



**INCIDENT AND COMPLAINT SUMMARIES
FOR THE
FIRST QUARTER 2010***

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Regulatory Services Division
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* Any complaint and/or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051(d). These summaries will not appear in this report.

**Incident and Complaint Summaries
First Quarter 2010**

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Incidents Opened First Quarter 2010

I - 8696 - Lost Source of Radioactive Material - Lantheus - North Billerica, Massachusetts

On January 5, 2010, the Agency received a phone call from the United States Department of Transportation (USDOT) informing them that on December 27, 2009, 38 molybdenum generators containing various activities of molybdenum (Mo) – 99 were shipped from a company in Massachusetts to the Dallas/Fort Worth Airport. Some of the generators were to be delivered to various surrounding states and 24 were intended for delivery to licensees in the State of Texas. One of the devices containing four curies of Mo-99 for a licensee in Abilene, Texas, was missing. USDOT and the manufacturer contacted all companies who had received generators contained in this shipment, but none of them indicated that they had received the missing generator. The air cargo and the ground carrier stated that a search of all transportation vehicles used to transport the devices was conducted, but the device was not located. The shipping company in Massachusetts and the transportation company in Texas conducted additional searches for the device, but the device was not located. Discrepancies in various documents provided by all parties made it impossible to determine where or when the device was lost. The manufacturer stated that they are screening all returned device serial numbers and will notify this agency if the device is returned to them. No violations were cited.

File closed.

I - 8699 - Badge Only Overexposure - Non-Destructive Inspection Corporation - Lake Jackson, Texas

On January 12, 2010, the Agency was notified by the licensee that it had received a report from its dosimetry processor that one of its radiographers had received 1.451 rem on his badge, exceeding an annual exposure limit. The licensee's Radiation Safety Officer (RSO) stated that as soon as he received the report he contacted the radiographer. The radiographer involved stated that while he was packing up his equipment following radiography on the second half of a 16 hour shift, he found his badge lying on the ground between the radiography camera and the end of the guide tube. He stated that he forgot to inform the RSO of the event at the time of occurrence. The RSO reviewed the radiographer's daily dose records and determined that the dose recorded by self reading pocket dosimeter was 127 millirem for the exposure period. This dose was consistent with the exposure received by his coworker. The radiographer was assigned 127 millirem for the exposure period, lowering his total exposure for the year below the limit. The RSO reviewed the event with his workers at a weekly safety meeting and instructed them to report any events to him immediately. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8701 - Potential Exposure to Public - Team Industrial Service, Inc. - Port Arthur, Texas

On January 19, 2010, the Agency received an email from the Nuclear Regulatory Commission regarding a potential overexposure to a member of the public. The report received stated that the United States Coast Guard (USCG) had detected the potential overexposure in Port Arthur, Texas. An investigator from the Agency contacted USCG and spoke with one of the officers involved who stated that he and his crew were performing routine facility patrols of the port when their electronic dosimeters alarmed. The officer reported that their highest reading was about 5500 microR/hour when they were less than 100 yards away a radiography crew performing work. The officer stated that they identified the licensee and called the Beaumont office to verify that they were permitted to work with radioactive materials. The officer then used a radioisotope identifier to verify nuclide was iridium (Ir) – 192. The investigator asked the officer if he believed that any member of the public had been exposed, or that there was potential for a member of the public to be exposed and he said no. On January 20, 2010, the investigator contacted the licensee's Radiation Safety Officer and asked him to send the daily surveys performed by the radiography crew, showing that they indeed verified the perimeters when they began working. The survey documented that the radiography crew had properly identified the exposure boundaries. No violations were cited.

File closed.

I - 8702 - Shutter Failure - Huntsman Corporation - Port Neches, TX

On January 19, 2010, the Agency was notified that the shutter on an Ohmart Vega fixed gauge failed in the open position on January 18, 2010. The gauge houses a 375 millicurie cesium (Cs) - 137 source. Dose rates taken in the area were normal, and the licensee did not report any exposure to personnel. The licensee's Radiation Safety Officer (RSO) contacted the manufacturer and they agreed to fix the shutter. On February 17, 2010, the licensee confirmed that gauge was repaired the previous day. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8703 - Equipment Malfunction - Valero Three Rivers Refinery - Three Rivers, Texas

On January 20, 2010, the Agency was notified by the licensee that while conducting routine operational tests of a Thermo Nuclear Model 5192 level gauge containing a 100 millicurie (original activity) cesium (Cs) – 137 source, dose rates were measured to be greater than 200 millirem per hour (mrem/hr) on the top of the gauge. The initial survey for this device was done in November 1981 and indicated a reading of 40 mrem/hr at the same location on the gauge. The licensee measured the highest dose rate in any area that could be occupied by company personnel at 0.3 mrem/hr. On the ground below the gauge, the dose rate was measured at 0.02 mrem/hr. On January 21, 2010, an Agency inspector performed an on-site investigation of the event. A dose rate survey using a Eberline RO 20 dose rate instrument confirmed the high readings with a dose rate measurement of 120 mrem/hr. Dose rates were less than 0.020 mrem/hr in areas where access was not restricted. The gauge was removed by the manufacturer on April 14, 2010, and replaced with another gauge. The manufacturer performed an inspection of the gauge shielding and found a void in the lead. The manufacturer believes that the void was created during a fire in July of 2001. The manufacturer has seen this type of voiding previously in other gauges, but could not provide any documents to support this statement. The licensee does not believe that the fire caused the void because all surveys conducted by a service company and the licensee after the fire did not show elevated dose rates. A review of the licensee's surveys found that they recorded the highest reading found on the gauge, but did not indicate where on the gauge the reading was taken. The licensee stated that no other event had occurred near the gauge, which could explain the voiding in the gauge shielding. The fire appears to be the only plausible cause for the void in the lead shielding which caused the elevated dose rates. No violations were cited.

File closed.

I - 8704 - Information Notice from NRC - Various Licensees and Locations.

On January 12, 2010, the Nuclear Regulatory Commission notified the Agency that a licensee using a QSA Model 87703 in Massachusetts had experienced problems with source disconnects. The licensee sent the device back to the manufacturer, and QSA Global consequently discovered a manufacturing defect of the female connector end. The defect causes the male connector to not be fully inserted in the sleeve of the connector, causing the device to not lock properly. This could give the user the false impression that the source is locked to the drive cable when it is not. If the user does not fully inspect the connection, the source assembly may not be secure and this could cause source disconnects. QSA Global has sent a notification to all of their customers who possess these devices describing the issue. On January 22, 2010, the Agency sent a letter to all the Texas licensees who possess these devices and the Agency's inspectors were also alerted.

File closed.

Incidents Opened First Quarter 2010

I - 8705 - Waste Alarmed Portal Monitor - Valley Baptist Medical Center - Harlingen, Texas

* Health and Safety Code Chapter 241.051(d).

One violation was cited.

File closed.

I - 8706 - Source Disconnect - Desert Industrial X-Ray - Abilene, Texas

On January 26, 2010, the Agency was notified by the licensee that a source disconnect had occurred on January 22, 2010. A radiographer was cranking a 26 curie iridium (Ir) -192 source out of a Spec 150 radiography camera when he began having difficulty driving the source. He decided to retract the source into the camera when the source pig tail disconnected from the drive cable. The source was then driven into the collimator at the end of the guide tube. The radiographer contacted the licensee's Radiation Safety Officer and informed him of the event. An individual authorized to perform source retrieval was sent to the location. The source was retracted into the camera, and the camera was returned to the licensee's facility. The licensee determined that the drive cable had broken at the connector attached to the end of the cable. The entire source crank mechanism was returned to the manufacturer for inspection. The manufacturer found that the drive cable was rusted and brittle near the end where the source connects. The manufacturer stated the probable cause was inadequate maintenance of the cable. The licensee provided additional training to their radiographers on proper inspection procedures for the device. No violations were cited.

File closed.

I - 8707 Badge Overexposure - University of Texas at San Antonio - San Antonio, Texas

On January 26, 2010, the Agency received a report from the licensee's Radiation Safety Officer (RSO) stating that they had been notified by their dosimetry processor that one of their workers had received 230 rem to the badge in his left hand and 1.420 rem to the right hand for the same period. The RSO stated that the individual involved handled predominantly fluorine (F)-18. His deep dose equivalent (DDE) for the same period was 439 millirem. The RSO stated that the typical exposure to the hands was between 500 and 1,200 millirem and that the DDE was about 250 millirem per exposure period. The RSO believes the exposure was to his badge only. The RSO stated that on December 23, 2009, the individual was involved in a spill of F-18 and his badge may have become contaminated causing the exposure. The licensee believed the individual contaminated his badge when he removed his gloves. Surveys of the room after the spill indicated that the door handle used to exit the room by the individual was contaminated. The individual frisked his hands after leaving the room and they were not contaminated. He believes the badge became contaminated when he removed his gloves. Calculations indicate that based on the specific activity of the F-18 involved, as little as 1.49 E-4 milliliters would be required to cause this dose to the badge. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8708 - Leaking Source - Baker Hughes Oilfield Operations Inc - Houston, Texas

On Monday February 8, 2010, the Agency was notified by the licensee that a leak test performed on a 0.1 curie cesium (Cs) - 137 source indicated a removable contamination level of 0.006 microcuries. The source was in storage and was being prepared for disposal. The source was placed inside of a cylinder recommended by the United States Department of Energy (USDOE) and leak tested on February 9, 2010. The leak test results were below the acceptable limit, and USDOE has agreed to dispose of the source. No violations were cited.

File closed.

I - 8709 - Radiography Source Disconnect - Southern Services Inc. - Lake Jackson, Texas

On February 9, 2010, the Agency was notified by the licensee that while performing radiography a 22 curie iridium (Ir) - 192 source could not be retracted into the camera. The radiographer noted that when he returned the source to the camera, the auto-locking mechanism failed to activate. The radiographer then cranked the source back out and tried again to lock the source in the camera. The locking mechanism failed to lock the source in place. The source drive cable was left in the position where the source should be shielded by the collimator. The radiographer performed a dose rate survey on the guide tube. He found the dose rates near the end of the guide tube were elevated and he contacted the licensee's Radiation Safety Officer. An individual authorized to perform source retrieval went to the location and retrieved the source. No overexposures were reported. An inspection of the source pig tail and drive cable found that the ball on the drive cable side of the connection had broken off from the drive cable. The cable was returned to the manufacturer for inspection. The manufacturer stated that the connector showed signs of wear and some bending. No violations were cited.

File closed.

I - 8711 - Medical Event - Baylor Medical Center - Irving, TX.

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8712 - Medical Event - University of Texas Health Science Center at San Antonio - San Antonio, Texas

On February 23, 2010, the Agency received a report from the registrant's Radiation Safety Officer (RSO) stating a medical event had occurred at the facility on February 18, 2010. The event involved the radiation dose of 18 MeV electrons to the incorrect treatment area of a patient. The patient was administered 178 centigray (cGy) to an incorrect region. The patient was prescribed 300 cGy per fraction, for ten fractions, resulting in a total dose of 3,000 cGy. The mistake was realized during the first treatment fraction. The error was corrected and the treatment was continued the same day. The medical physicist was not made aware of the incident until February 22, 2010, when both the radiation oncologist and the patient were notified of the event. The oncologist does not think there were any resulting damage to the patient from the exposure. The corrective actions the registrant enumerated in the report include; changing the paperwork used by the therapists when treating patients, revising their Operating and Safety Procedures manual, as well as additional training for staff. No violations were cited.

File closed.

I - 8713 - Gauge Shutter Failure - Alcoa World Alumina Atlantic - Point Comfort, Texas

On February 23, 2010, the Agency was notified by the licensee that the operating mechanism for the shutter failed on a Thermo Fisher model 5201 nuclear gauge. The gauge contains a cesium (Cs) – 137 source with an original activity of 100 millicuries. The gauge is normally operated with the shutter in the open position. The licensee stated that the current condition of the gauge poses no additional health risk to any individuals. The gauge is located 10 feet off of the ground, and is accessed using a ladder to a platform. The area has been posted to prevent anyone from performing maintenance in the area. On March 11, 2010, the manufacturer replaced the failed piece and returned the gauge to service. The manufacturer inspected the failed parts and determined that the weld between the shutter operating arm and the shutter block failed due to harsh environmental conditions and age of the gauge. The manufacturer concluded that no design change is warranted. No violations were cited.

File closed.

I - 8714 - Overexposure - Blazer Inspection - Texas City, Texas

On February 25, 2010, the Agency received a report from the licensee stating one of their radiographers had received 5,563 millirem for the year 2009, exceeding the annual limit for deep dose equivalent. The licensee's Radiation Safety Officer (RSO) stated that he was aware of how much dose the individual had prior to the last exposure period and cautioned him to closely watch his exposure to prevent the overexposure. The licensee's investigation into the event determined that the radiographer had been performing radiography on small diameter pipes with a high activity source, and was not able to reduce his time near the crank out cables due to the short exposure times. The dose recorded on the individual's daily radiation reports indicated that the individual's exposure was 4,192 millirem for the year. No explanation for the discrepancy between the two dose records could be identified. The licensee stated that they reviewed the event with all of their workers in a safety meeting, and provided training on the company's policy for controlling personnel dosimetry. The licensee was cited for the overexposure.

File closed.

Incidents Opened First Quarter 2010

I - 8715 - Source Abandonment - Warrington Inc. - Pflugerville, Texas

On February 25, 2010, the Agency received a phone call from a local realtor stating that one of their commercial tenants who used radioactive material in their business had abandoned the rented facility. After coordinating with the licensing unit, it was determined that the licensee properly disposed of a cesium (Cs) - 137 source, however, they were also licensed for cobalt (Co) - 57 sources. On February 25, 2010, two Agency inspectors performed an investigation at the licensed facility. Two button sources were found, one was a carbon (C) - 14 source and the other was a Cs - 137 source. The quantities of the sources were exempt from licensing requirements. The sources were taken back to the Agency. There were no Co-57 sources found. Several contamination swipes were taken throughout the facility. The wipes were counted on March 4, 2010, by the Agency and all samples were within applicable limits. The three swipes with the highest counts were sent to the laboratory on March 5, 2010. The laboratory results were indicated that no regulatory limits were exceeded. No violations were cited.

File closed.

I - 8716 - Source Leak Test Exceeds Limit - Methodist Willowbrook Hospital - Houston, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8717 - Badge Only Exposure - Sealed Air Corp. - Iowa Park, Texas.

On February 24, 2010, the registrant was contacted by a dosimetry processor who informed the registrant of a high (>7 rem) but static exposure--which indicates the badge was stationary at the time of exposure--on an individual's badge. The badge was assigned to an employee that had worked on the process line which utilized a 500 KV industrial radiography device. It was discovered that the employee had dropped his badge underneath the device and, according to the operator log, it was exposed with a voltage of 500 KV and an estimated "dark current" of 200-300 uA. Not knowing of this phenomenon, the technician found his badge and placed it on the badge storage area without reporting the situation to the Radiation Safety Officer (RSO). The RSO changed the company policy to have all lost badge incidents reported and provided employee training on being aware of the presence of radiation when the high voltage is activated on the device even if the beam is set at zero current. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8718 - Radiography Truck Accident - Blazer Inspection - San Leon, Texas

On March 10, 2010, the Agency was notified by a representative of the Regional Public Health Preparedness Program (RPHPP) of the Department of State Health Services that there had been a vehicular accident involving an industrial radiography truck and from the reports he had received he did not think that proper safety precautions were taken by first responders. The representative wanted to know if Radiation Control had heard anything about the incident and how we would respond. The Agency told the representative that they had not received a report from any government entity regarding the event, but that they would contact the licensee involved. The Agency contacted the licensee the same day and learned that the accident was minor and the radiographer driving the truck performed a survey on the scene and assessed that there was no cause for concern. The Agency contacted the representative from RPHPP and told him that there was no reason to think that the emergency personnel were exposed to radiation. No violations were cited.

File closed.

I - 8719 - Wrong Patient Examined - St. Paul University Hospital - Dallas, Texas

On March 11, 2010, the Agency was notified by the registrant that on March 10, 2010, the wrong patient received computerized tomography (CT) scan without contrast. The incorrect patient was scanned because they had the same last name as the patient intended to be examined. The wrong patient responded when the last name was called. The patient received approximately 1,720 millirem from the CT scan and was notified of the error. To prevent recurrence of this event, the Imaging Department of the registrant conducted a review of department policy for patient identification and provided remedial training for their personnel. No violations were cited.

File closed.

I - 8720 - Overexposure - Valley Positron, LLC - McAllen, Texas

On March 12, 2010, the Agency's incident investigations program received a phone call from an Agency inspector who stated that during a recent inspection she found one of the licensee's employee badges had received a dose to 59,130 millirem (mrem) to his left hand during the one month period from July 15 - August 14, 2009. This brought the employee's annual dose to 62,800 mrem, exceeding the limit of 50,000 mrem. The inspector stated that when she asked the licensee's Radiation Safety Officer (RSO) why the licensee did not report it, the RSO stated that the licensee was unaware of the reporting requirement. The Agency contacted the individual involved who stated that when they make the PET doses, they usually have a mechanism that handles the doses, but it was broken during the period of the overexposure. The individual stated that they had repeatedly asked the manufacturer to send the part to repair the mechanism, but it was on back-order and so he handled the doses himself. The individual stated that when he learned his dose was high, he immediately quit working with radiation for the remainder of the year. The Agency received the badge reports for the entire year of 2009 for the individual. After reviewing the reports, it was determined that the individual continued to receive dose after he was made aware of his overexposure. The licensee submitted a written report to the Agency which verified the overexposed individual continued to receive dose even though the regulatory limit had been exceeded. The licensee was cited for the violation.

File closed.

Incidents Opened First Quarter 2010

I - 8721 - Gauge Shutter Failure - Totak Petrochemicals USA - Deer Park, Texas

On March 12, 2010, the Agency received a request to perform work in the State of Texas under reciprocity from a nuclear gauge manufacturer. The request was to repair two nuclear gauges with stuck shutters. The gauges are Ronan Engineering model SA1-C10 each containing 200 millicuries each of cesium (Cs) -137. The Agency contacted the Radiation Safety Officer (RSO) for the licensee for more information. The RSO stated that the two gauges had been removed from storage and installed on a piece of equipment for use. A service company was testing the equipment prior to placing it in service and found that the gauge shutters would not function. The licensee then contacted the gauge manufacturer to repair the gauges. The RSO stated that he was not aware of the reporting requirement and would submit a written report to the Agency. On March 17, 2010, the gauge shutter was repaired. It was determined that the shutter seal lubricant had dried up while the gauge was in storage. The licensee stated that they will notify the Agency within the required time period in the future. The licensee was cited for failure to report the event within the required time period.

File closed.

I - 8722 – Radioactive Material Abandoned – Austin Positron Emission Tomography, LP – Austin, Texas.

On February 22, 2010, the Agency attempted to conduct a routine inspection at a medical imaging center that had apparently closed on December 31, 2009, presumably as a result of filing for bankruptcy. The Agency inspector had arranged to meet the licensee's former technologist at the licensee's only authorized site to perform the inspection. When they arrived, it was determined that a different medical practice, one that does not use radioactive material, occupied the building and that the licensed practice was no longer present. Following this discovery, the property owner requested the Agency return to the facility. A different Agency inspector visited the facility and found that all equipment and furniture had been removed and the entire facility was empty. The area was then surveyed for radiation and no readings above background were detected. Using information provided by the property owner, the Agency was able to determine that the equipment and sources were sold and subsequently moved to a facility in Pennsylvania. The Pennsylvania Bureau of Radiation Protection was notified. They were able to determine that two sources were still in the scanner and the remaining sources were in the possession of an unlicensed imaging equipment provider in their state. Leak tests of all sources verified that none of the sources were leaking. The Texas radioactive material license was terminated. No violations were cited as the legal entity no longer exists.

File closed.

I - 8723 - Sources Abandoned Down Hole - Schlumberger Inc. - Zapata County, Texas

On March 15, 2010, the Agency was notified by the licensee that they had abandoned a 16 curie americium (Am) - 241/beryllium (Be) source at 14,547 feet and a 1.7 curie cesium (Cs) – 137 at 14,574 feet. A 100 foot red dyed cement plug was placed above the source tool and a whip stock placed above the cement plug as a deflection device. The radioactive sources were abandoned according to Texas Railroad Commission regulations. A plaque will be mounted at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well the radiation control program contact information. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8724 - Individual Impersonating an Agency Inspector - Goolsby Testing Laboratories Inc. - Humble, Texas

On March 17, 2010, the Agency received a report from a licensee informing them that one of their radiographers working at a temporary job site was approached by an individual impersonating an Agency inspector. The impersonator opened and closed the radiographers truck doors, went into the dark room and looked at various items, and then observed the radiographers perform operations for about one hour from beyond the two millirem barrier ropes and. The impersonator was wearing a jacket with TDH on the back of it. The impersonator did not try to gain access to the source. Based on questions asked and statements made by the impersonator, it appeared that this individual had a working knowledge of radiography. Two informational letters were sent to all radiography licensees reminding them that Agency inspectors carry credentials while performing inspections. The letters reminded radiographers that they are within their rights to ask for these credentials when they are approached by someone attempting to perform an inspection. No violations were cited.

File closed.

I - 8725 - Gauge Shutter Failure - Structural Metals, Inc. - Seguin, Texas

On March 19, 2010, the Agency was contacted by the licensee's Radiation Safety Officer (RSO). The RSO stated that the licensee had experienced a gauge shutter failure. The Agency contacted the RSO for the licensee who stated that the source had failed in the open position, which is the normal operating position. The source is a 2.51 millicurie cobalt (Co) – 60 source, and the RSO stated that the licensee would not be using the device until it was fixed. Dose rates taken in the area were normal. The licensee stated that molten steel had spilled onto the gauge preventing the shutter from operating properly. The licensee stated that it was going to have the source removed and put into a functioning device by a licensed vendor. It was requested that the licensee update the Agency when the transfer had been complete. No violations were cited.

File closed.

I - 8726 - Well Logging Tool Ejected from Well - Weatherford - Howard County, Texas

On March 19, 2010, the Agency was notified by the licensee that a blow-out had occurred in a well in Howard County, Texas. The well was being logged using a tool containing a 1.5 curie cesium (Cs) - 137 source and a 5 curie americium (Am) – 241/beryllium (Be) source. The well operator noted that the flow from the well was returning to the surface and ordered the well logging tool removed from the well. As the tool reached 3,500 feet, the withdrawal of the tool was stopped because the flow out of the well had increased to a point where it was forcing the tool and wire line out of the well. The crew was ordered to evacuate the drilling rig due to the hazards associated with the high down-hole pressure. A short time later, the tool and wire line were ejected from the well bore. The flow preventers were then operated and flow from the well was controlled. A logging company manager conducted radiation surveys and found the tool with the sources still in place near the logging truck. The sources were removed from the tool and placed in their shipping casks. Neither source appeared to be damaged. The sources were returned to the licensee's facility and leak tested. The leak test results for both sources were satisfactory. No violations were cited.

File closed.

Incidents Opened First Quarter 2010

I - 8727 - Radioactive Material Found at a Scrap Yard - Texas Port Recycling - Conroe, Texas

On March 30, 2010, the Agency was contacted by a scrap yard who reported that a container of scrap metal alarmed their radiation monitors. The scrap yard inspected the material and found the alarm was caused by a gauge panel containing several gauges. The Agency went to the scrap yard on April 5, 2010. The gauges were found to contain radium (Ra) - 226. The gauge panel was impounded by the Agency and returned to Austin, Texas for storage until disposal. The Agency contacted the United States Army Rad Waste Operations Division for assistance in disposing of the gauges. They agreed to receive and dispose of the gauges. No violations were cited.

File closed.

I - 8730 - Theft of Radioactive Material - ProTechnics - Alice, Texas

On March 19, 2010, at 2350 hours, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that 120 millicuries of iridium (Ir) – 192 was stolen from one of their trucks parked at a Wal-Mart parking lot in Alice, Texas at about 2320 hours. The iridium was packed in six, 20 milliliter vials each containing 20 millicuries (15 grams) of Ir-192 in the form of sand. Each vial was placed into a labeled lead pig and each pig was then shrink-wrapped. The six pigs were then placed into a zip lock bag. The zip lock bag was placed into an unlocked tool box in the back of the pick up truck. On March 24, 2010, it was determined that two individuals were responsible for the theft of the materials, and the radioactive materials were recovered at the private residence of one of the suspects. Dose estimates for the members of the public were below applicable limits. An unannounced investigation was performed at the licensee's Alice, Texas location on March 25, 2010, and an unannounced routine inspection was performed on March 26, 2010. Agency investigations cite seven violations for the incident and four were cited for the routine inspection.

File closed.

I - 8740 - Use of Veterinary X-Ray Equipment for Humans - Texas A & M University - College Station, Texas

On January 25, 2010, the Agency was contacted by the licensee's Radiation Safety Officer (RSO) and notified that the RSO was investigating an event that involved a student who x-rayed herself after she was stepped on by a horse. On May 5, 2010, the RSO provided a written report of the event. The document stated that two, fourth year veterinary students were working with a horse when the horse stepped on one of the students. The student was in great pain and decided to x-ray herself. The student went to the small animal x-ray device and x-rayed herself. When asked about the event, the student stated that she was not aware this was a violation the registrant's permit. On February 16, 2010, in response to the event, a professor in the radiology department sent a letter to all fourth year students informing them that this activity is not allowed and that it could result in disciplinary actions against the student and/or the university. The student was counseled by her supervisor and received additional training. The registrant was cited for the violation.

File closed.

Incidents Opened First Quarter 2010

I - 8741 - Use of Veterinary X-Ray Equipment for Humans - Texas A & M University - College Station, Texas

On May 5, 2010, the Agency received a letter from the registrant stating that on February 24, 2010, a faculty member's wife had injured herself at home. The faculty member took an x-ray of her using an x-ray device registered for veterinary practice. The faculty member was interviewed by the Hospital Administrator. A letter was sent out by the Dean of Veterinary Medicine to every individual in the College of Veterinary Medicine stating that "there can be absolutely no human use of their x-ray equipment," and that to do so was a violation of both university policy and Agency regulations. The registrant was cited for the violation.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2010

I - 8667 - Radioactive Material Found at Scrap Yard - ELG Metals Southern Inc. - Houston, Texas

On September 14, 2009, the Agency was notified that while performing a final radiation survey of a container of scrap stainless steel, the facility's radiation monitor alarmed. The container was unloaded and a GammaMat radiography camera was identified. An Agency inspector picked the camera up on September 15, 2009, and took it to the Agency's main office. A radiation survey of the camera found the maximum dose rate on contact with the camera was 1.66 millirem/hour. The radionuclide was identified as uranium (U) - 238 using a SAMS 935. Literature from the manufacturer found on the internet stated that depleted uranium was used in the camera for shielding. The manufacturer was contacted. The manufacturer traced the sale of the device to a company in Germany, but could not track it any further. No violations were cited.

File closed.

I - 8671 - Radioactive Material Found at Scrap Yard - Latimore Material Corp. - McKinney,

On September 18, 2009, the Agency was notified by the Alabama Office of Radiation Control that a gauge containing a 0.9 millicurie cesium (Cs) -137 source was found in a scrap yard in Axis, Alabama. The gauge had been shipped to the scrap yard from a company located in Texas. The Texas company had acquired the gauge as part of a dredge included in the purchase of another company in August of 2009. The company was not informed that they had purchased a device containing radioactive material. They dismantled the barge and shipped it to the scrap yard as part of a large load of scrap. The labeling on the gauge had been painted and the device appeared to be just another part of the piping system. The scrap yard gate radiation monitor alarmed on the load of scrap and the gauge was located by the scrap yard. The scrap yard stated they recognized the gauge contained radioactive material and took precautions to minimize exposure to their workers. The gauge was picked up by the manufacturer and has been properly disposed of. The company stated that they have no intentions of owning radioactive material in the future. An investigation by the Agency determined that no individual was exposed to more than 20 millirems during this event. No violations were cited.

File closed.

I - 8673 - Failure to Retract Source - University of Texas Southwestern Medical Center - Dallas, Texas

On September 22, 2009, the Agency was notified of an incident that occurred on September 21, 2009, involving a patient undergoing brachytherapy. The patient did not receive the proper dose due to the 9.6 curie iridium (Ir) - 192 source failing to retract back into the high dose rate after-loader unit. The administering physician retrieved the source from the patient and placed it in a shielded container. After an investigation by the Agency was performed on September 29, 2009, it was determined that no overexposure occurred because the dose to the patient differed by less than fifty percent for the fraction of that treatment, and by less than four percent for the entire treatment. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2010

I - 8683 - Stuck Gauge Shutter - Ticona Polymers Inc - Bishop, Texas

On October 30, 2009, the Agency was notified by the licensee that a stuck shutter was found during a routine inspection on September 22, 2009. The gauge was stuck in the open position, which is the normal operating position for this gauge. Dose rates in the area were measured and found to be normal. The gauge is a Thermo Fisher model SH-F2 containing 100 millicuries of cesium (Cs) - 137. The gauge is installed on the side of a vessel and does not pose any additional risk to the workers. The licensee contacted the manufacturer to schedule the repair of the shutter. The manufacturer evaluated the gauge and decided that his model was not appropriate for the operating environment. The licensee replaced the gauge with a model designed to withstand the operating environment. The licensee received a notice of violation for failure to report the stuck shutter within the required time frame.

File closed.

I - 8685 - Shutter Failure -Valero Three Rivers Refinery - Three Rivers, Texas

On November 6, 2009, the Agency was notified that the shutter on a Ronan Engineering level gauge containing 2,000 millicuries of cesium (Cs) - 137 failed to operate properly. The gauge is installed on the top of a vessel that is 16 feet high. The vessel had been taken out of service and the licensee's Radiation Safety Officer (RSO) went to the location to perform a shutter operation check. He found that the shutter could not be fully closed. Dose rates in the area were normal. The RSO's investigation found that as many as four individuals may have entered the vessel while the gauge shutter was not fully closed. A dose rate survey taken between the gauge and the vessel indicated that the dose rates were 150 millirem per hour. Dose calculations for those who had entered the vessel indicated that the maximum exposure any of them could have received was 3.75 millirem. The Agency performed an on-site investigation of the event on January 21, 2010. The inspector found that the dose estimates were based on sound health physics principles. No violations were cited.

File closed.

I - 8693 - Stolen Moisture/Density Gauge - H.H. Holmes Testing Laboratory Inc. - Houston, Texas

On December 16, 2009, the Agency was notified that sometime during the previous night, a company truck containing a Humboldt model 5001 EZ moisture/density gauge was stolen from an employee's home. Local law enforcement was notified of the event. On December 21, 2009, the licensee was notified by the Harris County Sheriff's office that the gauge and truck had been found. The gauge was still triple locked to the bed of the truck. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2010

I - 8694 - Radioactive Material Found - CALTEX Holdings - Houston, Texas

On December 17, 2009, the Agency was notified that scrap metal from the decommissioning of paper mill buildings alarmed the gate monitor at a scrap yard. The Agency performed an on-site inspection on December 21, 2009. The inspector determined that the material to be low level naturally occurring radioactive material, radon-226 and progeny. The material was recycled in accordance with applicable regulations. No violations were cited.

File closed.

I - 8697 - Medical Event - Spohn Hospital - Corpus Christi, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8698 - Misadministration - Wrong Patient Treated - Memorial Hermann Southwest Hospital - Houston, 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 2010

I - 8700 - Overexposure - IRIS NDT Inc. - Deer Park, Texas

On November 15, 2009, the Agency was notified by the licensee of an event that occurred while radiography operations were being conducted at a facility in Ingleside, Texas. They had set up their boundaries and had walked the area with the facility personnel to ensure that no individuals were working in the area where the radiography would occur. An announcement was made over the company intercom system for all workers to stay clear of the area set up for radiography. Three minutes into the third seven minute shot, a radiographer noticed an individual exiting a portable trailer inside of the barricades approximately 15 feet from the source. The radiographer immediately went to the camera and cranked the source back to the shielded position. An investigation into the event determined that two individuals had been located inside the trailer during radiography awaiting job assignments. Their trailer was attached to a truck that was running. The personnel in the trailer stated that the engine noise prevented them from hearing the intercom announcement to leave the area. They also stated they did not have a radio in the trailer to hear the announcement. A reenactment of the event was done using OSL badges to record the dose to each of the individuals. The total exposure time for the individuals was also determined. The dose to the individuals was assessed at 25 millirem and 15 millirem. Neither individual exceeded the total exposure limit, but both exceeded the limit of 2 millirems in any hour. An investigation into the event revealed that the licensee's personnel inspected the cab of the truck, but failed to check the trailer. To prevent a recurrence, all personnel entering the facility in Ingleside will be issued a two-way radio, and procedure changes were made to the permit and operating procedures at the facility. The licensee was cited for the violation.

File closed.

Complaints Opened First Quarter 2010

C - 2238 - Regulatory Violations - One Step Diagnostic - Houston, Texas.

On November 17, 2009, the Agency received a phone call from an anonymous caller who filed a complaint against the licensee/registrant. The complainant provided an email containing allegations and locations where the violations were allegedly committed or existed. The Agency conducted unannounced on-site investigations at all of the license and registration authorized sites involved in the complaint. The investigation did not produce any evidence to substantiate the complaint. No violations were cited.

File closed.

C - 2239 - Regulatory Violations - El Paso Institute of Eye Surgery - El Paso, Texas

On January 27, 2010, the Agency was notified by the Patient Quality Care Unit that during an inspection at an ambulatory service company they noted that laser services were being provided at the same facility in the surgery center. They inquired about the use of the laser with an individual who uses the laser and the answers the inspector received lead them to believe that various violations were occurring. An Agency inspector performed an on-site inspection on February 5, 2010. The inspector's investigation covered all the specific items in the complaint. One violation for improper postings was identified. The violation was cited.

File closed.

C - 2240 - Regulation Violations - SonoBello Body Contouring Center - Austin, Texas

On January 29, 2010, the Agency received a complaint alleging that the company was violating several regulations, including laser regulations. The complainant was briefly employed at the company. According to the complaint, the facility performs liposuction surgeries with the aid of a laser. The complainant stated that: the physicians using the lasers did not wear protective eye shields while using the laser; the door to the surgical suite where the laser was being used was not properly posted; and administrative staff came into the operating room when the laser was being operated and did not wear proper eye protection. There were many allegations enumerated by the complainant, and most of them did not relate to the Agency's laser regulations. The complaint was forwarded to both the Drugs and Medical Devices group of DSHS and the Texas Medical Board. On February 17, 2010, an unannounced investigation was performed. The specific aspects of the complaint could not be substantiated, but the facility was cited for two violations.

File closed.

Complaints Opened First Quarter 2010

C - 2241 - Regulation Violations - DFW MRI LP - Dallas, Texas

On February 2, 2010, the Agency received a phone call from an anonymous source with a long list of very detailed violations on a variety of radiation producing machines against the registrant. The facility has computerized tomography (CT) and radiographic machines and the complaint was submitted by a person who described himself as a "concerned technologist". According to the complainant, the violations had been occurring since July 2009. On October 10, 2010, the Agency conducted an investigation/inspection at both of the registrant's licensed sites. No violations were cited.

File closed.

C - 2242 - Unregistered Laser - Skin by Ann Webb - Austin, Texas

On February 11, 2010, the Agency received an email from an individual who alleged that her previous employer was performing laser hair removal and may not be registered with the Agency. The individual stated that the employer did not post signs in areas where lasers were being used and that the individuals operating the intense pulsed light device had not been trained to use it. An on-site investigation conducted by the Agency found that the facility was not registered with this Agency. The investigation also found that the rooms utilizing lasers were not posted with the required signs, the inspections of safety glasses had not been documented, and none of the applications of lasers to humans had been supervised by a licensed practitioner of the healing arts. A total of six violations were cited. The complaint was substantiated.

File closed.

C - 2243 - Groundwater Contamination - Various Companies - Sonora, Texas

On February 24, 2010, the Agency received a complaint referred to them by the Nuclear Regulatory Commission from an individual who was concerned about exposure to radioactive contamination during his work at oil and gas wells. He expressed a concern over contamination of his well water by fracturing operations of gas wells on his property. On March 31, 2010, an Agency inspector performed an on-site investigation. The inspector took samples from three different water sources on the complainant's property. A contamination survey was conducted at the company where he had worked cleaning frac valves. The water samples did not contain any activity other than trace amounts of Naturally Occurring Radioactive Materials. The contamination survey indicated that contamination levels were at or just above background. The complainant was informed of the results. No violations were cited. The complaint was not substantiated.

File closed.

Complaints Opened First Quarter 2010

C - 2244 - Uncredentialed Technologists - Sherman Medical - Sherman, Texas

On February 25, 2010, the Agency received a call from an individual who stated that the registrant was allowing x-ray devices to be operated by uncredentialed individuals. An Agency inspector performed an inspection at the facility on April 14, 2010. The inspector found that three individuals who operated x-ray equipment were not credentialed. The registrant was cited for the violation. The complaint was substantiated.

File closed.

C - 2245 - Uncredentialed Technologists - Baaxten Imaging Center LLC - Mission, Texas

On March 5, 2010, the Agency received a complaint alleging that limited medical radiologic technologists are conducting computerized tomography scans, and that there is no physician on stand-by during iodine injections. An Agency inspector performed an on-site inspection on March 17, 2010. The registrant was cited for two violations. The complaint was not substantiated.

File closed.

C - 2246 - Improper Disposal of NORM - Enbridge Pipeline Company - Dallas, Texas

On March 5, 2010, the Agency received a complaint forwarded by the Nuclear Regulatory Commission stating that a company is improperly disposing of waste oil containing Naturally Occurring Radioactive Material (NORM). The complaint was forwarded to the Texas Railroad Commission for investigation as this falls under their jurisdiction. No violations were cited.

File closed.

C - 2247 - Radiographer Rule Violations - Marco Inspection Services, LLC - Marshall, Texas

On March 11, 2010, the Agency received an allegation that a radiographer was performing radiography by himself, without a survey meter, and without properly operating dosimetry. The complaint also stated that on one occasion the radiographer did not secure the camera during transit and on another occasion did not determine the proper boundaries. The complaint stated that the radiographer worked mainly out of the Louisiana office but that on at least one occasion was observed working in Marshall, Texas. On April 2, 2010, the licensee's Radiation Safety Officer (RSO) was contacted. The RSO also stated that neither the radiographer nor the complainant was still employed by the licensee. The RSO stated that the complaint had been investigated by them as well as by the State of Louisiana regulatory program. The complaint was forwarded to the State of Louisiana. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2010

C - 2248 - Naturally Occurring Radioactive Material - Fairfield, Texas.

On March 11, 2010, the Agency was notified by Texas Commission on Environmental Quality that an individual was fired from his job at a Freestone County area construction firm for allegedly expressing concern for him and co-workers from possible exposure to contamination from de-scaled oil field pipe. The complainant also stated that the workers had been salvaging the pipe for scrap and some loads were rejected from scrap yards due to radiation being detected. As the pipe was returned to the originating construction company, the complainant stated that the owner of the construction company ordered his workers to rinse out the pipe to remove the scale. The NORM decontamination was said to have occurred on several sites throughout the 80 acres of property. On June 3, 2010, two Agency inspectors performed an on-site inspection. The inspectors surveyed the property and focused on racks of pipe and cleared patches of dirt which gave the appearance of work or prep areas. Most all areas (including stacks of pipe) were at background levels ranging from 7-15 $\mu\text{R/hr}$ with one "patch" elevated to 44 $\mu\text{R/hr}$. The property owner denied any participation in de-scaling pipe and stated that others are given permission to store pipe on his property. The complaint was not substantiated and no violations were cited.

File closed.

C - 2249 - Burns from a Laser - Novopelle - Addison, Texas

On March 17, 2010, the Agency received a complaint from an individual alleging that she had undergone a laser hair removal procedure on several areas. She stated that a particular technician performed her last scheduled treatment on February 16, 2010. As a result of this treatment, the complainant suffered extensive burns on the areas treated. The complaint stated that she contacted the registrant and that they asked her to return the next day, and when she did the lead technician examined her and then gave her topical treatments for the burns. On March 17, 2010, the Agency contacted the complainant for more information. The complainant stated that she went to her primary physician who agreed that she was indeed burned by the laser, and her physician prescribed lotion to treat the burns. The complainant stated that technician who performed the final treatment no longer works at the facility, and that she did not know if the burns were reported to the State of Texas, as required by rule. The complaint was forwarded to the Agency's Drugs and Medical Devices Group and the Texas Medical Board. On May 13, 2010, the Agency contacted the registrant and asked if they were aware of the incident. The Laser Safety Officer (LSO) stated that he was aware of the incident, but he did not report the event to the Agency because he was unaware of reporting requirements. The Agency instructed the LSO that he was to submit a report to the Agency. The LSO agreed to submit a report to the Agency. One violation was cited for failure to report the burns. The complaint was substantiated.

File closed.

Complaints Opened First Quarter 2010

C - 2265 - Burns Caused By Medical Device - Prevention First PA - Dallas, Texas

On February 9, 2010, the Agency was contacted by an individual who stated that she had received multiple burns to areas on her body during a thermage treatment in a Dallas, Texas doctor's office. It was determined that this Agency does not have any regulatory authority over this type of device. The complaint was referred to the Agency's drugs and medical devices group and the Texas Medical Board for further investigation. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2010

C - 2189 - Regulations Violations - Cook Children's Medical Center - Fort Worth, Texas

* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

C - 2199 - Unregistered Laser - Bella Fontana Spa, Ltd. - Sherman, Texas

On June 25, 2009, a telephone complaint was received by the Agency's registration program alleging that a spa was using lasers without being registered with the Agency, and that clients of the facility had suffered burns from the lasers. An initial search did not yield a certificate of registration for the facility. The complaint was forwarded to the Agency's x-ray inspection unit for further review. An inspector performed an inspection and found that the lack of registration with the Agency was substantiated, but the alleged burns from the laser could not be substantiated. One violation was cited.

File closed.

C - 2218 - Radiation Exposure to General Public - Private Residence - Houston, Texas

On September 25, 2009, the Agency received a phone call from an individual who stated that she was being exposed to radiation and excessive heat directed at her house by two individuals in her neighborhood. The individual was provided a thermoluminescent dosimeter for a period of 48 days. The dosimeter reading was 8.4 millirem. The individual was informed that the level of exposure recorded on the badge did not pose any radiological risk and was within normal background levels. She asked if she could be provided with a radon test kit. The kit was ordered for her. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2010

C - 2220 - Potential Inadvertent Exposure - Texas A&M University - College Station, Texas

On September 22, 2009, the Agency received a phone call from an employee of the registrant who stated that he was able to gain access to the electron beam cell while the device was energized and generating radiation. The individual stated that a short time after this event, he experienced his eyes dropping, spots that appearing and disappearing a short time later, reddening of his skin, swelling of his left ear, watering of his eyes, and itching of the skin. The registrant's Radiation Safety Officer (RSO) had contacted the Agency before the complaint was received. The RSO stated that they had sent a sample of the individual's blood to REAC/TS for analysis. An on-site investigation by this Agency was conducted on October 7, 2009. Interviews were conducted with the three university individuals involved in the event. The system interlocks were tested and equipment status log generated by the computer integrated with the device were reviewed. During the test, the noise made by the operation of the device was evident from outside the room with the door shut. When tested, the system interlocks shut the device down as designed. The review of the computer log confirmed that the device was shutdown at nearly the same time entry was made into the room. The actual time for each of the actions of the individuals involved is not well documented therefore, there was no way to compare the times on the computer log directly to any activity of the individuals involved in the alleged exposure. A document from REAC/TS was provided to the Agency stating that their study indicated that no exposure above background had occurred to the complainant. Two complete blood counts were conducted on the complainant and the results of both indicated normal readings. Based on the information provided by REAC/TS, the results of two CBC studies, the test results on the interlocks, and the statement by the individual involved that he did not hear the increased noise level created by the e-beam tube and air knife when he entered the room, it was determined that the individual was not exposed to radiation from this event. An incident investigation of this event was also conducted under incident file number I-8666. The complaint could not be substantiated. A notice of violation was issued for a related violation.

File closed.

C - 2223 - Machine Inspections Overdue - Various Registrants - Various Locations

On October 28, 2009, the Agency received a complaint from a registrant during an enforcement conference. The complainant stated that other than him, there are seven veterinarians in his family and they all have x-ray machines. He stated that they are all properly registered with the Agency, but none of them have ever had their machines inspected by the Agency. During a phone interview on December 16, 2010, he would not provide the names of the veterinarians. An initial search on the Texas Board of Veterinary Medical Examiners yielded only one other veterinarian with the same last name as the complainant. On March 10, 2010, an Agency inspector performed an unannounced investigation of the one known sibling of the complainant. The complaint was substantiated because a sibling was found that was not registered with the Agency and therefore had never been inspected by the Agency. Four violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2010

C - 2229 - Contaminated Pipe - Springtown, Texas

On November 6, 2009, the Agency's incident investigation program received a telephone call from a complainant stating that there was some radioactive pipe from an old barn in a residential area in Springtown, Texas. The complainant stated that he believes the property manager improperly disposed of the waste, after it was rejected at a scrap metal yard. On December 7, 2009, an Agency inspector performed a survey of the pipe and did not measure any radiation higher than background. No violations were cited.

File closed.

C - 2231 - Unreported Misadministration - Spohn Hospital - Corpus Christi, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2232 - Regulation Violations - Conam Inspections & Engineering Inc. - Pasadena, Texas.

On December 3, 2009, the Agency received a phone call from a former employee of the licensee. The individual stated that she terminated employment with the licensee on January 26, 2008, but is still getting calls from the security service for the licensee when an alarm occurs at the location where the sources are stored. An on-site investigation was conducted by the Agency on January 28, 2010. The Radiation Safety Officer (RSO) provided documents showing that the complainant was not listed on the contact list provided to the company providing security services during the time stated by the complainant. The RSO stated that they had problems with the previous security company and had signed a contract with a new company on December 3, 2009. The complainant is not on that call list either. The RSO stated that he did not know why the alarm company would have called the complainant unless she had instructed them to do so since she was the daughter of the previous owner. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2010

C - 2233 - Failure to Give Notice of Reciprocity - Unknown Licensee - Decatur, Texas

On December 8, 2009, the Agency received an anonymous complaint from an industrial radiographer in Texas complaining that an unmarked radiography vehicle from Oklahoma was seen performing work in the state of Texas without notice of reciprocity. The inspector stated that the complainant told him they were currently not working and were staying at a hotel in Decatur. The inspector agreed to investigate and determine if they have reciprocity with the state. That same day, the inspector attempted to locate the radiographers at the hotel named by the complainant, but was unable to locate the radiographers. No violations were cited.

File closed.

C - 2234 -Uncredentialed Technicians - Diagnostic Outpatient Imaging Partnership - El Paso, Texas

On December 18, 2009, the agency received a complaint alleging that the registrant was allowing uncredentialed technicians to perform mammogram studies. On January 8, 2010, an Agency inspector performed an on-site investigation of the complaint. The inspector found that individuals who were performing mammogram studies were properly credentialed. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2236 - Uncredentialed Technicians - Bowie Memorial Hospital - Bowie, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.