



# **INCIDENT AND COMPLAINT SUMMARIES FOR FIRST QUARTER 2013\***

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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**

**1st Quarter 2013**

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## Incidents Opened First Quarter 2013

I - 9029 – \* - The Methodist Hospital - Houston, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9030 - Stolen Radioactive Material - Rone Engineering - Houston, Texas

On January 2, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that a Troxler model 3430 containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source could not be located at the licensee's facility. The licensee conducted an inventory of all of its gauges and accounted for all but the one. The licensee's records indicated that the gauge had been returned by a technician and locked in the storage area on December 31, 2012. The licensee's tracking system, which tracks the location of its vehicles, confirmed that the truck used by the technician had been returned to the licensee's location at the close of business on December 31. The RSO stated that the storage area had no signs of tampering. The RSO stated that the technician assigned to use the gauge had been interviewed, but the technician did not provide any information useful to recover the gauge. The RSO stated that the local police had been notified of the theft. The RSO stated that the offering of a reward would be discussed with company management. The RSO stated that the gauge was locked inside a transportation case and that the operating rod was locked in the shielded position. The RSO stated that he did not believe there was any risk of exposure to a member of the general public. The Federal Bureau of Investigation interviewed the technician, vice president and RSO. They did not obtain any additional information for the event. No violations were cited.

File closed.

I - 9031 - NORM Waste at Landfill - Permian Enterprises, Inc. - Odessa, Texas

On January 4, 2013, the Agency was contacted by a landfill operator in Canyon, Texas, who reported that a container of waste had caused the radiation monitor at the facility to alarm. The Agency approved return transport of the container to the originator. The Agency conducted an on-site investigation at the originator's Odessa, Texas, location and determined the source of radiation to be naturally occurring radioactive material collected as a result of pipe reclamation/inspection services conducted by the originator. It was determined the originator was authorized by General License to possess the material. The originator contracted with a licensed company for the disposal of the material. The originator has increased radiation surveys and will dispose waste more frequently to ensure it maintains compliance with Agency regulations. No violations were cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9032 – Potential Overexposure - Eagle NDT LLC - Abilene, Texas

On January 9, 2013, the Agency received a written report from the licensee for an incident that occurred on December 21, 2012. A radiographer trainer walked up to a pipe weld to change out film while the source was still outside the camera next to the weld. The camera operator, a radiographer trainee, quickly cranked the source back into the camera after approximately 5-10 seconds. The radiographer trainer's badge was sent for immediate processing and indicated he had received an exposure of 200 millirem for the month. The radiographer trainer stated that his radiation pager did not alarm. The company conducted drug and alcohol tests on both workers and the results were negative. The radiographer trainer quit his job that day. The licensee determined the incident occurred due to the radiographer trainer's inadequate supervision of the trainee and poor attention to detail. The company conducted training on the incident. No violations were cited.

File closed.

### I - 9033 - Gauge Shutter Failure - Valero Refining - Texas City, Texas

On January 17, 2013, the Agency received notification from the licensee that while performing preparations for maintenance the shutter on a Ronan model SH1 nuclear gauge containing a 1,000 millicurie cesium-137 source was found stuck in the open position. The licensee stated that open is the normal operating position for the shutter and the gauge would not pose an exposure risk to any individual. On February 1, 2013, the gauge was repaired by the manufacturer. The manufacturer stated that a build-up of debris around the shutter mechanism had prevented the gauge shutter from operating properly. No exposure limits were exceeded due to this event. No violations were cited.

File closed.

### I - 9034 - \* - Presbyterian Hospital of Plano - Plano, Texas

\*Health and Safety Code Chapter 241.051(d)

Per policy, a severity level four violation was not cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9035 - Radiography Source Disconnect - Desert NDT, LLC - Abilene, Texas

On January 22, 2013, the Agency was notified by the licensee's radiation safety officer (RSO) that a radiography crew performing radiography operations at a field location had experienced a source disconnect. The crew was using an INC IR 100 exposure device containing a 38 curie iridium-192 source. The crew had performed nine exposures and was moving the camera to the next location when they discovered the source was still in the guide tube. A source recovery team was sent to the location and the source was returned to the exposure device and locked in the fully shielded position. The licensee determined that the radiographers failed to challenge the pig tail connection to the crank cable and they failed to conduct surveys of the camera and source tube after each use. The incident resulted in a whole body exposure of 791 millirem and an extremity exposure to the left hand of 2.8 rem to one of the radiographers. Additionally, an inspection by the manufacturer determined that two small crimps at the connector could cause the source to disconnect from the drive cable. Both radiographers received an additional 8 hour training course and the licensee briefed all company radiographers on the lessons learned from the incident. Three violations were cited.

File closed

### I - 9036 - Expired Radioactive Material License - Frontera Materials Incorporated - Elsa, Texas

On January 23, 2013, the Incident Investigation Program (IIP) was asked by the Agency's Radioactive Material Licensing Group to investigate a licensee that had not renewed its license. The licensee was licensed to possess moisture/density gauges. A review of documents in the licensee's file and information gathered by previous employees of the company determined that the gauges had been transferred to entities licensed to possess them. A letter was sent by IIP to the licensing group concurring with license termination. No violations were cited.

File closed.

### I - 9037 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On January 11, 2013, the licensee reported that it had been contacted by one of its customers regarding a unit dose that the customer received. The licensee stated that the dose was dispensed for an activity of 10 millicuries of technetium-99m at the time of use. The customer stated the activity measured two hours prior to the use time was only 8 millicuries. The licensee's pharmacist coordinated with the customer to provide a replacement unit dosage. The investigation of the event by the licensee was unable to determine the cause for the lower than expected activity. The licensee stated the counting system it currently uses does not produce a record of the count results of unit samples. The licensee stated that it is installing a new system that will electronically capture the assay results for all unit doses. No violation was cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9038 - Recovered Moisture/Density Gauge - U.S. Customs and Border Protection - Sierra Blanca, Texas

On January 28, 2013, the U.S. Customs and Border Protection (CBP) notified the Agency that a trailer had caused its radiation monitor to alarm at its checkpoint in Sierra Blanca, Texas. Further investigation by the CBP and the Agency revealed that the source of radiation was a Troxler Model 3430 moisture/density gauge. The individual in possession of the gauge was not licensed to possess radioactive material. The individual stated he had purchased the gauge at a swap meet in Beaumont, California, in August or September of 2012 and understood it was a device to locate underground pipe. He stated he had never attempted to use it and had kept it in his storage shed until he packed it into the trailer with his belongings to move to Texas. The gauge was impounded by the Agency and the individual willingly surrendered it. Further investigation by the Agency revealed that the gauge had been stolen in December 2006 in San Jacinto, California, from a California licensee. The State of California and the licensee were notified. The gauge was picked up by a licensed service company hired by the licensee. No violations were cited.

File closed.

### I - 9039 - Gauge Shutter Failure - Equistar Chemical, LP - Pasadena, Texas

On February 7, 2013, the Agency was notified by the licensee that the shutter on an Ohmart model SH-F1A nuclear gauge was stuck in the open position. The gauge contains a 50 millicurie cesium-137 source. The gauge normally operates with the shutter in the open position. This gauge had previously failed in February of 2012. The licensee sprayed penetrating oil on the gauge for a short period of time in an attempt to free the shutter and then scheduled a repair. On February 21, 2013, a service provider (SP) representing the manufacturer arrived at the facility to repair the gauge. The SP found that the shutter was working freely. The SP verified he was working on the correct gauge. The SP stated that the penetrating oil must have finally caused the operating arm to free up. The licensee stated the cause for the failure was a build-up of debris and corrosion products. No violations were cited.

File closed.

## Incidents Opened First Quarter 2013

### I - 9040 - Radioactive Material Found - Unknown Owner - Taiwan

On February 7, 2013, the Agency received an e-mail stating a nuclear gauge containing a cesium-137 source had been found in a shipment of scrap metal received in Taiwan. The material was being returned to Texas via California. Some information was provided, but the identification plate was damaged and the information may be incorrect. A search of Agency records for the licensee found that the licensee listed on the document had terminated its license in February 1981. A letter dated February 24, 1981, was found in the license file that indicated that the gauge was returned to the manufacturer for inspection and storage until the owner could get a license for a new facility. That facility was never licensed. The investigation into this event is ongoing.

File open.

### I - 9041 - \* - University Medical Center at Brackenridge Imaging Department - Austin, Texas

\*Health and Safety Code Chapter 241.051(d)

Per policy, a severity level four violation was not cited.

File closed.

### I - 9042 - Radiography Source Disconnect - Weldsonix, Inc. - Houston, Texas

On February 16, 2013, the Agency was contacted by the radiation safety officer (RSO) for a manufacturer requesting reciprocity to work in the State of Texas. The RSO stated the manufacturer had been contacted by a Texas licensee who requested the recovery of an 85 curie iridium-192 source from a Sentinel Model 880 radiography camera. The RSO stated that the disconnect occurred during the first exposure of the day. Later that day, the manufacturer reported that the source had been recovered. The manufacturer inspected the equipment and found no evidence of mechanical failure and reported all components were within specifications. The cause was human error when the radiographer failed to connect the drive cable ball to the source connector prior to attaching the drive assembly to the exposure device. The highest exposure received by either of the radiographers involved was 56 millirem. This was according to the individuals' dosimetry badges and included exposure for the 12 day period they had been worn. No violations were cited.

File closed

## **Incidents Opened First Quarter 2013**

### I - 9043 - Stuck Source - Formosa Plastics - Point Comfort, Texas

On February 20, 2013, the Agency was notified by the licensee that on February 19, 2013, during routine maintenance checks, the sources on two nuclear gauges were found stuck inside the dip tubes. Both gauges were Berthold model 21357 gauges and each contained a 500 millicurie (original activity) cesium-137 source. The sources were stuck in the normal operating position and did not pose an exposure risk to any individual. The gauges were repaired by the manufacturer on March 12, 2013. The licensee stated it believes a build up of corrosion products and kinks found in the cables caused the sources to stick. The cables were cleaned by the manufacturer and the gauges were tested satisfactorily. The licensee is redesigning the guide tubes to allow the sources to move more freely. No violations were cited.

File closed.

### I - 9044 - Equipment Malfunction - Sterigenics US, LLC - Fort Worth, Texas

On February 20, 2013, the licensee notified the Agency that, while securing the source racks in the irradiator, a tote on the conveyor became lodged against the rack's protective barricade upright causing it to halt before the source rack was completely secured. The source was adequately shielded to allow the maintenance manager and an operations technician to move the conveyor belt and dislodge the tote. The source rack then continued to its secure position in the irradiator pool. Neither employee received any additional exposure to radiation. All alarms and interlocks functioned as designed. There was no damage to the source rack or sources nor was there any contamination. The licensee conducted an in-depth evaluation. To prevent recurrence, the licensee installed additional guard rails on the rack on the side where the carriers are open. No violations were cited.

File closed.

### I - 9045 - \* - Methodist Rehabilitation Hospital - Dallas, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9046 - Badge Overexposure - Advanced Corrosion Technologies and Training, LLC - Angleton, Texas

On February 26, 2013, the licensee reported to the Agency that it had been notified by its dosimetry processor that an employee's badge for the exposure period January 1-31, 2013, indicated an exposure of 8,110 millirem. The licensee stated that the employee started working on January 7, 2013, and did not begin working in the field until January 17, 2013. The employee's daily exposure records indicated an exposure of 104 millirem during that period. The employee stated that on one occasion his badge had dropped off its badge holder, but he did not think it had been exposed. Interviews conducted with other employees he had worked with did not indicate an overexposure to the employee had occurred. The licensee assigned a dose of 104 millirem to the individual for the exposure period. No violations were cited.

File closed.

### I - 9047 - Equipment Malfunction - Sterigenics US, LLC - Fort Worth, Texas

On March 1, 2013, the Agency was notified by the licensee that on February 28, 2013, one of two source racks in its irradiator, which is used to sterilize medical supplies, failed to fully lower into its storage pool. The rack had descended 11 of 24 feet and was in the pool, but not fully at the bottom of the pool, when it stopped. The licensee stated all alarms and interlocks functioned as designed. The licensee determined that the motor for the hoist mechanism had failed. The motor was removed from the hoist mechanism and the sources descended fully into the pool. No exposure was received by any individual as a result of this event. The licensee stated that on March 1, 2013, the motor was replaced and successfully tested. No violations were cited.

File closed.

### I - 9048 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On March 7, 2013, the licensee notified the Agency that on February 28, 2013, there had been a dispensing irregularity at its facility in Houston, Texas. One of the licensee's customers was placing a vial of 100 millicuries of technetium-99m (Tc-99m) pertechnetate, into decay-in-storage after the daily bulk dose was delivered. This vial was ordered for as needed after-hours use the previous day and had not been used. At that time the customer discovered the vial was empty. The licensee's investigation revealed the pharmacist had drawn the bulk Tc-99m pertechnetate dosage quantity into a syringe, performing the assay in the dose calibrator. The nuclear pharmacist labeled the vial but inadvertently failed to transfer the Tc-99m into the vial to complete the dispensing process. Corrective action included counseling all dispensers and implementing a new bar code tracking system. No violations were cited.

File closed.

### I - 9049 - \* - Scott and White Hospital - Killeen, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9050 - Stolen Moisture/Density Gauge - CMT Engineering, Inc. - Lubbock, Texas

On March 7, 2013, the Agency was notified by the licensee that on March 6, 2013, a Troxler Model 4640 moisture/density gauge was stolen out of the back of one of its trucks at a temporary work site in Lubbock, Texas. The licensee reported that the technician had secured the gauge in the back of the truck and left the immediate area to speak with the contractor about the job. When he returned, he got in the truck and began driving to the licensee's facility. While in route, he observed that the tail gate was down. He stopped and discovered the gauge was gone and both locks had been cut. The licensee stated that local law enforcement had been immediately notified. Within 2 hours of the licensee's report to the Agency, the licensee notified the Agency that the gauge had been found. The licensee stated that a member of the general public (MGP) had found the gauge the night of March 6, 2013, but it was dark when they found it so they did not know what it was. The MGP stated the next morning when they saw what it was they contacted the licensee. The licensee retrieved the gauge and returned it to its facility. The licensee reviewed the event with its employees and reviewed company's policies regarding the use of these gauges. No violations were cited.

File closed.

### I - 9051 - Overexposure - Central Texas Day Surgery Center, LP - Killeen, Texas

On March 11, 2013, the registrant reported to the Agency that its two physicians had potentially exceeded the regulatory dose limit for 2012. The registrant conducted an investigation and reported to the Agency that the two physician's annual doses were 6,494 and 6,084 millirem. The registrant reported that no badges for any of its employees had been processed for the second quarter 2012 and one of the two physicians had not been monitored for the portion of first quarter 2012 that he was employed there. The registrant performed dose assessments and assigned doses for these missing quarterly doses. The registrant implemented corrective actions to include training for all staff, improved daily/weekly monitoring of fluoroscopy times for the physicians, added protection with the installation of lead table skirts and additional protective eyewear for one physician, reduction in use of fluoroscopy during procedures when it is not necessary, proper placement of the dosimetry at the collar as required, and review of practices and procedures to identify areas to reduce dose for all staff. Three violations were cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9052 - Lost Equipment Containing Radioactive Material - Burge-Martinez Consulting Inc. - San Antonio, Texas

On March 12, 2013, the Agency was notified by the licensee that one of its technicians had lost a Troxler moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was lost somewhere between the licensee's office in San Antonio, Texas, and the job location in Pflugerville, Texas. The technician stated that when he arrived at the work site he found the tailgate of the truck was down and the gauge was missing. The chains and locks for securing the gauge during transport were not cut. The licensee's radiation safety officer (RSO) stated that both the case and operating rod were locked. The RSO stated the San Antonio police, the County Police, and Texas Department of Transportation had been notified of the event. At 1132 hours that same day, the local police contacted the RSO and stated they had located the gauge in the median of the access road at the exit to the licensee's facility. The RSO stated he went to the location and surveyed the gauge and all readings were normal. The gauge was not damaged. The licensee's investigation determined that the technician failed to lock the gauge into the truck prior to leaving the licensee's facility. The licensee conducted a safety meeting with all of its technicians to review the company's radiation safety policies. One violation was cited.

File closed.

### I - 9053 - Abandoned Well Logging Source(s) Down Hole - Allied Wireline Services - Reagan County, Texas

On March 16, 2013, the licensee contacted the Agency to report that it was abandoning two well logging sources, 11 millicuries of californium-254 and 2 curies of cesium-137, down hole. The sources were abandoned at 6,291 feet. A plug with a 610 foot column of Class H red dyed cement was completed. A whip stock was installed at 5681 feet above the cement plug as a deflection device. A plaque was installed at the well site as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

## **Incidents Opened First Quarter 2013**

### I - 9054 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On March 13, 2013, the Agency was notified by the licensee that on March 8, 2013, it had processed an order for two 10 millicurie dosages of technetium-99m (Tc-99m) mertiatide (MAG3) for one of its customers. When the customer assayed the dosages upon receipt, they were found to have 15 millicuries each. The customer adjusted the dosages to the requested quantities prior to administration. The licensee reported that, based upon its investigation, it believes the customer's order was received and entered into a new order tracking system with default quantities of the radiopharmaceutical requested. The system had 15 millicuries as the default quantity for the Tc-99m MAG3. The dispenser did not notice the difference between the dosage quantities ordered and dispensed. In order to prevent recurrence of a similar event, the licensee reported it has implemented procedures to reprogram the new order tracking system for default quantities of radiopharmaceuticals for all customers and the topic will be addressed for all dispensers at the next staff meeting. No violations were cited.

File closed.

### I - 9055 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On March 20, 2013, the Agency was notified by the licensee that on March 12, 2013, it had received an order for five (5) multiple dosages of technetium-99m sestamibi which the customer intended to be staggered for calibration every 15 minutes. The customer notified the pharmacy upon receipt that four of five dosages received had less activity than requested at the intended calibration time(s). The licensee erroneously entered the same calibration time for all five doses. The customer decided to use the lower dosages for patient administration. In order to prevent recurrence of a similar event, the licensee reported it has implemented a new order tracking system to capture more information from the customers. The incident will be addressed for all dispensers at the next staff meeting. No violations were cited.

File closed.

### I - 9056 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On March 21, 2013, the licensee notified the Agency that on March 19, 2013, it received a request for four sets of resting and stress cardiac imaging doses from a hospital. The doses were to be of technetium-99m and each set timed for two hours apart. Instead of setting the doses at two hour intervals, the pharmacy set them all at the same time resulting in lower than requested activities for the later studies. The licensee used the lower doses and was able to get the desired results. The licensee stated that the error was due to the pharmacist entering the information incorrectly. The licensee stated it counseled all employees involved in the event. No violations were noted.

File closed.

## Incidents Opened First Quarter 2013

### I - 9057 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On March 13, 2013, the Agency was notified by the licensee that on March 11, 2013, it had processed an order for one dosage of technetium-99m (Tc-99m) medronate (MDP) and one dosage of Tc-99m sulfur colloid for one of its customers. When the customer received the order, it notified the licensee that it had received two dosages of the sulfur colloid and had not received the MDP. The licensee provided the dosage of MDP to the customer immediately. The licensee reported that based upon its investigation, it is believed that the administrative staff had taken the customer's telephone order but then entered the order incorrectly. In order to prevent recurrence of a similar event, the licensee reported it has implemented procedures to reprogram the new order tracking system for default quantities of radiopharmaceuticals for all customers and the topic will be addressed for all dispensers at the next staff meeting. No violations were cited.

File closed.

### I - 9058 - \* \_\_\_\_\_ - Seton Medical Center - Round Rock, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 9059 - Medical Event - Rosa of North Dallas, LLC - Dallas, Texas

On March 28, 2013, the Agency was notified by the licensee that a medical event had occurred on March 27, 2013. The licensee stated the event occurred when the wrong length guide tube was used during 3 of 4 high dose rate brachytherapy treatments. The error was discovered prior to the fourth treatment. The radiation safety officer (RSO) stated the intended treatment area was under-dosed by more than 50 percent. The treatment plan prescribed 2400 centigray (cGy) over four treatments, but the intended treatment site received 1,390 cGy instead. Two areas other than the intended treatment site received total doses in four treatments of 1,607 cGy and 1,549 cGy. The RSO stated that the patient and the patient's physician were notified as soon as the error was discovered. The patient's physician stated the patient would be monitored over the next several months for effects to tissue that received higher than intended exposure. To prevent recurrence of this type of event the licensee made changes to its operating procedures and training program for physicists. The licensee also labeled all of the guide tubes to indicate their length. No violations were cited.

File closed.

## Incidents Opened First Quarter 2013

### I - 9060 – Damaged Radiography Equipment - Petrochem Inspection Services - Port Arthur, Texas

On March 27, 2013, the Agency was notified by the licensee that a pipe had fallen onto a Sentinel model 880Delta exposure device's guide tube at a temporary field site preventing the retraction of the 51 curie iridium-192 source. The source was recovered by the licensee according to the terms of its license. The recovering employee received 475 millirem whole body exposure and 1.75 rem exposure to the hand. The radiographer trainer and radiographer trainee that had performed the initial setup received training regarding potential hazards. No violations were cited.

File closed.

### I - 9061 - \* \_\_\_\_\_ - NIX Healthcare System - San Antonio, Texas

\*Health and Safety Code Chapter 241.051(d)

Per policy, a severity level four violation was not cited.

File closed.

### I - 9062 - \* \_\_\_\_\_ - Hill Country Memorial Hospital - Fredericksburg, Texas

\*Health and Safety Code Chapter 241.051(d)

Per policy, a severity level four violation was not cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in First Quarter 2013**

### I - 8932 - Gauge Shutter Failure - B P Products North America Inc. - Texas City, Texas

On February 10, 2012, The Agency was notified by the licensee that the shutter on an Ohmart model SH-LG 2 nuclear gauge containing 8.5 curies of cesium-137 was found to be stuck in the open position. The gauge normally operates with the shutter in the open position so the failure did not pose any additional exposure risk. The licensee began lubricating the operating arm in an effort to free the shutter. The licensee contacted the manufacturer for assistance. The manufacturer stated that a replacement gauge would not be available until February 2013. On March 12, 2013, the gauge was replaced by the manufacturer. The manufacturer stated that the gauge shutter failed due to a buildup of corrosion in the operating area. The gauge is housed in an enclosure, but due to the harsh environment, the enclosure could not prevent corrosion for long periods. The gauge had been installed for 21 years. No violations were cited.

File closed.

### I - 8982 - Lost Radioactive Material - Imaging Associates of Abilene - Abilene, Texas

On August 30, 2012, a company contracted by a licensee to conduct a closeout of an imaging facility notified the Agency that the licensee had sold an ADAC Gamma/PET Camera early in July 2011 without proper shipping and transfer paperwork and with a 20 millicurie cesium-137 sealed source located inside the PET scanner. The PET scanner was brokered/sold four times and finally a company in Staten Island, New York, purchased and removed the PET machine. The company in New York provided a letter to the Agency stating that it did not transport the PET machine with a source nor did it remove the source. The last radiation safety officer and nuclear medicine technician left the licensee's company in December 2010. During 2011 and 2012, there was no one assigned at the licensee's facility to conduct weekly surveys, conduct a closeout survey, or inventory the sources. Without supervision of the radioactive material, the source went missing and is presumed lost. A formal closeout of the facility was completed by a hired consultant. One violation was cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in First Quarter 2013**

### I - 8993 - Possible Overexposure - GCT Inspection, Inc. - Pasadena, Texas

On October 8, 2012, the licensee reported to the Agency that it had been notified by its dosimetry processor that two of its employees' badges for the period of August 15, 2012, to September 14, 2012 had received a total radiation exposure that exceeded the annual regulatory limit of 5,000 millirem. A radiographer trainer's badge had a reading of 10,290 millirem and a radiographer trainee's badge had a reading of 8,391 millirem. The licensee's investigation of the event was hampered because both of the individuals involved in the event terminated their employment prior to the date the licensee received the results of their badge readings. On February 20, 2013, the licensee notified the Agency it had determined that the exposures were to the badges only. This determination was based on a report from the dosimetry processor, interviews with one of the radiographers and other employees that both radiographers had previously worked with, and daily records documenting self-reading dosimeter readings. The licensee assigned a dose of 416 millirem for the exposure period for both radiographers. No violations were cited.

File closed.

### I - 8994 - Radiography Source Disconnect - Team Industrial Services - Borger, Texas

On October 17, 2012, the licensee notified the Agency that on October 16, 2012, a radiography source had disconnected from the drive cable of a SPEC 150 exposure device containing a 50 curie iridium-192 source during radiography at a field location. The radiographers had completed an exposure and during their survey found the dose rates at the front of the device were higher than expected and the device would not completely lock. The radiographers contacted their Radiation Safety Officer and a source recovery team was sent to the location. The source was recovered without incident. None of the individuals involved received an over exposure and there was no exposure to a member of the general public due to this event. The licensee inspected the device and equipment involved and its inspection did not reveal any problems or nonconforming components. The exposure device and source assembly were sent to the manufacturer for evaluation. The manufacturer reported the device was determined to be operational. The licensee failed to send the drive assembly with the exposure device as it had been discarded following its inspection after the incident. The licensee provided its previous inspection records that indicated the drive assembly's condition was acceptable. The licensee was unable to determine and confirm the exact cause--whether it was a misconnect or whether it became disconnected by other means during operation. The details of the event were shared with the licensee's branch offices to improve awareness of the possibilities of source misconnect/disconnect. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2013

### I-9007 - Stolen Moisture/Density Gauge - Carrillo & Associate, Inc. - Laredo, Texas

On Tuesday, November 6, 2012, the licensee notified the Agency that one of its employees discovered that a Troxler Model 3411B moisture/density gauge had been stolen from the company-owned vehicle while it was parked at his residence in Laredo, Texas, during the preceding weekend. The licensee reported that on Friday the employee had gone to his residence from a temporary worksite due to a family emergency and had failed to return the gauge to the licensed location. The employee stated he had forgotten the gauge was still in the truck. The gauge contained one 8 millicurie cesium-137 source and one 40 millicurie americium-241/beryllium source. The licensee notified local law enforcement, conducted physical searches of areas near where the theft occurred, notified local contractors and testing labs, alerted the nuclear gauge manufacturer and several service companies, and posted flyers on street corners offering a reward. The Agency notified the Texas Association of Pawnbrokers. The Agency's investigation revealed that not only did the licensee's employee fail to properly store the gauge, the licensee was not employing two independent barriers to secure the gauge as required. As corrective actions, the licensee retrained the employee and restricted his use of the company truck. The licensee held a safety meeting for all of its employees regarding the handling of gauges and they will attend a previously scheduled course for hazmat materials on nuclear gauges. The licensee stated it is having metal cages fabricated for all of its trucks to carry nuclear gauges and to provide another barrier. The gauge has not been recovered as of January 7, 2013. Two violations were cited.

Update: On February 2, 2013, the licensee reported to the Agency that it had recovered the stolen gauge.

File closed.

### I - 9011 - \* - University Medical Center of El Paso - El Paso, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in First Quarter 2013**

### I - 9014 - Medical Event - Texas Oncology at Klabzuba - Fort Worth, Texas

On November 19, 2012, the Agency received a written report from the licensee that a medical event may have occurred. The licensee reported that on January 5, 2012, a patient received an implant of sixty-three iodine-125 seeds. Verification films taken that day confirmed that the implant appeared normal. In February 2012, a computed tomography (CT) scan was performed for post-implant evaluation; however, a post plan was not created for evaluation until late August/early September. During the evaluation, the staff physicist noticed the seed placement appeared inconsistent with the pre-plan. The licensee completed the post plan and conducted an investigation. The licensee determined the seed distribution was inferior from the intended position by up to 3.5 centimeters and that only 25% of the area prescribed to receive 144 gray in the written directive actually received that dose. The licensee determined the reference location of the target organ was incorrectly identified. To prevent recurrence, a timeout procedure was established for personnel to confirm agreement of the precise target organ location prior to implantation. The licensee recognized that a prompt evaluation of the post-implant CT had not been performed. The post-implant evaluation timeline procedure was enhanced to prevent the delay of discovery of any variances with the goal of having all post-plans reviewed and approved within one month of the post-implant CT. No violations were cited.

### I - 9015 - Medical Event - The University of Texas Medical Branch - League City, Texas

On November 20, 2012, the Agency was notified by the registrant of a medical event. A treatment with a linear accelerator resulted in a total dose of 40.5 gray instead of the prescribed 30 gray dose. The registrant reported there was no adverse effect to the patient. The registrant determined the event was the result of errors during modification of the treatment plan on the day of treatment. The registrant identified that during the modification attempt, there had been miscommunication between team members, failure of the dosimetrist to notice the incorrect prescription, a lack of review by the physicist, and a lack of functionality of the software to record and verify. To prevent recurrence, a new login system and additional physician and physicist quality assurance reviews for plan modifications have been implemented by the registrant and reviewed with all staff. No violations were cited.

File closed

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2013

### I - 9022 - Nuclear Pharmacy Error - Triad Isotopes, Inc. - Dallas, Texas

On December 6, 2012, the Agency received a report from the licensee that on November 2, 2012, it had been notified by one of its hospital customers, that diagnostic radiopharmaceuticals received from the licensee and administered to two patients did not produce the expected biodistribution pattern. The licensee checked the kits from which those patient doses were drawn and found that a vial of technetium-99m DTPA had been inadvertently placed in the dispensing shield instead of technetium-99m MAA. The licensee notified all customers that received the affected doses. No other patients were injected with the incorrect product. The root cause was determined to be inadequate verification of the vial before dispensing. The radiopharmacy has implemented new protocols to verify products and conducted training with staff on the protocols and incident. No violations cited.

File closed.

### I - 9023 - \* - Kindred Hospital San Antonio - San Antonio, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 9024 - Medical Waste Released Before Decay - University of Texas Southwestern Medical Center - Dallas, Texas

On December 13th, 2012, the Agency received notice that a container of waste from one of the licensee's facilities had been detected as radioactive by the disposal facility. The licensee retrieved the container. The licensee's investigation determined that bio-hazardous waste from a nuclear medicine patient undergoing a non-nuclear procedure had been put into the regular waste cycle. The licensee stated it is purchasing portal monitors with which to survey outgoing waste containers. The licensee is also taking steps to better identify nuclear medicine patients during non-nuclear procedures. Per policy, this severity level four violation was not cited.

File closed.

### I - 9025 - \* - Dallas Regional Medical Center - Mesquite, Texas

\*Health and Safety Code Chapter 241.051(d)

Per policy, a severity level four violation was not cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2013

I - 9026 - \* - Spring Branch Medical Center - Houston, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9027 - Medical Waste Released Before Decay - University of Texas Southwestern Medical Center - Dallas, Texas

On December 13th, 2012, the Agency received notice that a container of waste from one of the licensee's facilities had been detected as radioactive by the disposal facility. The licensee retrieved the container. The licensee determined that bio-hazardous waste from a nuclear medicine patient undergoing a non-nuclear procedure had been put into the regular waste cycle. The licensee stated it is purchasing portal monitors with which to survey outgoing waste containers. The licensee is also taking steps to better identify nuclear medicine patients during non-nuclear procedures. Per policy, this severity level four violation was not cited.

File closed.

I - 9028 - Medical Waste Released Above Background - Methodist Health Care System of San Antonio LTD LLP- San Antonio, Texas

On December 27, 2012, the Agency was notified by a landfill operator that a load of waste received from a local hospital had set off its gate radiation monitor. The landfill notified the hospital of the alarm. The Radiation Safety Officer (RSO) for the hospital contacted the Agency and stated he had gone to the landfill and identified the radionuclide as indium-111. The RSO stated the waste had come from a patient who had been treated at another facility and released. The patient was later checked into the licensee's facility and the patient's waste had been processed through the normal waste stream. The RSO stated that two radiation monitors have been placed to check all medical waste prior to disposal to prevent recurrence of this type of event. He also stated that the staff receives weekly awareness training and the charts for patients treated with radionuclides flagged. Per policy, this severity level four violation was not cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2448 - Potential Criminal Internal Contamination - Residential Property - Boerne, Texas

On January 2, 2013, a member of the public reported that she and her sister were being intentionally poisoned with radioactive material by the sister's husband due to a separation and potential divorce. They reported reddening of the skin in multiple locations. They went to a military medical center in San Antonio, Texas, where they were monitored for radioactive contamination. There was no sign of radioactive contamination. The complaint could not be substantiated. No violations were cited.

File closed

### C - 2449 - Unregistered Use of X-ray Machines - Ajax Environmental & Safety Supply Inc. - Houston, Texas

On January 4, 2013, the Agency received a complaint alleging that a registrant was leasing x-ray devices and its registration did not allow this. On January 30, 2013, the Agency conducted an on-site investigation of the complaint. The registrant stated that it was unaware its registration needed to include the leasing of the device. The registrant filed for a new registration to include "Provider of Equipment" on February 1, 2013. One violation was cited.

File closed.

### I - 2450 - \* - Scott & White Memorial Hospital - Temple, Texas

\*Health and Safety Code Chapter 241.051(d)

The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2451 - Regulatory Violations - Arends Inspection, LLC - Houston, Texas

On January 3, 2013, the Agency received a complaint alleging that the licensee was violating several of the Agency's rules while performing radiography operations in the field. On February 12, 2013, the Agency was able to observe radiographers from the licensee perform operations at a facility in Houston, Texas. The radiographers failed to maintain constant surveillance of the radiography device while it was not secured, failed to perform required surveys, and failed to zero their self-reading dosimeters prior to starting work. The licensee and radiographer trainer were both cited for multiple violations.

File closed.

### C - 2452 - Personnel Monitoring Not Provided - Southwest Endoscopy and Surgery Center, Ltd. - Burleson, Texas

On January 9, 2013, the Agency received a referral from the DSHS Health Facility Compliance Group that a facility in Burleson, Texas, that was registered for fluoroscopy was not monitoring the radiation exposure of its staff and had not completed an annual performance evaluations of the C-arm machine. Records also indicated the facility had not performed the required check of its protective devices (aprons and collars) since June 2010. On January 17, 2013, the Agency conducted an on-site investigation and inspection. The facility had no dosimetry program and had not had performance evaluations completed on the fluoroscopy machine in 2010, 2011, and 2012. The complaint was substantiated. Six violations were cited.

File closed.

### C - 2453 - Radiation Exposure Concern - Quell Petroleum Services - Penwell, Texas

On January 28, 2013, the Agency was contacted by an anonymous complainant who was concerned about radiation exposure he/she may have received at an oil filter recycling plant in Penwell, Texas. An Agency investigator contacted the Texas Railroad Commission and it agreed it had jurisdiction for investigating the complaint. The Agency forwarded the information it had gathered.

File closed.

## Complaints Opened First Quarter 2013

### C - 2454 - Unregistered Radiography Training - LAMCO and Associate - The Woodlands, Texas

On January 29, 2013, the Agency received a complaint from a licensee that another company was providing radiographer training and issuing certificates with the licensee's name. The Agency determined that an individual set up a fictitious class in a hotel and offered non-certified training to five individuals and issued certificates using the licensee's name. A review of Agency licensing files found that no radiography company has submitted any of the fraudulent certificates with a request to license radiography trainees. The Agency was unable to determine the identity of the individual who conducted the training. The complaint was substantiated. No violations were cited.

File closed.

### C - 2455 - Unregistered Use of X-Ray Machines - Mobile X-Ray - Weslaco, Texas

On January 29, 2013, the Agency received a complaint that the entity was operating a mobile x-ray business without registration. The Agency investigated and determined that the complaint address was only a call center and business office. The entity was properly registered and dispatched all of its mobile x-ray units from the address on its registration. The complaint could not be substantiated. One unrelated non-cited severity level IV violation was found.

File closed.

### C - 2456 - Uncredentialed Dental X-ray Technicians - Bailey Orthodontics - Houston, Texas

On February 4, 2013, the Agency received an anonymous phone call stating that the registrant had uncredentialed employees taking x-rays. During the Agency's investigation, the registrant provided documentation regarding credentials of staff performing x-rays at the facility. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2457 - Unregistered Laser Facility - Austin Dermagraphix - Austin, Texas

On February 7th, 2013, the Agency received a forwarded complaint that the entity was operating a laser tattoo removal business without licensure or certified technicians. Documentation provided to the Agency by the facility indicated that the laser device was a class 1b and thus falls below the categories requiring registration. The device operators had received training from the device manufacturer and were not required by rule to register with the Agency. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2458 - Radiation Exposure To Member Of General Public - Element Materials Technology Houston - Houston, Texas

On February 12, 2013, the Agency was contacted by a member of a local law enforcement agency. The officer stated that while driving in the area of the licensee's facility his radiation pager alarmed. The officer stated that he performed a survey with his pager and saw readings as high as 800 millirem per hour 100 yards away from the facility. The Agency conducted an on-site investigation on February 13, 2013. A review of dosimetry records indicated the dose to supervisors in the building where radiography is conducted averaged 98 millirem for the year 2012. The licensee does not possess one tenth of the activity necessary to create the dose rates reported. The licensee agreed to post dosimetry to monitor the dose at its perimeter fence line. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2459 - Potential Exposure to Individual - Catch-A-Fault - Fort Worth, Texas

On February 15, 2013, the Agency received a phone call from the Emergency Management Coordinator for Ft. Worth. He stated the police had detected radiation he believed was emanating from a tank head manufacturing site. He expressed a concern that individuals at the site were being exposed to radiation levels that exceeded this Agency's rules. On February 26, 2013, the Agency conducted an on-site investigation of the complaint at the facility where the licensee was providing radiography services. The investigation found that the maximum dose rates 60 feet from the area where radiography was being performed was 1.02 millirem per hour. The dose rate at the facility gate was 0.120 millirem per hour. The complaint could not be substantiated. One violation was cited.

File closed.

### C - 2460 - Regulation Violations - Howmet Castings & Services, Inc. - Wichita Falls, Texas

On March 5, 2013, the Agency received an anonymous complaint alleging that the x-ray machines at the registrant's facility were not being properly checked for radiation leakage, that there was no active radiation safety officer present, and that there were employees operating the x-ray machines who were not properly certified. The Agency performed an on-site investigation on April 15, 2013. A review of maintenance documents did not find any discrepancies. A review of the last three exposure reports did not find any unusual exposure readings. A copy of the current operating procedures was located at each x-ray device. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2461 - Unsafe Practice/Unregistered Laser Facility - Aqua Blue Beauty and Bodyworks – Pflugerville, Texas

On March 8, 2013, the Agency received an anonymous complaint alleging the technician performing a photo facial had removed the complainant's eye protection. The complainant did not have an injury but was concerned that this could result in an injury to someone in the future. During the Agency's investigation the technician stated that on occasion she had removed the protective eyewear but left moist cotton rounds over the individual's eyes and also covered the eyes with her hand in order to treat the area between the eyebrows which would have been covered by the eyewear. The owner of the facility stated she has instructed the technician on the correct procedure and has ordered acceptable alternative eye protection to use in this type of situation. It was also discovered that the facility was not registered with this Agency for lasers or as a laser hair removal facility. The owner took immediate corrective action and submitted the appropriate applications and fees. The complaint was substantiated. No violations were cited.

File closed.

### C - 2462 - Nonregistered Technicians - Brown Dental Health Management, Inc. - Fort Worth, Texas

On March 23, 2013, the Agency received a complaint from a dentist stating that non-credentialed clerical workers were sent out to take dental x-rays using a mobile unit. Additionally, they did not ensure lead aprons were used on patients and many exposures were not useable for diagnostics and had to be retaken. The Agency conducted an on-site investigation on April 16, 2013. The new x-ray technician was interviewed and operation of the equipment was tested. The new certified technician is using aprons and is the only person currently taking x-rays. One administrative assistant admitted helping a previous technician at least four times and pushing the button on the mobile x-ray unit while the technician was holding the film in the patients mouth. This information was forwarded to the Texas Dental Board. The other issues in the complaint could not be substantiated. Three non-related violations were cited.

File closed

### C - 2463 - Regulatory Violation - University Health Science at San Antonio - San Antonio, Texas

On March 22, 2013, the Agency received a complaint alleging that the reviewing physician's name on mammography studies had been changed to a physician who had not reviewed the film. An on-site investigation was performed by the Agency on April 4, 2013. The investigation found that the reports provided by the complainant were for internal use only and were not used in any official capacity. The reports provided to the patients and their physicians included the appropriate physician's name. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2464 - Not Registered for Radiation Machine - Dr. Peter Mah - San Antonio, Texas

On March 25, 2013, the Agency received a complaint referred from the Texas Commission on Environmental Quality (TCEQ). An anonymous complainant had contacted them alleging that an individual was collecting, storing, and modifying new and old imaging and radiography equipment in his home. The complainant was concerned the equipment could generate radiation and he/she did not know if the equipment was registered and tested per Agency regulations or if it was being disposed of per TCEQ regulations. The Agency conducted an on-site investigation. The individual did have at least 5 x-ray devices at his residence but there was no evidence that they were being energized, that he was performing any salvage activities, and none of the units contained hazardous chemicals that would be an issue with disposal. There was no apparent risk to the public health and the individual is aware of the regulations concerning use and disposal. No violations were cited.

File closed.

### C - 2465 - \* \_\_\_\_\_ - Baylor Regional Medical Center at Grapevine - Grapevine, Texas

\*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### C - 2466 - Regulatory Violation - Digital Motion X-ray - Palm Harbor, Florida

On April 25, 2013, the Agency was contacted by a registrant who reported that he had discovered that his x-ray device had been installed by a company who did not have a valid Texas registration. A review of the registrant's file did not find any document indicating the device had been installed by the company alleged to have installed it. There were documents indicating the company had removed the device from the registrant's location. The Agency made seven attempts to contact the company, which is located in Palm Harbor, Florida. Several messages were left with the company's receptionist, but company management did not return the calls. On May 28, 2013, the Agency contacted the State of Florida's Bureau of Radiation Control and made them aware of the complaint. Repeated attempts to contact the Texas registrant were also unsuccessful. No violations were cited.

File closed.

## Complaints Opened First Quarter 2013

### C - 2467 - Not Licensed For Radioactive Material - Lydick Engineers and Surveyors, Inc. - Clovis, New Mexico

On March 26, 2013, the Agency received a request from the Region IV Nuclear Regulatory Commission (NRC) office requesting the status of an allegation against a State of New Mexico licensee it had received in January 2013. The allegation was that the licensee had used radioactive material in the State of Texas without requesting reciprocity. The New Mexico licensee was contacted and the radiation safety officer (RSO) stated that they were not aware that the New Mexico license did not allow them to work in the State of Texas without authorization from Texas. The RSO stated the licensee had used radioactive material in Texas on one occasion in June 2012. The device was a Seaman moisture/density gauge containing licensed quantities of americium-241 and cesium-137. On March 28, 2013, the Agency received a copy of the application for reciprocity from the New Mexico licensee. One violation was cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2013

### C - 2417 - Regulatory Violations - Lorenzo Kunze - Golden, Colorado

On July 17, 2012, the Agency received a complaint alleging an individual had taught laser hair removal (LHR) courses using a laser college's name to students within the state of Texas and gave out the laser training college's certificates of completion without the college's knowledge or consent and without the students attending the college. The complaint alleged the individual had also backdated LHR training course certificates to allow the supposed graduates to be grandfathered when the new Texas LHR rules took effect and that laser spas in Texas helped the individual in the backdating scheme. The complainant alleged that laser spas within Texas who did not have approval from Texas Workforce Commission have conducted laser training with the individual as the instructor. On July 19, 2012, a written request was sent to the complainant to provide more specific information and names so that an investigation could be conducted. The Agency did not receive a response or any further information. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2423 - Regulatory Violations - Kids Dental and Orthodontics - San Juan, Texas

On August 8, 2012, the Agency received information that a dental facility in San Juan, Texas, was using a dental x-ray unit from China that was not in compliance with Food and Drug Administration (FDA) regulations. The complaint also alleged that the Radiation Safety Officer (RSO) was no longer employed there and his absence may exceed the 30-day notification requirement to the Agency. The Agency conducted an on-site investigation in conjunction with the facility's initial inspection. Further investigation revealed that the x-ray unit is an FDA approved make/model. Also, the registrant stated that even though the RSO was no longer working within the office, he remained as the RSO. The registrant changed its RSO to a dentist working at the facility. The complaint was not substantiated. As a result of the inspection, five violations were cited.

File closed.

### C - 2424 - Unregistered Laser Facility - Revitalize Laser and Aesthetics Clinic - Denton, Texas

On August 2, 2012, the Agency received a complaint that a facility in Denton, Texas, was performing laser hair removal and other aesthetic procedures using lasers and it was not registered with the Agency. The Agency's investigation revealed that the facility had been using a laser without being registered. In response, the facility submitted an application to the Agency in August 2012 for the appropriate laser registration. The complaint was substantiated. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2013

### C - 2427 - Unregistered Use of X-ray Machines - K-Spinal Rehab Center - Garland, Texas

On August 27, 2012, the Agency received information that the registrant had moved and failed to notify the Agency, that the registrant should have terminated one registration and applied for a new one due to business change, and that the registrant had begun performing x-rays at a second site that was not on any registration. The Agency's investigation revealed that a new registration application had been submitted in March 2012 but it was incomplete. The registrant had failed to respond to letters and phone calls from the x-ray registration group concerning the application and the termination of the old registration and it continued to be unresponsive during the investigation. Therefore, an on-site investigation was conducted and at that time the registrant provided the necessary documents to complete the application and termination. The registrant had opted not to use the second location. One violation was cited.

File closed.

### C - 2431 - Inadequate Credentialing - Abilene Bone and Joint Clinic - Action Sports Medicine - Early, Texas

On October 4, 2012, the Agency received a complaint alleging that individuals who are not qualified were performing x-rays at a facility in Early, Texas. Investigation revealed that a Non-Certified Technician (NCT), who had completed all of the required training, had performed x-rays at the facility between August 18, 2012 and October 5, 2012 prior to receiving proper credentialing from the Agency. The investigation also revealed that the registrant who owned and operated the facility had failed to register the facility as a site on its registration within 30 days of operating an x-ray machine at the site. A recommendation was made to refer information concerning the NCT's activities to the Agency's Medical Radiologic Technologist Certification Program. Two violations were cited.

File closed.

### C - 2434 - \* - Jack County Hospital District - Jacksboro, Texas

\*Health and Safety Code Chapter 241.051(d)

The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2013

### C - 2438 - Monitoring Not Provided - Osteo Relief Institute of Dallas PLLC - Dallas, Texas

On November 8, 2012, the Agency received a complaint from the United States Department of Labor, Occupational Health and Safety Administration. The complaint alleged that an individual at the registrant's location was performing fluoroscopic procedures and was not monitored for exposure. On January 4, 2013 the Agency conducted an on-site investigation. The investigation revealed that several full-time staff were issued dosimetry badges after several weeks on the job and dozens of part-time physicians that conducted fluoroscopy were not issued dosimetry badges. The complaint was substantiated. Two violations were cited.

File closed.

### C - 2441 - Moisture/Density Gauge Regulatory Violations - Alpha Testing Inc. - San Antonio, Texas

On November 19, 2012, the Agency received a complaint from Region 4 Nuclear Regulatory Commission alleging the licensee had multiple regulatory violations. Violations included a worker using a moisture/density gauge without a personnel monitoring device, inadequate gauge security, inadequate maintenance, and an insufficient training program. On December 13, 2013, the Agency completed an investigation. All personnel who used moisture/density gauges routinely left their dosimetry in the office. The required 6 month maintenance of all gauges was not completed on time. Several gauges were improperly braced and did not have two independent physical controls to prevent access in the back of unaccompanied worker's trucks. The complaint was substantiated. Six violations were cited.

File closed

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2013

### C - 2442 - Not Licensed for Radioactive Materials - ALS Laboratory Group, Environmental Division - Houston, Texas

On November 30, 2012, the Agency received a complaint referral from the Nuclear Regulatory Commission. The complaint alleged that an environmental laboratory in Houston, Texas, was routinely receiving shipments of radioactive materials, including high concentrations of naturally occurring radioactive material and source materials, without having a license to do so. The complaint also stated a concern that the facility does not have the proper security for radioactive materials. The Agency conducted an on-site investigation and found that the facility possesses and uses gas chromatographs with eight electron capture detectors, which contain nickel-63 sources. Leak test wipes are routinely performed and the wipes are mailed out of the facility. Occasionally, detectors (including their source) are mailed out and returned by mail to the facility when they are sent for cleaning. These are generally licensed devices and do not require heightened security. The investigators performed radiation surveys in the receiving area and in sample storage areas. There were no radiation levels above background observed. The laboratory director stated they do not perform any radiation surveys on samples they receive. He stated samples to be processed that are suspected or known to contain radioisotopes or that are being analyzed in regard to their radioactivity are sent to their facility in Fort Collins, Colorado, and not to the Houston facilities. The complaint was not substantiated. During the investigation, the facility could not provide documentation to show that all of its sources had been leak tested every six months as required. One violation was cited.

File closed.

### C - 2443 - Unregistered Laser Hair Facility - The Ritz - Burleson, Texas

On December 4th, 2012, a complaint was received by the Agency alleging that a salon in Burleson, Texas, was performing laser hair removal without being registered to do so. Furthermore, it was alleged that the employee performing the procedure was also uncredentialed. It was found during the Agency's investigation that the facility was new and in the process of registering. The Agency is currently processing registration paperwork submitted by the facility. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2013

C - 2445 - \* - Seton Family of Hospitals (University Medical Center Brackenridge) - Austin, Texas

\*Health and Safety Code Chapter 241.051(d)

The complaint could not be substantiated. No violations were cited.

File closed.

C - 2446 - Regulation Violation - JSW Steel USA, Inc. - Baytown, Texas

On December 13, 2012, the Agency was contacted by an individual reporting that while he and a coworker were changing radiography film on a pipe in the shooting bay, a radiographer energized the x-ray tube. On January 29, 2013, the Agency conducted an on-site investigation of the event. The investigation determined that the radiation safety officer (RSO) had pressed the energize button for the x-ray device to test the system alarms, but released the button prior to the tube energizing. There is a four second time delay between pressing the button and the tube energizing. This test is required daily. A review of the dosimetry record for the individuals involved indicated that one of the individuals had not received any exposure for the year 2012, and the other had received 30 millirem for the year, and zero for the fourth quarter. The registrant has changed its operation procedure to require the keys to be removed from the control panel anytime an entry into the test room is required. The RSO was counseled by management regarding his poor judgment in this event. The complaint was not substantiated. No violations were cited.

File closed.

C-2447 - Response to Public Concern - East Side Imaging, Inc. - Houston, Texas

On December 18th, 2012, the Agency received a complaint alleging that following a screening mammogram the registrant had referred the complainant for a biopsy. The complainant obtained a second opinion that determined the biopsy was unwarranted and had concerns that this was a frequent occurrence for this facility. The Agency's investigation did not reveal any violation of its rules nor any indication that a referral to the facility's accrediting body should be made. The complaint was not substantiated. No violations were cited.

File closed.