sources and is now in the process to terminate the license. The poor management of source location and inventory had been cited previously by the Agency. The complaint was partially substantiated. No violations were cited.

File closed.

C - 2765 - Laser Registration - Beverly Hills Rejuvenation Center - Southlake, Texas

On August 30, 2017, the Agency received a complaint, in part alleging that laser treatments were provided at a facility, in violation of rule. A registration could not be found for the facility or facilities in the same organization. Investigation revealed that the facility did not have a laser registration and was offering various laser treatments and services. The complaint was substantiated. One violation was cited.

File closed.

C - 2766 - Laser Registration 302 - Women Want Moore - Austin, Texas

On August 23, 2017, the Agency received a complaint alleging a facility was performing laser treatments without registration from this Agency. The investigation into this event is ongoing.

File open.

C - 2767 - Radiation Exposure To Member Of General Public - Gammatron - Friendswood, Texas

On September 19, 2017, the Agency received a complaint alleging that a licensee was exposing workers of a company that shares a building complex to radiation levels that may exceed regulatory limits. The investigation into this event is ongoing.

File open.

## Complaints Opened Third Quarter 2017

C - 2768 - Regulatory Violations - Medical Facility – South Lake, Texas

On September 5, 2017, a complaint was received from a person alleging that a facility had a doctor performing mammograms of the patients and was training admin staff and her young daughter on how to complete bone density scans. Onsite investigation September 20, 2017, revealed one violation of performing body fat composition scans without a referring doctors order. Complaint was partially substantiated. One violation cited.

File closed.

C - 2769 - Laser Hair Removal Burn - Sigma Laser Med Spa - Farmers Branch, Texas

On September 26, 2017, the Agency received a complaint of a burn received from a Laser Hair Removal (LHR) treatment. The complainant stated that the setting of the LHR machine was twice the required amount and that she will have permanent scarring from the treatment. On October 10, 2017, a joint investigation with Texas Department of Licensing and Regulation (TDLR) was conducted on site. The Agency determined that the burn was not caused by improper setting of the machine nor was there any gross negligence during the LHR treatment. The Agency did determine that the facility did not report the injury to DSHS or the FDA. Additionally, the facility was not registered to conduct LHR or Laser tattoo removal. The complaint was not substantiated. Four LHR violations were turned over to TDLR for investigation. One violation was cited for DSHS.

File closed.

C - 2770 - Unregistered Laser Equipment - Waco

On September 29, 2017, the Agency received a complaint alleging an individual may be removing tattoos using a laser without registration. The investigation into this event is ongoing.

File open.

C - 2774 - Regulatory Violations - Rio Grande Urology PA - El Paso, Texas

On October 27, 2017, the Agency received an anonymous complaint about a clinic reporting that the registrant conducts multiple unnecessary x-rays on patients, including over seventy on one patient on one day. An investigation in the complaint in ongoing.

File open.

## Complaints Opened in a Previous Quarter and Closed in Third Quarter 2017

C - 2744 - Laser Hair Removal Violations - Pristine Image Med Spa - Tyler, Texas

On February 28, 2017, the Agency received a complaint about a Laser Hair Removal (LHR) facility including improper treatment for a burn, no procedures for the lasers, and inappropriate LHR treatment on patients. On May 5, 2017, the Agency contacted the facility and determined that the facility was not registered to conduct laser hair removal. The facility had no complaints from clients about burns. The facility had registered LHR technicians. The facility did not know a registration with the Agency was required, the owner stated he would quickly submit an application. Concerns from the complainant were discussed. The facility reported it had laser procedures and conducted continual training for the employees working the machines. On July 13, 2017, the Agency verified the facility owner had submitted an application and fee for registering the facility. The complaint was partially substantiated. No violations were cited.

File closed.

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

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

File closed.

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

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

File closed.

## Complaints Opened in a Previous Quarter and Closed in Third Quarter 2017

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

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

File closed.

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

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

File closed.