



INCIDENT AND COMPLAINT SUMMARIES FOR FIRST QUARTER 2014*

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

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Incident and Complaint Summaries

1st Quarter 2014

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Incidents Opened First Quarter 2014

I - 9145 - Gauge Shutter Failure - Ascend Performance Materials Operations LLC - Alvin, Texas

On January 10, 2014, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on an Ohmart Vega model SGLG gauge containing a 500 millicurie cesium-137 source was found stuck in the open position. Open is the normal operation position of the gauge shutter. The RSO stated a contractor was performing calibration of a level detector on January 9, 2014, and could not get the gauge shutter to close. The contractor sprayed the shutter with a light oil and attempted to rotate the handle and operating arm. While trying to free the shutter, the operating arm separated from the gauge. The contractor was able to insert the operating rod into the gauge, but the shutter would not move. The gauge is scheduled for replacement. No violations were cited.

File closed.

I - 9146 - Lost/Recovered Moisture/Density Gauge - MLA Labs, Inc. - Austin, Texas

On January 16, 2014, the licensee notified the Agency that it had lost a Troxler Model 3440 moisture/density gauge containing one 40 millicurie americium-241/beryllium source and one 8 millicurie cesium-137 source. One of the licensee's technicians left a job site in western Travis County and when he was within a few blocks of the licensee's office in Austin he discovered the tailgate was down and the gauge was missing from the back of his truck. He immediately called the contractor at the job site and the licensee's radiation safety officer (RSO). The contractor and licensee's staff searched the construction site area and the technician's route of travel, but the gauge was not found. The RSO reported that the technician stated he had secured the gauge and closed the tailgate before leaving the site. However, the RSO stated that when the technician returned to the office he observed two chains and two locks in the back of the truck but the locks were open. The licensee notified local law enforcement and the Agency notified several area fire departments and the Texas Association of Pawnbrokers. On January 17, 2014, a concrete contractor, who had been working in the area the day before, stopped by the site to see if someone was missing a gauge. He had found it the previous morning on the side of the road near the site. The RSO was contacted and he retrieved the gauge. The locks on the transport case lid were secure and there was no damage to the case or the gauge. The licensee determined from its investigation that the technician had failed to follow procedures for transporting the gauge and had not secured it to the truck. The licensee reported it will increase training and institute periodic checks weekly of the condition of the chains and locks and their proper use by all employees. Three violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9147 - Lost Equipment Containing Radioactive Material - The Quaker Oats Company - Dallas, Texas

On January 21, 2014, the Agency was notified by the licensee that while conducting a routine source inventory it could not find a beverage fill device containing a 100 millicurie americium-241 source. The licensee stated the unit was removed from the production line several years ago and placed in storage. The licensee stated the source shutter on the device was locked in the closed position when it was placed in storage. The device was a Pepco Controls Corporation Model Gamma 101P that was used for beverage fill level detection. The Health, Safety and Environmental Manager (HSEM) stated no known employee exposures have occurred as a result of the loss of this device. Personnel at the facility and facility contractors had no knowledge of the source's whereabouts. No scrap metal was identified as radioactive or returned to the company. Per the HSEM, the facility's security company will begin documented visual checks of the site's radiation sources at regular intervals. In addition, the radiation refresher training has been updated to include the lessons learned from this event, radiation devices' locations, and specific regulations regarding the restriction of moving devices. The audience for the updated training shall include contractors on site, employees and all new hires going forward. This includes a safety check-list to be signed off by all contractors and employees before beginning work in the facility. No violations were cited.

File closed.

I - 9148 - Licensed Facility Broken Into - Fox NDE LLC - Abilene, Texas

On January 22, 2014, the Agency was notified by the licensee that an individual had broken into its facility. The licensee's radiation safety officer (RSO) stated the individual removed various items including extension cords and a generator. The RSO stated there was not an apparent attempt to access the radioactive material stored at the site. The RSO reported the individual who broke into the facility was apprehended by local law enforcement while still on the premises. The RSO stated the individual was not a previous employee. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9149 - Badge Only Overexposure - Element Materials Technology Houston Inc - Houston, Texas

On January 22, 2014, the licensee notified the Agency that it had received a report from its dosimetry processor indicating one of its employees had received 11.27 rem DDE on his dosimetry badge for the exposure period of December 1, 2013, to December 31, 2013. The licensee conducted an investigation and determined that the employee, an industrial radiographer trainee, left his jacket, with the dosimetry badge inside, in the bay after his shift one night. He recovered his jacket the next day. The licensee assigned the trainee a dose of 416 millirem for the month of December. The trainee was counseled and assigned non-radiological duties for 30 days. Training was conducted with all radiography personnel. No violations were cited.

File closed.

I - 9150 - Stolen Moisture/Density Gauge - HTS Inc. Consultants - Houston, Texas

On January 29, 2014, the Agency received notice from the licensee that a Troxler model 3430 moisture/density gauge had been stolen along with one of its trucks. It was not believed that the gauge was the target of the theft. The gauge contained an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The licensee filed a police report and the Agency sent a notice to the Texas Association of Pawnbrokers. The licensee conducted additional training regarding gauge security for all of its employees. The device was not recovered. No violations were cited.

File closed.

I - 9151 - Overexposure - NQS Inspections LTD - Corpus Christi, Texas

On January 29, 2014, the Agency received a report from the licensee stating two of its radiographers had exceeded the annual DDE exposure limit for the year 2013. The licensee reported one individual received 5,130 millirem and the other received 7,495 millirem. The licensee stated neither individual was still employed by its company, but it had sent notices to their last known addresses. The Agency performed an on-site investigation on March 13, 2014. During the investigation, the Agency found the exposure information for the two individuals was incomplete. No explanation for the overexposure could be identified. One of the two individuals was contacted by the Agency, but he could not provide an explanation for the high exposure. The Agency's attempts to contact the second individual were unsuccessful. On March 18, 2014, the Agency received updated exposure records for the individuals from the licensee. The reported exposures had increased to 6,231 millirem and 8,326 millirem. The licensee's corrective actions included the hiring of additional personnel to manage its records, it held safety meetings with its employees and reviewed the event, and it instructed all its employees to stop work any time they lose control of their dosimetry on a job. Two violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9152 - Equipment Malfunction - Texas Gamma Ray LLC - Houston, Texas

On January 31, 2014, the licensee notified the Agency that one of its radiography crews had been unable to retract a 19 curie iridium-192 source into a SPEC 150 exposure device while performing radiography at a field location. The radiographers were testing a pipe when a second pipe fell on the guide tube and crimped it enough that the source could not be returned to its shielded position. The radiographers contacted their manager and informed him of the problem. Two individuals qualified to retrieve sources went to the location. They were able to reshape the guide tube enough to retract the source. No overexposures occurred due to this event. The guide tube was disposed of. The radiographers received additional training in setting up a work site to prevent damage to their equipment. No violations were cited.

File closed.

I - 9153 - Device Containing Radioactive Material - CMC Steel Texas - Seguin, Texas

On January 29, 2014, the Agency was notified by a steel mill that it had found a device containing radioactive material in a car body in a load of scrap metal that had been brought in to its facility. Labeling on the device indicated it contained 6.25 microcuries of radium-226. The Agency's investigation revealed it was an Alnor Type 7000 dew point machine and it is a General License device. The Agency attempted to identify the original owner or a recent owner through the manufacturer and a service company whose labels were on the machine, but was unsuccessful. The steel mill will ensure proper disposal of the radioactive material. No violations were cited.

File closed.

I - 9154 - Inability to Retract Source - Fugro Consultants - Houston, Texas

On February 5, 2014, the Agency received notice that on February 3, 2014, the licensee was unable to retract an 84.5 curie iridium-192 source. The camera and guide tube had fallen from a 22 inch pipe while in use. This caused damage to the guide tube near the camera. The source was retrieved according to license conditions. The retrieval employee received 9 millirem from the retrieval. No member of the public was exposed at rates above the regulatory limit. The damaged equipment was retired from service and will be replaced. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9155 - Radiography Source Disconnect - Texas QA Services, Inc. - Grand Prairie, Texas

On February 7, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that a source disconnect had occurred on February 6, 2014. The disconnect occurred while radiographers were working at a field location using a QSA model 880D exposure device with a 39 curie iridium-192 source. The radiographers had been working in a shooting bay for about five hours when they were unable to retract the source. The RSO responded to the site and performed the source retrieval. He reported that the guide tube had been positioned with a sharp bend near the collimator which caused the source to become jammed and disconnect from the cable. Following the retrieval, the exposure device and drive cable connectors were checked with a "go-no go" device and both passed. No individual received any exposure that exceeded regulatory limits and no member of the public received any exposure as a result of this event. No violations were cited.

File closed.

I - 9156 - Radioactive Material Found - Tyler Pipe - Tyler, Texas

On February 11, 2014, the Agency received notice that a small bottle containing uranium oxide was found in an old laboratory in what used to be a metal foundry. The amount contained in the bottle falls within general license criteria. No violations were cited.

File closed.

I - 9157 - * _____ - NIX Healthcare System - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

No violations cited.

File closed.

Incidents Opened First Quarter 2014

I - 9158 - Transportation Event - US NDI LLC - Abilene, Texas

On February 17, 2014, the Agency was notified by the licensee that one of its trucks carrying a QSA 880D exposure device containing a 79.7 curie iridium-192 source was involved in a traffic accident. The licensee's truck was struck when another driver ran a red light and hit the licensee's vehicle. The radiographer performed surveys around the truck and found the dose rates to be normal. He then opened the darkroom door and found the camera was still in the transportation container. The radiographer inspected the camera and performed a survey of the camera. The camera was not damaged and radiation levels were normal. The licensee sent a radiography crew who retrieved the camera. The licensee reported no individual received any exposure to radiation due to this event. No violations were cited.

File closed.

I - 9159 - Gauge Shutter Failure - Calfrac Well Services Corporation - San Antonio, Texas

On February 24, 2014, the Agency received a reciprocity request from a company from the State of Tennessee to perform emergency repairs on a Berthold model LB 8010 nuclear gauge containing a 20 millicurie cesium-137 source. The Agency contacted the Texas licensee and asked if there had been a shutter problem with the gauge. The licensee stated on February 24, 2014, while it was moving the gauge from one location to another, one of its employees noted the operating arm on the shutter appeared bent. The employee attempted to straighten the operating arm and it broke off the gauge. The gauge was placed in the licensee's storage location. The licensee contacted the manufacturer who repaired a bracket weld on the source pipe on February 25, 2014. The gauge was then returned to service. The licensee stated no personnel received any significant exposure from the event. No violations were cited.

File closed.

I - 9160 - Overexposure - Thermo Process Instruments LP - Sugarland, Texas

On February 6, 2014, the Agency received a report from the licensee stating one worker had exceeded the annual deep dose equivalent (DDE) exposure limit for the year 2013. The individual was initially reported to have received 5,035 millirem. However, the licensee's subsequent re-evaluation of the employee's exposure for the year revealed a large overestimate for a particular exposure. After an adjustment of quality factor for that exposure by the dosimetry provider, the total DDE for the year was reduced below limit to 3,897 millirem. No violations were cited.

File closed.

I - 9161 - Therapy Event - University of Texas M.D. Anderson Cancer Center - Nassau Bay, Texas

On March 4, 2014, the registrant notified the Agency that on March 3, 2014, it was reviewing a patient's file and discovered that on January 7, 2013, a therapy event involving a linear accelerator may have occurred. Following a thorough investigation by the registrant, it determined--and the Agency agreed--that a reportable event had not occurred. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9162 - Stolen Gauge - Ulrich Engineers, Inc. - Houston, Texas

On March 7, 2014, the Agency was notified by the licensee that one of its vehicles had been stolen. The vehicle was transporting a Troxler model 3340 moisture/density gauge. The gauge contained a 40 millicurie americium-241/beryllium source and an 8 millicurie cesium -137 source. The licensee notified local police. Neither the vehicle nor the gauge has been recovered. The licensee updated its reporting procedures and trained staff on the importance of radioactive gauge safety, handling, storage, and theft prevention. No violations were cited.

File closed.

I - 9163 - Radiography Source Disconnect – AXIS, Inc. - Culberson County, Texas

On March 10, 2014, the Agency was notified of a radiography source disconnect that occurred on March 6, 2014. Two radiographers were performing radiography using a QSA 880D exposure device containing a 92.2 curie iridium-192 source. The radiographers were performing rechecks of welds that had been repaired. After the first exposure, one of the radiographers approached the camera and disconnected the guide tube from the exposure device. He then went to the end of the guide tube and picked it up by the collimator. The radiographer felt the source moving down the guide tube and dropped the guide tube to the ground. The radiographer saw the end of the source pig tail sticking out of the guide tube and told the other radiographer to stay clear of the area. The radiographers contacted another radiographer in the area who retrieved the source. There were no over exposures due to this event. The investigation determined there was no disconnect, but the radiographers failed to connect the source pig tail to the drive cable. The licensee required the radiographers involved in the event to attend a 40-hour radiation safety course. The licensee also retrained all of its radiographers on its equipment check list and increased its field inspections to quarterly. The licensee and radiographer were cited for violations.

File closed.

I - 9164 - Abandoned Well Logging Sources Down Hole - Weatherford International, LLC - Henderson County, Texas

On March 10, 2014, the Agency was notified that a well logging tool was being abandoned down hole in a well in Henderson County, Texas. The top of the logging tool, which contained a 5 curie americium-241/beryllium source and a 1.5 curie cesium-137 source, was estimated to be at 14,620 feet measured depth (MD). The directional well bore was being drilled through a casing window at 12,300 feet MD. A bridge plug was set in the casing just above the window and 285 feet of red dyed cement was placed on top of the plug with a whipstock, to serve as a deflection device, set directly above the cement plug at 11,974 feet. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A plaque has been ordered to mount at the well head 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 current plan is to sidetrack the well above the whipstock. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9165 - Stuck Shutter - OEXA Chemical - Bishop, Texas

On March 11, 2014, the Agency received notice that an Omhart Vega SH-F1A nuclear gauge containing 12 millicuries of cesium-137 failed to close during testing. The gauge was left open and operational until repairs could be completed on March 21, 2014. It was found that some rust and other debris was the cause. No violations were cited.

File closed.

I - 9166 - Stolen Radioactive Material - Paradigm Consultants, Inc. - Houston, Texas

On March 11, 2014, the Agency was notified by the licensee that a Humboldt model 5001EZ moisture density gauge containing a 40 millicurie americium-241/beryllium source and a 10 millicurie cesium-137 source had been stolen out of one of its trucks at a temporary job site. The technician had placed the gauge inside its transport case, which was secured with 2 chains and locks to the bed of the truck, but failed to secure the case lid. The gauge handle was locked to secure the source rod. He left the immediate area to speak with the site foreman and when he returned about 30 minutes later the gauge was gone. An immediate search of the area was unsuccessful and the licensee notified the Agency and local law enforcement. The gauge was returned to the licensee the next morning. A worker at the construction site had found the gauge approximately one half mile away as he was leaving work. He could not locate the technician so he took the gauge home for the night. There was no damage to the gauge and the handle was still locked. One violation was cited.

File closed.

I - 9167 - Overexposure - Acuren Inspection, Inc. - La Porte, Texas.

On March 13, 2014, the Agency was notified by the licensee's site radiation safety officer (SRSO) that a radiographer trainee may have received an overexposure while performing radiography at a field site on March 12, 2014. The SRSO stated that the trainee was trying to remove the guide tube from an exposure device, a QSA 880 containing a 69 curie iridium-192 source, when he discovered the source had not been retracted to its fully shielded position. The Agency conducted an on-site investigation on March 26, 2014. The investigation found that the radiographer who had attached the drive assembly to the exposure device failed to connect the source pig tail to the drive cable prior to attaching the drive assembly. On April 20, 2014, the licensee notified the Agency that, based on the information gained during a reenactment of the event, it had assigned a dose of 3.960 rem to the radiographer's hand and a total effective dose equivalent (TEDE) dose of 12.0 rem for the event. This brought his annual exposure to 15.680 rem to the hand and the TEDE dose to 12.369 rem. The licensee suspending the trainer's qualifications and conducted company-wide stand down meetings to review the event with all personnel. The licensee also removed the trainees involved in the event from duties involving radiography work for the remainder of 2014 and required its SRSOs to perform five unannounced audits of its radiographers. The licensee and the radiographer trainer were cited for multiple violations.

File closed.

Incidents Opened First Quarter 2014

I - 9168 - Lost Equipment Containing Radioactive Material - Alcon Laboratories, Inc. - Fort Worth, Texas

On March 14, 2014, the licensee notified the Agency it was unable to locate a gas chromatograph device that contained a 15 millicurie nickel-63 source during a routine six month inventory. The source was contained within an electron capture detector inside the Agilent 6890A gas chromatograph (GC). The GC had been stored in an obsolete laboratory with other equipment. In the last quarter of 2013, equipment was sold as surplus or disposed of at a metal recycling center. The licensee reported there were no records of surplus and the unit was so obsolete it was most likely discarded as scrap metal. Wipe tests were performed at the metal recycling center for possible residue or contamination. The results were less than .012 microcurie. The licensee submitted a report with corrective actions. Each GC will be tagged with a label containing instructions that the RSO be contacted before moving or surplusing the instrument. Training was conducted to reinforce information that any device leaving the facility will have a general safety inspection by trained staff to identify any sources before the device/instrument is sold, donated or disposed. One violation was cited.

File closed.

I - 9169 - Therapy Event - Targeted Stereotactic Radiation Cancer Center, LLC - Houston, Texas

On March 25, 2014, the registrant reported to the Agency that a therapy event had occurred at its facility. During a course of treatment, one fraction was delivered using the wrong energy. Two therapists were treating the patient--one therapist was controlling the machine while the other was inside the room setting the field on the patient. There was no verbal or visual confirmation between the two therapists. The plan loaded in the machine did not match the field resulting in the incorrect energy for one block of the treatment. The patient was notified. Although a different energy level was used, the total dose for the treatment only varied by 1%. No adverse effects to the patient are expected. A new protocol will require three points of verification by both therapists involved including the electron block, the room monitor, and the physician's field drawn on the patient. Training was conducted with all staff. No violations were cited.

File closed.

I - 9170 - Possibly Contaminated Individual - Southwest Immunodiagnostics - San Antonio, Texas

On March 25, 2014, the Agency received notice from a nuclear diagnostic facility of an incident involving an individual contaminated with technetium-99 metastable. The contamination consisted of a small spot on his clothing found after the diagnostic study was completed. The patient was contacted and reported that he had not been working with any radioactive materials since the termination of his license. It is likely that the contamination occurred while the patient was waiting for his scan. A small drop of liquid could have transferred if the individual crossed his arms after injection. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9171 - Nuclear Pharmacy Error - Rio Grande Nuclear Pharmacy, LLC - El Paso, Texas

On March 26, 2014, a nuclear pharmacy licensee reported to the Agency that two separate patients at two separate facilities each received a 5 millicurie dose of technetium-99m MAA instead of a 5 millicurie dose of technetium-99m mebrofenin that was ordered. The licensee was notified by one of its customers that after administering the dose to one of its patients, activity was only showing in the lungs instead of the hepatobiliary region like normal. The licensee attempted unsuccessfully to notify its other customer who had ordered the same radiopharmaceutical before the dose was administered to its patient. No adverse patient outcomes are expected and the patients were re-scheduled to receive the correct diagnostic agent. To prevent recurrence, the licensee will no longer store MAA and mebrofenin in the same location in its pharmacy. The licensee instructed staff involved about keeping the kits separate and provided training on the differences in appearance between the two kits. No violations were cited.

File closed.

I - 9172 - Stolen Radioactive Material - CNA Metals, LTD - Stafford, Texas

On March 28, 2014, the Agency received a letter from the licensee stating it had determined a Thermo Niton model XLP-818Q analyzer, containing 30 millicuries of americium-241, had been stolen by one of its employees. The licensee stated that after several weeks of no contact with the employee, it began trying to locate him. Its attempts were unsuccessful. The licensee contacted local and federal law enforcement. The licensee's radiation safety officer stated he did not believe any individual would receive any exposure due to this event. The licensee reported that neither the employee nor the device has been located. The licensee was unable to provide the Agency with proof the analyzer was taken by the employee. The licensee will continue to search for the device. No violations were cited.

File closed.

Incidents Opened First Quarter 2014

I - 9173 - Lost Source of Radioactive Material - University of Texas Southwest Medical Center – Dallas, Texas

On March 31, 2014, the Agency was notified by the licensee that it could not locate a 134 microcurie iodine-125 seed source. The source was placed in a patient as part of a two seed treatment on March 17, 2014. On March 18, a specimen with the seeds included was removed from the patient. The specimen was surveyed and verified to have radioactive material, but the activity was not verified. The licensee removed one seed from the specimen and placed it in a lead container. The patient was surveyed to verify all seeds were removed. The individual who removed the single seed stated they surveyed the specimen after removing the seed and did not detect any activity. On March 19, 2014, the specimen was radiographed and a single small rod shaped metal object was seen in the specimen. The individuals looking at the slides of the specimen decided the metal object was a metal clip. The specimen was then processed for slide blocks. This requires the use of large quantities of water. On March 24, 2014, an inventory of the iodine seeds indicated one of the seeds was missing. On March 25, 2014, the licensee conducted a search of the treatment area for the missing seed. A radiologist and a surgeon reviewed the slide of the specimen and determined the metal rod in the specimen was in fact the second seed and not a metal clip. The licensee believes the seed was lost down the drain when the specimen was being prepared to make the slides. The licensee surveyed the slide preparation area and the drain system several times in an attempt to locate and recover the source. The source was not located. No exposure to members of the general public is likely due to this event. No individual would have received a significant exposure to their hand during the preparation of the slides. Personnel who perform this procedure received additional training to prevent recurrence of this type of event. The licensee's notification procedure was modified to require immediate notification to the radiation safety group for this type of event. The licensee was cited for one violation.

File closed.

I - 9174 - Radiography Source Disconnect - Big State X-Ray - Odessa, Texas

On March 26, 2014, the Agency received information during a complaint investigation (C-2550) that a radiography source disconnect had occurred at a temporary field site on November 12, 2013. The Agency contacted the licensee. The licensee reported that the radiography crew had been using a QSA model 880D exposure device that contained a 66.7 curie iridium-192 source. The licensee's radiation safety officer reported he had inspected the equipment following the disconnect and subsequent source retrieval. He found that the equipment showed abnormal wear and he could not connect the controls without making a complete pigtail connection. He determined the pigtail had not been properly connected. The source was retrieved without any overexposures and the drive cable was replaced. The licensee failed to report the incident to the Agency. One violation was cited.

File closed.

Incidents Opened First Quarter 2014

I - 9176 - Potential Laser Injury - University of Texas Health Science Center - San Antonio, Texas

On March 26, 2014, the registrant notified the Agency that a potential laser injury event had been reported by one of its employees. The employee was examined by a physician who reported there was no injury. The registrant conducted a thorough investigation and reported its findings to the Agency. It was determined that this was not a reportable event. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9113 - Unable to Retract Radiography Source - Mistras Group, Inc. - Tilden, Texas

On September 16, 2013, the Agency received notification from the licensee that on September 12, 2013, one of its radiography crews working at a temporary work site in Tilden, Texas, had been unable to retract a 99 curie iridium-192 source back into its SPEC 150 exposure device. After several attempts, the connector on the end of the drive cable came off which allowed the cable to come all the way through the device and left the source inside the guide tube. Source retrieval was performed by an authorized person who received 120 millirem, an assistant who received 55 millirem, the radiographer trainer who also assisted received 100 millirem (including the day's work) and the radiographer trainee who received 32 millirem (including the day's work). No member of the public received any radiation exposure as a result of this event. On November 25, 2013, the Agency conducted an onsite investigation and interviews of the radiographers and found no personnel errors. Additionally, the licensee presented records showing inspections of the cable over the last four quarters. The licensee had the crank assembly, cable, and connector evaluated by the two manufactures who built and tested the cable. The end connector on the cable appeared to fail due to cycling and excessive use over the last two years. The licensee purchased all new crank-out assemblies for its exposure devices. No violations were cited.

File closed.

I - 9114 - Unable to Retract Radiography Source - Mistras Group, Inc. - Tilden, Texas

On September 16, 2013, the licensee notified the Agency that on September 13, 2013, one of its radiography crews had been unable to retract a 99 curie iridium-192 source back into a SPEC 150 exposure device at a temporary work site in Tilden, Texas. The radiography crew, using the same camera, had experienced a source disconnect the previous day (see I-9113). Then, following the first exposure of the morning, the source pigtail would not retract fully into the device. An authorized person performed the source retrieval. This individual received 20 millirem and the individual that assisted him received 10 millirem. The licensee's radiation safety officer inspected the source guide tube using a scope and found that the end piece that connects to the camera was not crimped onto the guide tube properly which caused some obstruction to the source. The source guide tube was inspected by the repair facility which had crimped on a new swivel end piece. The retest for the source tube after repair included cycling a dummy source in and out of the source tube, including a 250 pound pull test, five times. The repair facility performed the test and it failed when the source tube was at specific angles. The repair facility changed retest procedures to conduct a visual inspection inside the source tube with a bore scope. On November 25, 2013, the Agency conducted an on-site investigation, interviews of the radiographers, and found no personnel errors. No violations were cited.

File closed

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9116 - * - Brownsville Doctors Hospital LLC - Brownsville, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 9131 - Overexposure - Renegade Services - Anderson, Texas

On October 25, 2013, the Agency was notified by the licensee's corporate radiation safety officer (CRSO) that the licensee had received a call from its dosimetry processor informing it one of its employees had a badge reading of 7,077 millirem, which exceeded the annual occupational dose limit. On November 27, 2013, the licensee contacted the Agency and stated it was not able to dismiss the exposure. The Agency conducted an on-site investigation on December 5, 2013. During the interviews it was noted that the individual had worn the same OSL dosimeter from June 2012 through March 2013. It was also noted the individual's exposure for the second quarter 2013 was not recorded. The CRSO stated he would provide the second quarter exposure information for the individual to the Agency. The CRSO stated the exposure recorded on the March 2013 reading would be assigned to 2012 and 2013 based on the number of months the badge was worn in each year. This would lower the exposure for 2013 to below the limit. The CRSO stated the individual would have handled material containing iridium – 192, scandium – 46, and iodine – 131 while performing his duties. The CRSO stated he would carry multiple vials of material containing less than 7 millicuries each, but he could have carried as much as 400 millicuries on his truck at a time. The licensee stated the individual was removed from all duties involving exposure to radiation for the remainder of the 2013 year. The CRSO stated he has issued self-reading dosimeters (SRD) to all the employees performing work with radioactive material. The CRSO stated he would review the weekly SRD readings for all employees. On February 19, 2014, the CRSO provided the exposure records for the individual which included the second quarter 2013 reading of 5,642 millirem and corrected dose for the first quarter 2013. The employee's total corrected DDE exposure was 10,011 millirem for 2013. The licensee was cited for three violations.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9133 - Overexposure - Metrostat Diagnostic Services - Garland, Texas

On November 4, 2013, the Agency was notified by a registrant that it had received a multiple employer exposure report for an employee that it had hired in October 2013. The report indicated that the employee had received a total annual dose of 5,700 millirem at the end of the second quarter of 2013, which exceeds the regulatory annual dose limit. The Agency had not received a report of an overexposure from the registrant the employee had previously worked for. A review of the exposure report provided to the Agency revealed a second employee who had also exceeded the annual exposure limit. On November 22, 2013, the registrant's RSO where the overexposures had occurred contacted the Agency and stated he was unaware of the issue and would provide a report to the Agency. The registrant's investigation found that both employees had exceeded the annual limit. The RSO stated in the future he would review all exposure records, send copies of the reports to his employees, and have them acknowledge their exposure. The RSO contacted the dosimetry processor and had additional notification levels put in place to help prevent a recurrence. The RSO provided additional training for all of the registrant's badged employees. One violation was cited.

File closed.

I - 9136 - Radiography Source Disconnect - Texas Gamma Ray, LLC - Houston, Texas

On November 20, 2013, the licensee notified the Agency that on November 19, 2013, one of its radiography crews experienced a source disconnect at a temporary field site while using a SPEC 300 exposure device that contained a 91 curie cobalt-60 source. The disconnect occurred on the first exposure of the day. Authorized persons performed the source recovery and no overexposures occurred as a result of this event. The licensee's radiation safety officer reported that during an inspection of the equipment immediately following the event he and four other employees observed that the spring on the source connector was not operating properly and was not putting any pressure on the ball from the drive cable connector. The exposure device was sent to the manufacturer for an evaluation. The manufacturer was unable to duplicate the spring failure reported by the licensee. It did note that the source connector was worn and deformation had occurred; however, it could not replicate a disconnect. The manufacturer replaced the source connector. As corrective action, the licensee reported it will continue to send the exposure device to the manufacturer routinely for maintenance and evaluation, it will take photos on a monthly basis to share with the manufacturer on the size and wear of the new connector in order to create a record on the wear and tear of the connector when it is used in everyday conditions, and the licensee's radiography staff will continue to challenge the connection when attaching the drive cable to the source. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9137 - Equipment Malfunction - QualSpec Services, LLC - Corpus Christi, Texas

On November 22, 2013, the Agency was notified by the licensee that on November 20, 2013, one of its radiography crews was unable to retract a 55 curie iridium-192 source into a QSA 880D camera. The radiography crew was performing work on a job that required the use of an 18 inch stainless steel extension tube sold by the manufacturer for use with the guide tube. Following the fifth of five shots, when they attempted to retract the source it would not move. The radiographers contacted the licensee's radiation safety officer (RSO) who responded to the location. The source was retracted and was returned to the fully shielded position. The RSO believes that over time the extension guide tube walls had weakened and collapsed to a point where the source drive cable could not pass through it. The RSO stated no one had exceeded any exposure limits. No other individuals received any exposure due to this event. The RSO submitted an amendment for the license and is aware of the notification timeframes for any future event reporting. The license was amended December 16, 2013, to add another authorized person for source retrieval. Two violations were cited.

File closed.

I - 9138 - Transportation Event - Mistras Group, Inc. - Andrews, Texas

On November 22, 2013, the Agency was informed by the emergency management group in Odessa, Texas, that an accident involving an industrial radiography truck carrying two radiography cameras had occurred near Andrews, Texas. The Agency contacted the licensee and the licensee's radiation safety officer reported the driver had hit a patch of ice on the road and rolled over several times. Both of the QSA Model 880 cameras, each loaded with an 85 curie iridium-192 source, breached the storage location inside the truck's darkroom. Another of the licensee's radiographers was following the truck and provided aid until emergency response personnel arrived at the scene. The second radiographer then located the cameras near the dark room and performed radiation surveys of them. Dose rates were found to be normal. The radiographer maintained control of the cameras until licensee's staff came from its Midland, Texas, location and picked them up. There were no overexposures to any individual as a result of this event. The driver of the truck that turned over had been taken by ambulance to a local hospital's emergency department following the accident. The driver was examined and released after approximately 5 hours. The cameras were sent to the manufacturer for inspection. The manufacturer stated neither camera had been damaged during the event. The manufacturer performed leak tests on both cameras and the results were satisfactory. The cameras were released by the manufacturer for continued use. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9140 - Equipment Malfunction - Steris Isomedix Services - El Paso, Texas

On December 2, 2013, the Agency received information from the licensee that on November 29, 2013, the drive mechanism on a Nordion JS-8900 (continuous) pool-type irradiator had failed to completely lower one of the source racks into the fully safe position at the bottom of the pool. The source rack was completely lowered into the pool by venting the source hoist air cylinder. The licensee has reported that the root cause was debris in the air system which caused the solenoid to get stuck, thus preventing the source hoist piston from completely lowering the source rack. The solenoid valve spools were replaced, the source cycled several times, and normal operation continued. To prevent recurrence, the licensee installed an air filter on the pneumatic line. No violations were cited.

File closed.

I - 9141 - Stolen Radioactive Material - Associated Couriers - Rowlett, Texas

On December 9, 2013, the Agency was notified that a molybdenum-99 generator, containing 5.7 millicuries, was stolen from a general licensee common carrier's vehicle in Rowlett, Texas. On the morning of Saturday, December 7, 2013, the generator, along with nineteen others, was loaded from the carrier's warehouse in Dallas, Texas, onto one of the carrier's vehicles. The vehicle was attempting to meet another of the carrier's tractor trailers to transfer the shipment. The generators were being returned to the manufacturer in Missouri. The meeting had to be aborted due to extreme ice/snow conditions in the Dallas area. The driver could not return to the warehouse due to the weather and traffic gridlock. He took the vehicle to his residence in Rowlett, Texas. When he got back into the vehicle on Monday, December 9, 2013, at approximately 8:30 am, he found that the vehicle's door locks had been compromised with some sort of tool and personal items were stolen. The cargo area of the van was also breached in the same manner and one of the generators was missing. Local law enforcement (LLE) was notified as well as the company that had shipped the generator. The carrier has followed up and reported to LLE several leads associated with the use of the stolen company phone and driver's debit card. The generator has not been located as of January 8, 2014, nor has there been any new information. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in First Quarter 2014

I - 9142 - Exposure to Member of the Public - Wilco NDT - Seminole, Texas

On December 11, 2013, the Agency was notified by the owner of a manufacturing company that an incident occurred at its facility involving industrial radiography of a pressure vessel. The reporting individual stated that the site foreman was working with the industrial radiographer. The radiographer and foreman approached the pressure vessel to check and discuss film position. While he was walking away from the vessel and camera, the radiographer kicked the crank out mechanism and realized the source had not been retracted and was still in the collimator. The industrial radiography licensee's radiation safety officer (RSO) was contacted by the Agency the day of the incident report. The RSO reported the radiographer was using a 67 curie iridium-192 source in a SPEC-150 camera. The amount of exposure, which had been reduced by the collimator, was calculated and dose was assigned to the radiographer and member of the public (site foreman). The radiographer reported that he touched the collimator for approximately 10 seconds, which resulted in a calculated dose of 9.88 rem to his hand. The calculated whole body doses were 2.06 rem for the radiographer and 515 millirem for the foreman. The radiographer and the site foreman were evaluated and released by medical facilities. The radiographer was not following proper procedures or using personnel monitoring equipment or a survey meter. The licensee terminated the radiographer's employment and retrained all other personnel on policy and procedures. Four violations were cited.

File closed.

I - 9143 - Abandoned Well Logging Sources Down Hole - Halliburton Energy Services - Webb County, Texas

On December 17, 2013, the Agency was notified by the licensee that a 15 curie americium-241 source, a 1.5 curie cesium-137 source, and two small check sources were to be abandoned down hole in a Webb County, Texas, well. The top of the logging tool is at a depth of 8,433 feet. A 400-foot red dyed cement plug was placed starting at the top of the tool and a whipstock was set above the cement plug. A permanent plaque has been ordered for placement at the well head 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 in a Previous Quarter and Closed in First Quarter 2014

I-9144 - Attempted Theft of Radioactive Material - Weldsonix, Inc. - Houston, Texas

On Dec 30, 2013, the Agency was contacted by the licensee who reported an attempted theft of radioactive material. The licensee stated it had been notified by its security company that the alarm at its facility had been activated. When the licensee arrived at the facility, it found the building where the storage area for its exposure devices was located had been breached. Inside the building it found one barrier had been breached but the lock on the final barrier to the exposure devices was still intact. Local law enforcement (LLE) and the Federal Bureau of Investigation (FBI) also conducted investigations. Two trucks and six truck hoods were stolen. The investigations by the company, LLE, and the FBI determined that the radioactive material was not targeted by the criminals. The company installed additional security devices. The incident did not involve radioactive material. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2529 - * - Guadalupe Regional Medical Center - Sequin, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

C - 2530 - Unregistered Use of X-ray Machines - Trinity X-Ray - Fort Worth, Texas

On January 6, 2014, the Agency received a complaint alleging the facility may be operating cabinet x-ray units without registration, proper shielding, or an exposure monitoring program. An on-site investigation was performed on March 5, 2014. The facility was found to have minimal threat x-ray machines in operation without registration. The type of machine being used does not require an exposure monitoring program. The machines were found to have adequate shielding. The complaint was partially substantiated. Two violations were cited.

File closed.

C - 2531 - Illegal Laser Shows - Illumination Fireworks - Houston, Texas

On January 8, 2014, the Agency received a complaint that a company was performing laser shows illegally in the State of Texas and specifically referred to a show in Houston on January 5, 2014. The Agency's investigation revealed that the company (Company-A) had contracted with another company (Company-B) to conduct the laser show in Houston. Company-B was not registered with this Agency. The investigation revealed that previous laser shows conducted by Company-A were conducted by a properly registered company that was owned by one of Company-A's owners. Company-A will ensure that in the future it will verify laser registrations for sub-contractors. Company-B immediately submitted applications for registration. The complaint against Company-A was not substantiated. No violations were cited.

File closed.

C - 2533 - Regulatory Violations - Laser Centers of North Dallas, LLC - Carrollton, Texas

On January 16, 2013, the Agency received information that a laser facility had failed to notify the Agency of a change in its contracted licensed practitioner. The registrant did have an agreement with a licensed practitioner at all times. The registrant filed the necessary documents on January 17, 2014, notifying this Agency of the change in its contracted licensed practitioner. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2534 – Potential Exposure to Public - TECHCORR USA, LLC - Houston, Texas

On January 16, 2014, the Agency received a complaint referred from the Nuclear Regulatory Commission that a licensee may be exposing members of the public to radiation. Specifically, a worker at a facility, company-A, measured elevated levels of radiation from industrial radiography that was being performed at an adjacent facility, company-B, during extended operations at night. The worker was using his own rate meter. The worker alleged his illness over the last six months was due to the radiation he was receiving. The Agency conducted an on-site investigation over multiple visits. An optically stimulated luminescence (OSL) dosimeter was placed at company-A on the outside wall of the building closest to the fence boundary between the companies. Radiography was being conducted at company-B inside a building close to the fence line. The Agency and a radiation consultant hired by company-A measured radiation levels over a two month time period. Radiation levels were higher than expected but did not exceed any regulatory limits. The industrial radiography licensee performing radiography at company-B reported it had moved the radiography for about 6 months from a bay with concrete walls to the building with thin metal walls. The licensee moved the radiography back to the bay and radiation levels measured on company-A's property were reduced significantly. The complaint was not substantiated. No violations were cited.

File closed.

C - 2535 - Potential Exposure to Individual - Richland Hills, Texas

On January 25, 2014, the Agency was forwarded a complaint that had been received by the US Environmental Protection Agency in which an individual alleged he/she was being exposed to radiation from an unknown source. On January 25, 2014, the Agency placed four self-reading dosimeters around the individual's yard. Radiation surveys of the individual's neighborhood found dose rates to be 5 microrem per hour. There was no industry in the area that would utilize radiation. The dosimeters were retrieved on March 3, 2014. All the dosimeters read below background. The complainant was informed of the results. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2536 - Laser Injury - Spa Corpo Sano - McAllen, Texas

On January 27, 2014, the Agency received a complaint alleging that an individual had received an injury as a result of a laser hair removal procedure. The complainant further alleged that when they complained to the facility an employee made the statement made that they had burned other people and the injuries went away in two weeks. The Agency checked its records and did not find a certificate of registration for laser services or for a laser hair removal facility for the facility nor did it find a laser hair removal professions certificate of registration for either of the two persons named by the complainant. An investigation into this complaint is ongoing.

File open.

C - 2537 - Regulatory Violations - Alamo Isotopes - San Antonio, Texas

On January 31, 2014, the Agency received a complaint alleging a nuclear pharmacy is preparing unit doses of Tc-99m Tetrofosmin and Tc-99m Exametazime for distribution from non-Food and Drug Administration (FDA) approved Tc-99m kits and selling it as generic on its company website. The nuclear pharmacy was contacted and reported it receives generator kits from two facilities which are listed on FDA website as approved for manufacture of Tc-99m kits. Shipping receipts and inventory documents from each company was requested, received and reviewed. The documents support proper ordering, receipt and preparation of Tetrofosmin (Myoview) and Exametazime (Ceretek) from the pharmacy. The pharmacy website was also reviewed for labeling language as a generic. No items of violation were found. The complaint was unsubstantiated. No violations were cited.

File closed.

C - 2538 - Regulation Violation - Portable Diagnostic Services, Inc. - Dallas, Texas

On February 5, 2014, the Agency received a complaint alleging that the registrant uses x-ray techniques that expose patients to a high concentration of radiation. The Agency conducted an inspection at the facility on April 3, 2014, and an on-site investigation on April 17, 2014. The investigation determined the registrant had technique charts available for use on each unit. The Agency did not identify any violations. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2539 - NORM at Metal Recycling Facility - Oak Cliff Recycling, Inc. - Waxahachie, Texas

On February 5, 2014, the Agency received a complaint that a metal recycling facility had a large amount of pipe and other metal objects that contain naturally occurring radioactive material (NORM) and the complainant was concerned about radiation dose, about the contamination on the ground at the facility, and about the company's disposal of the items. On February 25, 2014, the Agency conducted an on-site investigation and found pipe with NORM in 6 locations. The highest radiation reading was 600 microR/hr and no soil contamination was evident. The Agency recommended consolidating all of the radioactive pipe on the back of the property. The facility was given contact information for three companies that could help dispose of the pipe. The complaint was not substantiated. No violations were cited.

File closed.

C - 2540 - Uncredentialed Technologists - Precision Cancer Center San Antonio - San Antonio, Texas

On January 26, 2014, the Agency received a complaint alleging the registrant's technologists were not credentialed. During the Agency's investigation, the registrant was able to provide credentials for its technologists. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2541 - X-ray Machine Compliance - Brazos Mobile Imaging, Inc. - Hewitt, Texas

On February 27, 2014, the Agency received a complaint alleging that in September 2012 an individual had sustained an injury that had not been correctly diagnosed by an initial x-ray. The complainant was concerned whether equipment performance evaluations (EPEs) had been performed on the x-ray machine as required and was concerned that the machine may not have been working properly. The Agency's investigation determined that EPEs were performed as required in November 2011 and October 2013 and there were no issues identified that would have affected the x-ray image. Also, the registrant had not identified machine problems nor made any repairs to the machine during the period between the EPEs. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2542 - Uncredentialed Technicians - Unidentified Facility - Austin, Texas

On March 3, 2014, a complainant left a voice message on an Agency telephone. The complainant stated he was concerned about an outpatient facility in Austin, Texas, that he alleged was allowing unlicensed persons such as scrub techs and nurses to operate x-ray equipment. The complainant left his phone number. Multiple attempts were made to contact the complainant and messages were left on the voicemail of the number he provided that contained the Agency investigator's contact information. The Agency has not received a response. Without further information, specifically the name of the facility, the investigation could not move forward and was closed.

File closed.

C - 2543 - Regulation Violations - Advanced Corrosion Technologies and Training LLC - Angleton, Texas

On March 3, 2014, the Agency received a complaint alleging that an industrial radiography licensee was in violation of numerous Agency rules which compromised the safety of the radiographers. An on-site investigation was conducted by the Agency at a temporary work site and at the licensee's facility. The investigation was able to substantiate the allegations. The licensee and radiographer were cited for multiple violations.

C - 2544 - Unregistered Laser Facility - Nail and Skin Day Spa - Round Rock, Texas

On March 5, 2014, the Agency discovered information that a facility was performing laser hair removal procedures and it was not registered with the Agency. An investigation into this complaint was conducted and determined the facility ceased performing laser hair removal in February 2014. The Agency discussed the requirements to register with the owner in the event it desired to offer laser services in the future. The complaint was substantiated. No violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2545 - Unlicensed Activity - Zetex Enterprise, LLC - Burnet, Texas

On March 5, 2014, the Agency received a phone call from an inspector in the State of Pennsylvania. The inspector stated she was told during an inspection that a device was being sent from a Texas licensee to the Pennsylvania licensee and she wanted to verify the Texas licensee was licensed to do so. The Agency's investigation revealed that the Texas licensee was performing a leak test and maintenance on behalf of the seller of the device, which was permitted under its license. The original manufacturer was to perform the actual legal transfer on behalf of the buyer and seller. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2546 - Possible Excavation of Uranium - Simpson Crushed Stone - Falls City, Texas

On March 11, 2014, the Agency received a complaint forwarded from the Mine Safety and Health Administration. The allegation was that a sand and gravel operation was excavating near the site of a former uranium surface mining operation. The information came from a Railroad Commission (RRC) employee who was trying to determine jurisdiction. The employee provided image files of the area demonstrating the location of the sand and gravel operation to the former surface mine. The information was discussed with RRC and Texas Commission on Environmental Quality (TCEQ). RRC will review to determine appropriate action.

File closed.

C - 2547 - Laser Injury - M. Pulse Texas, PLLC - Plano, Texas

On March 12, 2014, the Agency received a complaint alleging the registrant had failed to report second degree burns to the Agency. The Agency's investigation revealed that the injuries had occurred and the patients that were injured were provided appropriate medical treatment. The facility had failed to report the injuries as required. The complaint was substantiated. Violations were cited.

File closed.

Complaints Opened First Quarter 2014

C - 2548 - No Protective Equipment Provided - Elgin Veterinary Hospital - Elgin, Texas

On March 13, 2014, the Agency received a complaint alleging the registrant was allowing its employees to hold animals during x-rays without protective devices. The Agency conducted an on-site investigation at the facility on April 16, 2014. The inspection found 5 lead aprons and two full sets of gloves at the x-ray area. The registrant provided records for the annual inspections of the aprons and gloves. No discrepancies were noted. The Agency reviewed the last three years of dosimetry records for the workers and no significant exposures were noted. The Agency interviewed four employees. None of the employees had seen or heard of someone involved with performing x-rays not wearing the appropriate personnel protective equipment (PPE). The radiation safety officer stated all the employees had recently attended additional training on the proper use of PPE. The complaint was not substantiated. No violations were cited.

File closed.

C - 2549 - Uncredentialed Technician - Southwest Orthopedic Group, LLC - Sugarland, Texas

On March 17, 2014 the Agency received a complaint from a member of the public questioning the experience and qualification of a registered technician who took a mobile x-ray of the complainant. Specifically, the patient suffered a cut when her hand got caught between a bed and the x-ray machine. On March 19, 2014, the Agency verified the medical radiologic technologist was qualified and held a current license. The injury does not fall under the jurisdiction of the radiation program. The complaint was not substantiated. No violations were cited.

File closed.

C - 2550 - Regulation Violations - Big State X-ray - Odessa, Texas

On March 17, 2014, the Agency received a complaint alleging an industrial radiography licensee was not complying with a number of the Agency's rules. An on-site investigation was conducted on March 26, 2014. A subsequent spot inspection at a temporary field site was performed on April 7, 2014. No violations related to the complaint were noted. The complaint could not be substantiated. One unrelated violation was cited as part of Incident I-9174.

File closed.

Complaints Opened First Quarter 2014

C - 2551 - Regulatory Violations - Amerejuve, Inc. - Houston, Texas

On March 10, 2014, the Agency received 8 complaints, one for each of 8 locations providing service for laser hair removal. The complaints alleged that at each location there was not a Senior Laser Hair Removal (LHR) Technician or LHR Professional present as required, the consulting physician had not performed audits, the laser safety officer had not performed audits, records of LHR procedures did not include the required information, the technicians' continuing education requirements were not being met, certified LHR technicians (certificates) were not posted, and routine inspections had not been conducted by the Agency. An investigation into this complaint is ongoing.

File open.

C - 2552 - Regulatory Violations - Ideal Image - San Antonio, Texas

On March 18, 2014, the Agency received a complaint alleging that two technicians had failed to provide proper eye protection during two separate visits to the registrant's facility for laser hair removal procedures. The Agency contacted the facility and requested its procedures for eye protection. The facility explained the eye protection procedures used during treatments. The facility's consulting physician explained facial treatments and explained that at times extra precautions were used with patients by placing gauze on the eye then goggles on top the gauze to comfort the patient. Technicians are registered and do provide eye protection to the patients during laser treatment. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2553 - Laser Burns - Rain Beauty S and R, LLC - Harker Heights, Texas

On March 26, 2014, the Agency received a complaint alleging that several individuals had received injuries as a result of laser hair removal (LHR) procedures performed at a facility. The complaint also alleged that the facility did not have an LHR Professional Technician on staff at the facility and has not had one since December 2013. An investigation into this complaint is ongoing.

File open.

Complaints Opened First Quarter 2014

C - 2554 - Regulatory Violations - Link Field Services - Olney, Texas

On March 26, 2014, the Agency received a complaint alleging that radiographers were told by the licensee to remove its dosimeters and place the dosimeters in the back of the truck while conducting radiography. The Agency conducted an inspection of the licensee's facility on May 16, 2014, and an inspection of a radiography crew at a temporary job site on June 24, 2014. The radiographers observed were wearing dosimeters. The Agency discussed the allegation with the radiographers and the radiation safety officer. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2555 - Regulatory Violations - Alamo Mobile X-ray & EKG Services - Dallas, Texas

On April 1, 2014, the Agency received a complaint alleging the registrant was not performing the required testing of its x-ray devices, that personnel exposures were not being monitored by the radiation safety officer, and that extra units had been added without notification to the Agency. An on-site investigation and inspection was conducted on April 30, 2014. Paperwork insufficiencies were noted, as well as a failure to conduct initial equipment performance evaluations in accordance with recent rule changes. Subsequent phone investigation revealed that additional units were in operation in excess of the number listed on the registration. The complaint was substantiated. Six violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2014

C - 2482 - Unregistered Laser Facilities - Amerejuve, Inc. - Houston, Texas

On June 4, 2013, during a search for requested information concerning whether a laser hair removal facility was registered, the Agency found that an entity was operating multiple laser/laser hair removal facilities in the Houston area and they were not registered with the Agency. An Agency investigator contacted the entity and the entity's representative agreed to submit proper applications and fees. In August 2013 the Agency received a laser registration application and a laser hair facility registration application for only one of the locations and the appropriate fees had not been submitted for the laser registration. In October 2013 the entity's representative was contacted again. He stated they had sent only one through to make sure everything was correct/complete before they sending the others. He was advised that the entity should immediately submit all appropriate applications and fees for all of its locations. In November 2013 the entity submitted applications and fees for all locations. No violations were cited.

File closed.

C - 2501 - Uncredentialed Technologists - North East Family Urgent Care Clinic - Humble, Texas

On September 9, 2013, the Agency received a complaint that the registrant may have uncredentialed technologists taking x-rays. The Agency conducted an on-site investigation on November 18, 2013. The investigation revealed that one technologist had neglected to apply for non-credentialed technologist status with the state. The complaint was substantiated. One violation was cited.

File closed.

C - 2503 - Regulatory Violations - Blazer Inspection, Inc. - Texas City, Texas

On September 30, 2013, the Agency received a complaint alleging multiple violations against an industrial radiography licensee. On November 14, 2013, the Agency conducted an on-site investigation at the licensee's facility. The owner of the company, current radiation safety officer, and a worker named by the complainant were interviewed. Records for the time frame given by the complainant were reviewed. The inspectors also went by locations found during the record review where the licensee performed work on a routine bases. No radiography work was in progress at any site. The complainant could not provide any additional information to help substantiate the allegations. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2014

C - 2511 - Inadequate Credentialing - Mid Cities Imaging - Desoto, Texas

On October 23, 2013, the Agency received a complaint alleging the licensee was allowing individuals to perform tasks outside their qualifications. On December 16, 2013, the Agency performed an on-site inspection at the facility. The inspector found that the operation of the device was limited to an individual who was qualified to operate it. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2512 - Unregistered Laser Facility - HMMC - Katy, Texas

On October 23, 2013, the Agency determined from information provided to it that the facility was performing procedures using an intense pulsed light (IPL) device and lasers, to include laser hair removal, and they were not properly registered with the Agency. Facility representative had submitted fee and application for license/registration. Certificate of registration was issued to the facility. No violations were cited.

File closed.

C – 2513 - Regulatory Violation - Tenaris Coiled Tubes - Houston, Texas

On October 28, 2013, the Agency received a complaint alleging a temporary employee was assigned to conduct x-ray radiography and was immediately put to work using radiography equipment without training or personnel monitoring. The Agency conducted an on-site investigation on November 13, 2013. The inspectors obtained documents signed by the complainant dated prior to the date she claimed to have operated the device indicating she had received training on operation of the equipment and safety related topics such as exposure to radiation. The inspectors could not confirm the complainant ever operated an x-ray device. On December 5, 2013, the Agency was contacted by the complainant. She provided the name of the individual she stated she was with when she operated an x-ray device. The individual was contacted by the Agency and stated they never allowed the complainant to operate the x-ray device as she was still in the observation phase of her training. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2014

C - 2516 - Uncredentialed Technologist - Gregorio Rodriguez - El Paso, Texas

On October 31, 2013, the Agency received a complaint that an individual was working as a nuclear medicine technologist in El Paso, Texas, without proper credentials--specifically, a medical radiologic technologist certification--to do so. The complaint was originally received by the Professional Licensing and Certification Unit and it requested assistance with the investigation. An Agency radioactive material inspector conducted interviews with the individual, staff at two area radiopharmacies, and the individual's previous and current employer. No evidence or information was obtained that indicated the individual had performed any unlicensed activity. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2522 - Regulatory Violations - University of North Texas - Denton, Texas

On November 21, 2013, the Agency received a complaint alleging the licensee had violated several license conditions due to its termination of employment of the assistant radiation safety officer. It was alleged that license conditions were in violation when the person was removed from employment. The Agency conducted an on-site investigation on December 3, 2013. There were violations cited for not completing personnel monitoring functions and ignoring the duties of radiation safety officer. The facility has assigned and hired new personnel to perform the duties of laser safety officer, radiation safety officer and environmental technologists to complete the functions in its radiation program. The facility updated records and submitted license amendments with new names and contact numbers. The complaint was substantiated. Three violations were cited.

File closed.

C - 2523 - Naturally Occurring Radioactive Material - Lotus LLC - Andrews, Texas

On October 21, 2013, the Agency received a complaint alleging the licensee was in violation of several naturally occurring radioactive material (NORM) rules. The Agency conducted an on-site investigation on January 14, 2014. The inspectors performed radiation surveys of the area and did not find any areas of concern. The tour of the area did not find any pools of water or areas where runoff appeared to be occurring. A review of dosimetry records did not find any person had received 100 millirem for the year. The radiation safety officer stated the facility did not accept any pipes reading greater than 50 microrem per hour to insure it stays in compliance with the Agency's rules. Soil samples of the area were taken. Sample results indicated elevated levels of radium-228 near the descaling unit, but samples taken near the facility boundaries were found to be at background levels. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2014

C - 2524 - Possible Contamination - PSC Industrial Outsourcing - Deer Park, Texas

On November 21, 2013, the Agency received a complaint referred from the Texas Railroad Commission that the licensee was contaminating the environment surrounding its naturally occurring radioactive material (NORM) decontamination facility. On January 8, 2014, the Agency conducted an initial inspection of the facility and an investigation into the complaint. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2526 - Unlicensed Possession of Radioactive Material - San Antonio Nuclear Cardiovascular Services - San Antonio, Texas

On December 9, 2013, the Agency was contacted by an employee of a former licensee. The facility's medical use license, which authorized diagnostic radiopharmaceuticals, had been revoked by the Agency on November 30, 2013, due to non-payment of fees. The employee was responding to the notice of revocation and notifying the Agency that the facility was in possession of radioactive material. The Agency's investigation revealed that at the time of the facility's last inspection it only had one cesium-137 calibration source. The former licensee contracted with a consultant who performed an inventory and confirmed there was only the one source. The consultant performed a close-out survey and the source was properly transferred to another license. No violations were cited.

File closed.

C -2527 - Regulatory Violation - Dexis - Granbury, Texas

On December 10, 2013, the Agency received an internal complaint from one of its x-ray inspection managers. The inspection group found a dental office conducting training and quality assurance/quality control (QA/QC) x-rays on other staff members. In this case, a service company, which installs a device to the x-ray machine to capture and process dental images, allegedly instructed the dental office personnel to test the equipment by x-raying each other for training and QA. The dental office co-operated with Agency inspections and provided names of the representatives who instructed the dental staff to complete these x-rays to demonstrate their equipment. The complaint has been substantiated that company representatives did instruct dental employees to complete prohibited practices and further need to be registered in the state of Texas for their equipment that supports or services x-ray machines. The device/equipment company has implemented new policies and corrective actions. Two violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in First Quarter 2014

C - 2528 - Radiation Exposure To Member Of General Public - Ion Power - College Station.

On December 20, 2013, the Agency received a complaint from an individual expressing a concern over an ion bracelet he/she had purchased at a local mall. After purchasing the bracelet, the individual took it home and surveyed it with a portable radiation survey instrument and observed measurements that were greater than background. The Agency performed an on-site investigation on February 19, 2014. The inspector found the seller had sold the bracelets for a few weeks, but due to limited sales they sold the remaining stock to a person in Midland, Texas. The vendor did not have any of the bracelets, but did have several sections of various styles of bracelets. These sections were surveyed and found to be emitting low levels of beta and alpha radiation. The dose rate on contact with the sections was five microrem per hour above background. The sections were sent to the Agency's laboratory for spectral analysis. The analysis of the bracelet part indicated the presence of decay products from radium-228 at levels below regulatory concerns. The Agency found the same allegation was being investigated by the United States Food and Drug Administration and the Nuclear Regulatory Commission in various locations in this country. The Agency will track the progress of their investigations. No violations were cited.

File closed.

C - 2532 - Regulation Violations - Luxe Lasers, LLC - Austin, Texas

On December 30, 2013, the Agency received a complaint that a laser hair removal (LHR) facility in Austin, Texas, was not in compliance with the rule requiring an LHR Professional or licensed health professional to be present to provide supervision during the facility's operating hours and the machine's key was being removed but was being left in plain sight which did not prevent unauthorized access. The complainant alleged other issues that were not under the radiation rules and she was provided contact information at other agencies for those issues. The Agency's investigation found the facility was registered and the technician has a certificate of registration. No violations were cited.

File closed.