



INCIDENT AND COMPLAINT SUMMARIES FOR SECOND 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.

Copies of this report are available on the internet at <http://www.dshs.state.tx.us/radiation/incident.shtm>

Incident and Complaint Summaries
2nd Quarter 2014

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Incidents Opened Second Quarter 2014

I - 9175 - Stuck Shutters - International Paper Company - Queen City, Texas

On April 2, 2014, the licensee notified the Agency that while it was doing lockouts on fixed nuclear gauges in preparation for the annual shutdown of its facility the handles on two shutters broke. The handles sheared the roll pins. Both gauges were manufactured by KayRay. One gauge, model 7063, contained 1.5 curies of cesium-137 and the other gauge, model 7063P, contained 1 curie of cesium-137. The two gauges were mounted on digesters and used for level control. The licensee was able to close one of the shutters but the other shutter remained stuck in the open position. There was no exposure risk to any person. The licensee contacted a service company and made arrangements for the company to come on-site and make repairs. An investigation into this event is ongoing.

File open.

I - 9177 - Damaged Device Containing Radioactive Material - Hi-Tech Testing Services - Tuleta, Texas

On April 4, 2014, the licensee notified the Agency that one of its radiography crews had damaged the source guide tube on a QSA 880 Delta industrial radiography camera, which contained a 71 curie iridium-192 source, and as a result the crew had been unable to retract the source. The incident occurred at a temporary job site near Tuleta, Texas. The crew was working in elevated pipe racks and had used a rope to suspend the camera. The knot on the rope loosened and the camera dropped onto the source guide tube. The resulting crimp in the source guide tube prevented retraction of the radiography source which was extended into the collimator. A second radiography crew on the site secured its camera and placed it on the collimator to shield the source. The radiographers then called a radiation safety officer to get advice and instruction to secure the source. The crew then dragged the camera to a shielded location behind a concrete pillar. The radiographer trainees were assigned to maintain a perimeter around the camera to prevent access by any individuals. The radiographer was able to use pliers to un-crimp the source guide tube and return the source to its shielded position. The licensee changed its policies to implement suspension/hanging procedures for radiography camera(s). The individual who retrieved the source was not an authorized source retrieval person on the license. One violation was cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9178 - Radiography Source Disconnect - Midwest Inspection Services - Abilene, Texas

On April 4, 2014, the Agency was notified by the licensee's corporate radiation safety officer (CRSO) that one of its radiography crews had experienced a source disconnect while using an INC IR 100 exposure device. The device contained a 70 curie iridium-192 source. The CRSO stated the radiographers had completed a shot and noted the dose rates on the camera had not returned to normal after the source was retracted. The radiographers increased the barricaded area around the exposure device and contacted their supervisor for assistance. The CRSO stated the source was recovered a short time later by an authorized individual. No individual received an exposure which exceeded any regulatory limits. No member of the general public received any exposure. The licensee's investigation into the disconnect determined the connector on the source pigtail had expanded, which caused the locking pin to stick in the open position. This allowed the ball on the drive cable to pop out of the connector. The licensee provided additional training to its employees on performing checks on the equipment prior to use and the proper response to a source disconnect event. No violations were cited.

File closed.

I - 9179 - Abandoned Well Logging Source Down Hole - Weatherford International, LLC - Crosby County, Texas

On April 8, 2014, the Agency was notified that a well logging tool was being abandoned down hole in a well in Crosby County, Texas. The top of the logging tool, which contained a neutron source, was recovered after a week of fishing. A 1.5 curie cesium-137 source, estimated to be at 4,563 feet measured depth (MD) was abandoned after part of the tool separated. The source was abandoned in accordance with Texas Railroad Commission and Agency regulations. On April 10, 2014, a red dyed cement plug was installed and extended 207 feet above the location of the source. A whipstock was set as a deflection device above the cement plug at 4,265 feet to prevent future inadvertent intrusion on the source. 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 person reentering the well with the radiation control program contact information. No violations were cited.

File closed.

I - 9180 - Radiography Source Disconnect - Hi-Tech Testing - Carrizo Springs, Texas

On April 9, 2014, the Agency received notice from the licensee that a radiography source disconnect had occurred at a temporary field site in Carrizo Springs, Texas. The camera was a SPEC 150 and contained a 28 curie iridium-192 source. The source was retrieved. An investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2014

I - 9181 - Working Without Reciprocity - Ark-La-Tex Wireline Services, LLC - Lavaca County, Texas

On April 14, 2014, the Agency received information from U.S. Customs and Border Protection that a company with a Louisiana radioactive material license had come into Texas with a 3 curie americium-241/beryllium source to perform well logging operations on April 10 and April 13, 2014. The company did not have a Texas radioactive material license nor did it have reciprocity. The Agency contacted the company. The representative stated he had just recently become aware of the necessity for reciprocity and had started actions to get into compliance. The company stated it would immediately stop bringing the radioactive source into Texas until it obtained proper authorization. On June 2, 2014, the Agency received the required information and fee for reciprocal recognition authorization to work in Texas. One violation was cited.

File closed.

I - 9182 - Stuck Shutters - Union Carbide Corporation-Dow Chemical Company - Seadrift,

On April 14, 2014, the licensee notified the Agency that during an instrument check on Friday April 11, 2014, technicians found they could not retract the source into the housing of two Ohmart model SHLM-BR-4 level indicators, each containing a 5,000 millicurie cesium-137 source. The technicians stated there was no apparent damage to the rod or the shutter mechanisms. On April 14, 2014, the licensee was able to retract the source and close the shutter on both gauges. The licensee attempted to cycle the source again and found one gauge operated normally while the shutter on second gauge could not be fully opened. The shutter on the second gauge will fully close. There were no exposures to any employee or members of the general public. The manufacturer has been contacted to inspect and repair the gauges. The licensee reported it believed the failure was caused by failure of the pin on the operating rod which allowed the rod to jam. The licensee decided to replace both gauges. No violations were cited.

File closed.

I - 9183 - Radioactive Material Identification - Permian Nondestructive Testing, Inc. - Laredo,

On April 13, 2014, the Agency was contacted by U.S. Customs and Border Protection concerning an industrial radiography truck at the Laredo West checkpoint. When the agents had surveyed the vehicle, their radioisotope identifier identified the isotope cobalt-60 (Co-60). The radiographers only had shipping papers for a selenium-75 source that was in their exposure device. The Agency contacted the licensee. The licensee stated that even though it is authorized to possess Co-60, it does not own any Co-60 sources nor has it ever transported any in this vehicle. The licensee performed surveys of the vehicle, exposure device, and associated equipment and did not detect any elevated radiation measurements. The Agency performed a survey of the vehicle using a radioisotope identifier and did not detect any Co-60. The Agency determined there must have been an anomaly with the initial identification or there was a source of Co-60 in the area that the Customs and Border Protection agents were not aware of. No violations were cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9184 - Radiography Source Disconnect - Marco Inspection Services - Martinsville, Texas

On April 16, 2014, the Agency received notice that on April 15, 2014, a radiography source disconnect had occurred at a temporary field site near Martinsville, Texas. The camera was a QSA 880D that contained a 22 curie iridium-192 source. The radiographers used a long stick to rotate the collimator towards the ground to minimize exposure to the public and they extended their barriers. The radiographers were not able to get in contact with the licensee's radiation safety officer (RSO) who was the only individual on the license authorized to retrieve the source. The licensee made contact with the RSO but he was a long distance from the incident site. The licensee sent another individual who had been to source retrieval school to the site and he retrieved the source. No individual involved in the event exceeded any exposure limits. No member of the public received an exposure. The equipment was returned to the manufacturer for inspection. The manufacturer stated the drive cable broke due to wear and tear, a possible previous impact, and improper maintenance of the cable as evidenced by significant rust on the cable. The RSO who had performed all previous inspections and maintenance on the drive cables terminated his employment with the licensee a week after the incident. The licensee made improvements to the inspection checklist and the inspection procedure to ensure all future maintenance and inspections are conducted properly. One violation was cited.

File closed.

I - 9185 - Possible Radiation Exposure To Member of General Public - Renegade Services - Andrews, Texas

On April 17, 2014, the licensee notified the Agency that it had received a dosimetry report from its processor that indicated the monitoring badge on one of its boundary fences had been exposed to 2,426 millirem for the first quarter of 2014. The investigation into this event is ongoing.

File open.

I - 9186 - Lost Source of Radioactive Material - Texas A & M University - College Station.

On April 18, 2014, the Agency was contacted by the licensee's radiation safety officer (RSO) and informed they could not find an eight millicurie nickel-63 source. The source was part of a gas chromatograph that had been removed from service and placed in storage. The source had been leak tested last in February 2014. The RSO stated as he was reviewing the results for the April 2014 leak tests, the results for this source indicated it was not there. The RSO stated in his investigation he determined the device containing the source was sold as surplus in either February or March of 2014. The licensee notified the surplus company on April 14, 2014, of the error and asked it to hold all material sent to it by the licensee. The licensee searched the surplus entity's location but did not locate the source. The licensee has labeled all remaining equipment in the area that contains radioactive material with instructions not to remove the equipment from the area without first contacting the radiation safety group. One violation was cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9187 - * - Methodist Hospital Houston - Houston, Texas

*Health and Safety Code Chapter 241.051(d)

No violations cited.

File closed.

I - 9188 - Abandoned Source Down Hole - Protechnics Division of Core Laboratories LP - LaSalle County, Texas

On April 22, 2014, the licensee notified the Agency that it was abandoning a one millicurie barium-133 source down hole in a well in LaSalle County, Texas. The source was located at 15,729 feet measured depth. A 360-foot red dyed cement plug was set with the top at 15,420 feet. A whipstock was installed on top of the plug to act as a deflection device. The well will continue production above the plug. 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 source was abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 9189 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On May 1, 2014, the licensee reported a dispensing error that occurred when vials for technecium-99m sulfur colloidal were misidentified and went out to two customers as technecium-99m sodium pertechnetate. Four patients had unexpected images. The licensee determined the pharmacist failed to follow standard operating procedures during kit preparation and verification. Corrective actions included progressive discipline of the technician, notification of all pharmacy directors of the error, removal of all other drug vials in the compounding area while preparing vials, and additional unannounced audits of all pharmacies. No violations were cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9190 - Source Retraction Failure - METCO - Houston, Texas

On May 7, 2014, the Agency received notice that a source retraction failure had occurred on May 6, 2014. The camera was a QSA Global 880D with a 46 curie iridium-192 source. The guide tube had fallen off of the guide tube stand and crimped. The source was retrieved by the licensee by uncrimping the guide tube. No overexposures resulted from this event. The guide tube was removed from service. All other parts are removed from service pending inspection by the licensee. An investigation into this event is ongoing.

File open.

I - 9191 - Stolen Moisture/Density Gauge - The Murillo Company Geotechnical & Environmental Consultants - Houston, Texas

On May 9, 2014, the licensee notified the Agency that one of its Humboldt model 5001EZ moisture/density gauges had been stolen from the back of one of its trucks in Houston, Texas. The licensee's technician had stopped at a fast food establishment on the way to the work site. After he arrived at the work site, he found that the truck's tailgate was down, one of the locks on one of the chains securing the gauge was missing, and the gauge was missing. Within a few hours, the licensee notified the Agency that the gauge had been recovered. A member of the public had found the gauge by the side of the road. The gauge's source rod handle was still locked and the gauge was inside its transportation case. The licensee reported to the Agency at the conclusion of its investigation that it had determined the gauge had not been properly secured by the double chains and padlocks, that the chains had not been properly positioned to secure the gauge and someone was able to remove the gauge by removing one padlock. To prevent recurrence, the licensee reviewed its policies and procedures and each of its inspectors have demonstrated how their gauge is secured in their truck. Additional procedures have been implemented and chains, padlocks, and handles on the cases have been replaced where necessary. In addition, the licensee conducted an additional nuclear gauge training class for all of its inspectors to review the policies and procedures for handling and securing portable gauges. One violation was cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9192 - Medical Event - The University of Texas Medical Branch - Galveston, Texas

On May 9, 2014, the licensee notified the Agency that a medical event had occurred at its facility on May 8, 2014. A patient was administered 10 microcuries of iodine-131 (I-131) for a diagnostic study. When unexpected results were observed on the patient image, the licensee began to search for the cause of an increased uptake level of iodide in the patient. The licensee determined the patient had actually ingested 26.35 microcuries of I-131. Instead of a prescribed dose of 26 rad to the organ, the calculated dose to the organ was 68.51 rad. The licensee's investigation revealed that the increased dose to the patient resulted when a water bottle, which is used to ensure all of the radiopharmaceutical administered is ingested by the patient, contained residue from a previous I-131 therapeutic treatment on another patient. The contaminated water bottle was found and removed from procedures. The licensee changed its procedures to use a pipet/syringe method. The licensee trained all associated staff on the new procedure and added the new procedure to all manuals/charts. No violations were cited.

File closed.

I - 9193 - Gauge Shutter Failure - Seadrift Coke LP - Port Lavaca, Texas

On May 14, 2014, the licensee notified the Agency that when it was locking out sources for a shutdown on May 12, 2014, it was unable to close the shutter on one of its Ohmart-Vega fixed nuclear gauges containing a 3 curie cesium-137 source. While trying to close the shutter for the gauge, the operation handle had been broken off. The handle was placed back on the gauge and the shutter was left in the open position. While reviewing the written report provided by the licensee, the Agency discovered it also had been unable to close the shutter on a second gauge. The second gauge's shutter had also been left in the open position. Both gauges are normally operated with the shutter in the open position. The licensee contacted the manufacturer. A service company came to the licensee's facility on May 14, 2014. The service provider closed the shutter on the gauge with the broken operating handle, removed the gauge, and shipped it back to the manufacturer for repair. The service provider lubricated the operating mechanism on the other gauge and was able to free up the shutter. The gauge was returned to normal service. No licensee employee received any exposure as a result of this event. The shutters failed to operate due to a buildup of debris in the operating mechanism. The licensee has changed its procedures to increase the cycling and lubrication of all its gauge shutters. The licensee will also purchase covers for the gauges to provide some protection from the operating environment. No violations were cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9194 - Badge Overexposure - Midwest Services, LLC - Odessa, Texas

On May 23, 2014, the Agency was notified by the licensee that it had received notice from its dosimetry processor that one of its previous employees had exceeded the annual TEDE limit. The employee's April 2014 dosimetry record indicated a dose of 5,318 millirem for the year, with 4,000 millirem received during the month of April. The licensee's corporate radiation safety officer stated that based on an initial review of records it was believed the dose was to the badge only. The employee who had the high dose on his badge quit working for the licensee during the investigation due to a pay issue. He refused to provide a statement to the company or the Agency. The Agency will evaluate whether to revoke the employee's radiography trainee certification with the Agency. As a result of an investigation by the licensee, the employee's April dose was adjusted to 285 millirem based on witness statements and pocket dosimeter readings. No violations were cited.

File closed.

I - 9195 - * - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

An investigation is ongoing.

File open.

I - 9196 - Regulatory Violations - Global X-ray & Testing Corporation - Portland, Texas

On May 19, 2014, the Agency received a complaint alleging multiple rule violations had been committed by an industrial radiographer working for the licensee. On May 27, 2014, during the complaint investigation, the licensee's site radiation safety officer (SRSO) stated that on April 25, 2014, the radiographer had taken one of the licensee's radiography trucks which contained a SPEC 150 exposure device with a 23 curie iridium-192 source following completion of a job in San Antonio, Texas. The radiographer had possession of the truck and exposure device with its source until April 30, 2014. The licensee's SRSO stated they attempted during that time to contact the radiographer and to locate the truck using its GPS locator system, but they were unsuccessful. The licensee located the truck at a recreational vehicle park in Portland, Texas. An investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2014

I - 9197 - Badge Overexposure - Radiographic Specialists, Inc. - Houston, Texas

On June 2, 2014, the licensee notified the Agency that it received a dosimetry badge report from its dosimetry processor that indicated a radiographer had received 7,450 millirem for a one month monitoring period. The licensee's radiation safety officer (RSO) stated he knew the radiographer could not have received that dose because he had been in the hospital. The RSO investigated and found the radiographer had worn the badge for five days before he was involved in a car accident. The radiographer had placed the badge in the company vehicle before the accident and the badge was found by another radiographer who, after discovering it in the vehicle, had turned it in with his badge at the end of the monitoring period. The vehicle had been used on several work sites for the entire month before the badge was turned in for processing. The RSO researched the five days the individual worked and assigned a dose of 70 millirem for the period. The RSO used information from field survey results and personnel monitoring results of other individuals working with the radiographer to assign the dose. To prevent recurrence, the RSO had a staff safety meeting with all of the licensee's radiographers to explain the importance of radiation safety and instill that no monitoring badges, dosimeters, or alarming rate meters are to be left in the company vehicles. No violations were cited.

File closed.

I - 9198 - Damaged Device Containing Radioactive Material - CMC Steel Texas - Seguin, Texas

On June 3, 2014, the Agency was notified by the licensee that a Berthold model LB300ML gauge had been hit with molten steel and the attachment points for a locking mechanism and the carrying handle had been damaged. There was no damage to the 2.5 millicurie cobalt-60 source or the gauge shutter. The gauge was removed from service and placed in a locked storage box until it was repaired by the manufacturer on June 5, 2014. The licensee stated a new gauge has been ordered to replace the gauge. The licensee has changed its operating procedure to prevent the event that caused the damage to the gauge. No violations were cited.

File closed.

I - 9199 - Nuclear Pharmacy Error - Triad Isotopes - Dallas, Texas

On June 5, 2014, a nuclear pharmacy licensee reported to the Agency an error that had occurred on May 5, 2014. A hospital ordered a 30 millicurie dose of technetium-99m sestamibi. An assay performed by the hospital in its dose calibrator indicated the dose received was almost 100 millicuries. The dose was not administered to a patient. The licensee determined its technologist added more sestamibi instead of sodium chloride to reach the required dispensing volume. The technologist then failed to assay the final product. The technologist received additional training and coaching. No violations were cited.

File closed.

Incidents Opened Second Quarter 2014

I - 9200 - Equipment Malfunction - Westlake Longview Corporation - Longview, Texas

On June 6, 2014, the Agency was notified by the licensee's radiation safety officer (RSO) that after retracting a 148 millicurie cobalt 60 source into a Vega model SHLM-CR gauge the source separated from the cable. The RSO reported the gauge shutter closed and locked in the closed position. The RSO stated the manufacturer had been contacted and would be at the facility on the morning of June 6, 2014. On July 1, 2014, the manufacturer contacted the Agency and stated the reason for the separation was the wrong crimping tool had been used when the gauge was manufactured. The manufacturer also found its facility had been going through some design changes and the individual who was to test the connection believed the pull test device was not available and did not test the connection. The manufacturer has implemented changes to its process and retrained its personnel on the testing requirements for all gauges. No violations were cited.

File closed.

I - 9201 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On June 10, 2014, the licensee notified the Agency that a labeling error had occurred. On June 3, 2014, one of the licensee's customers notified it that a syringe within a syringe shield (pig) labeled as technetium-99m (Tc-99m) exametazime labeled white blood cells for a patient did not have a radioactive material prescription label. The syringe had a patient identification (ID) label which matched the packing list, pig label, prescription form, and blood collection tube. After verification with the pharmacy, the customer administered the dosage. Based upon the licensee's investigation, the dosage was prepared using standard procedures and the dispenser noticed there was an unexpected low yield of labeled white blood cells for the patient dosage. After confirmation with the customer that the dosage was sufficient, the dispenser attached a patient ID label and placed the syringe into a labeled pig without attaching the radioactive material prescription label on the syringe. Dual verification procedures were not followed. The licensee has counseled all personnel involved with the labeling irregularity. No violations were cited.

File closed.

I - 9202 - * - Methodist Healthcare System of San Antonio LTD LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

An investigation is ongoing.

File open.

Incidents Opened Second Quarter 2014

I - 9203 - Operator Error - Hi Tech Testing - Longview, Texas

On June 13, 2014, the Agency was notified by the license's Radiation Safety Officer (RSO) they had received a exposure report by their dosimetry processor indicating two individuals had received higher than expected exposures. The investigation into this event is ongoing.

File open.

I - 9204 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On June 16, 2014, the Agency received a report from the licensee's radiation safety officer (RSO) stating the shutter on two Ohmart Vega model SHD gauges, each containing 250 millicurie cesium-137 sources, failed to shut during an operational check. Additionally, a third gauge appeared to cycle shut but there was no change in the radiation level. The gauges normally operate with the shutter in the open position. The gauges failed due to ageing and environmental conditions. The licensee has contacted a vendor to design a better shutter for the environment and replace all three shutters. The company contacted the manufacturer for repair advice. The manufacturer responded with a non-repair statement due to the age of the device. The company requested an exemption to use the device until replacement gauges are installed. An exemption was granted by the Agency's licensing section. No violations were cited.

File open.

I - 9205 - Lost Moisture Density Gauge - Raba-Kistner Consultants, Inc. - Austin, Texas

On June 20, 2014, the licensee notified the Agency that one of its Humboldt model 5001EZ moisture/density gauges had been lost from the back of one of its trucks in Austin, Texas on June 19, 2014. The licensee's technician had rushed off the job site due to a family emergency and did not secure the gauge and he left the pickup tailgate down. The device had been in the back of the truck towards the front of the bed but fell out between the worksite and his home. It was in the stored locked position inside the storage case with two outside locks on the case. The area was searched in an attempt to recover the device. On Saturday, June 28, 2014, the licensee reported via email the gauge had been found and was sent to be checked for damage and to have a leak test performed. It was reported that the gauge was not damaged and passed the leak test. Two violations were cited.

File closed.

I - 9206 - Radioactive Material Found - USA Environment LP - Houston, Texas

On June 20, 2013, a load of dirt from an excavation site in Houston, Texas, caused the radiation monitor at a landfill to alarm as it entered the facility. An investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2014

I - 9207 - Shipping Error - NSSI, Inc. - Houston, Texas

On June 27, 2014, the Agency received information of a source shipped to a facility in Texas from North Carolina. The shipping paperwork did not match the source found in the shipping container. The licensee receiving the shipment reported the shipping error to the Agency. An investigation into this event is ongoing.

File open.

I - 9208 - * - Methodist Healthcare System of San Antonio, LTD LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

The investigation is ongoing.

File open.

I - 9209 - Possible Overexposure - University of Texas Health Science Center at San Antonio - San Antonio, Texas

On June 30, 2014, the registrant notified the Agency that one of its employees reported he had possibly exposed his hand to the 8 keV beam from an x-ray diffraction device. An investigation into this event is ongoing.

File open.

Incidents Opened in a Previous Quarter and Closed in Second 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. This gauge normally operates with the shutter in the open position. 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 - 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 in a Previous Quarter and Closed in Second 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 - 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 that contained 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.

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

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 Agency was notified by the licensee 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 exposures to 15.680 rem to the hand and the TEDE dose to 12.369 rem. The licensee suspended the trainer's qualifications and conducted company-wide stand down meetings to review the event with all personnel. The licensee 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 in a Previous Quarter and Closed in Second 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 had been 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 an 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. There are 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 0.012 microcuries. 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.

Incidents Opened in a Previous Quarter and Closed in Second 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 reoccurrence, the licensee will no longer store MAA and mebrofenin in the same location in its pharmacy. Staff involved have been instructed on keeping the kits separate and have received training on the differences in appearance between the two kits. No violations were cited.

File closed.

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.

Complaints Opened Second Quarter 2014

C - 2570 - Failure to Provide Exposure Record - IDEV Technologies Inc - Webster, Texas

On June 3, 2014, the Agency received a complaint that a former employee had not received his radiation exposure record from the registrant as requested. The Agency's investigation found that the record had not been sent by the registrant. The record was subsequently sent by certified mail and received by the former employee. The complaint was substantiated. One non-cited severity level IV violation was noted.

File closed.

C - 2556 - Regulatory Violations - Spain-Short, LLC - Tyler, Texas

On April 10, 2014, the Agency received a complaint alleging that an individual with a Non-Certified Technician (NCT) certificate had taken x-rays of the complainant and had failed to collimate the beam to the area of clinical interest as required. The complainant questioned whether or not an NCT could perform the particular exams that she did and was concerned about her lack of knowledge for positioning the complainant for the exams. An investigation into this complaint is ongoing.

File open.

C - 2557 - Public Concern of Barrels of Radioactive Waste - Unknown - Rockwall, Texas

On April 10, 2014, the Agency received a complaint referral from the Nuclear Regulatory Commission. An anonymous complainant alleged that there were a lot of barrels of radioactive waste coming into the city of Rockwall, Texas. The Nuclear Regulatory Commission, Region IV, Allegation Coordinator was supplied with a letter stating a complaint was opened and assigned to an investigator. The investigation was limited due to the restricted amount of information provided to the Agency. The city officials the Agency contacted provided as much information as they could to assist with resolving the complaint. Without more information from the complainant, the investigation could not continue. The complaint could not be substantiated. No violations were cited.

File closed.

C -2558 - Uncredentialed X-ray Technician - Adonis Zuniga-Goldwater, MD - Laredo, Texas

On April 11, 2014, the Agency received a complaint alleging that the individual taking x-rays at a jail facility was not properly credentialed or trained, that the facility was not properly registered, and the x-ray machine did not appear to have ever been serviced or inspected. The Agency performed an on-site inspection on May 30, 2014. The inspection reviewed the credential of the individual performing x-rays and found he/she was qualified to perform them. The inspection did not identify any items of non-compliance including the test results of the x-ray device. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2014

C - 2559 - Norm Decontamination - Cactus Environmental Service - Crowley, Texas

On April 1, 2014, the Agency received a complaint that an unlicensed company was descaling a 68 foot tall vessel with radiation measurements of 5,000 microR/hr. The company packaged the sludge and waste in drums for disposal. On April 16, 2014, the agency conducted an on-site investigation. Approximately 55 large barrels of sludge with radiation levels from 5-8 millirem/hr were found and identified as radium-226. A follow-up phone conference with the company determined that it believed it was allowed to clean the vessel and pack plastic filters from inside it without a specific license. It was determined that non-radiation workers worked in areas of 2-5 millirem/hr over a 10 day period. A licensed company picked up the radioactive waste for disposal. The complaint was substantiated. Three violations were cited.

File closed.

C - 2560 - Regulatory Violations - Sonterra Cardiovascular Institute, PA - San Antonio, Texas

On April 28, 2014, the Agency received a complaint alleging that the licensee had failed to provide personnel monitoring as required, had syringe shields that were missing the glass and therefore did not provide adequate shielding, and was splitting unit doses of diagnostic radiopharmaceuticals. The Agency conducted an unannounced inspection and investigation at the facility on April 30, 2014. The licensee could not produce personnel and area monitoring records. The investigation also revealed that unit doses were being reduced for rest (before exercise, or "stress") imaging contrary to the license. The complaint was substantiated. Eight violations were cited.

File closed.

C - 2561 - Response to Public Concern - Greater Texas Metal Recycling Company, Inc. - South Houston, Texas

On April 29, 2014, the Agency received a complaint that a recycling facility had been burying radioactive material on its property. The Agency conducted an on-site investigation on May 1, 2014. Two pieces of adjoining property on which the facility was located were surveyed for radiation. No measurements above background radiation levels were noted. The investigator did not observe any areas on the ground that appeared to have been disturbed. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2014

C - 2562 - Not Registered To Provide Services - Medical Imaging Solutions Inc - Austin, Texas

On April 30, 2014, the Agency received a complaint alleging a company had provided services on x-ray equipment in the State of Texas and did not hold a registration to do so. The complaint also stated two of the individuals who provided services at the registrants facility did not possess the appropriate training. The Agency's investigation found that the company did have a current registration. The Agency requested training documents for the individuals who had provided the services. A review of the training documents found the individuals had received the appropriate training to provide the services rendered. The complaint could not be substantiated. No violation was cited.

File closed.

C - 2563 - Laser Injury - Dallas Laser Med - Dallas, Texas

On May 6, 2014, the Agency received a complaint alleging that the complainant had received an injury during a laser procedure in June 2013. Upon investigation, the facility had treated a patient for spider veins and rosacea. The patient signed a consent form to have the treatment performed. The technician treating the test area noticed no effect in treatment and clicked the laser instrument to a higher setting. After seeing a reddening of the skin, the technician stopped the procedure and informed the medical doctor of the patient's response. The medical doctor reviewed the patient history and referred the patient to a dermatologist for treatment. Procedures were followed and the patient received treatment from a dermatologist. The patient was unhappy with the actions of the laser facility and reported the experience as a complaint. Following a review of the documentation submitted, details of the event, and Agency regulations, it was determined the investigation could substantiate a violation for not reporting a medical event. Violations were cited.

File closed.

C - 2564 - Regulatory Violations - Element Materials Technology - Houston, Texas

On May 15, 2015, the Agency received a complaint alleging multiple industrial radiography violations including a potential overexposure, no oversight of radiography trainees by trainers, and surveys not being performed to verify radiation area boundaries. An investigation into this complaint is ongoing.

File open.

Complaints Opened Second Quarter 2014

C - 2565 - Unauthorized Radioactive Waste Burial - CMC Recycling - Vinton, Texas

On May 16, 2014, the Agency received a complaint regarding waste which sets off the radiation monitors at the entry gate of a recycling yard. The complainant stated the waste is then taken to an area at the back of the facility and dumped in a pit. Investigation into this complaint is ongoing.

File open.

C - 2566 - Regulatory Violations - Global X-ray and Testing Corp - La Porte, Texas

On May 19, 2014, the Agency received a written complaint form dated May 12, 2014, alleging regulatory violations had been committed by a former employee, an industrial radiographer, of the licensee. The complaint was a request for the Agency to take actions against the radiographer as the licensee was concerned the radiographer would continue to violate the industrial radiography rules as he performed industrial radiography. An investigation into this complaint is ongoing.

File open.

C - 2567 - Laser Injury and Unregistered Facility - Bliss Laser Spa - San Antonio, Texas

On June 20, 2014, the Agency received a call regarding burns received during laser hair removal treatment by a technician at an unregistered facility. Investigation into this complaint is ongoing.

File open.

C - 2568 - Unregistered Laser Equipment - Talos Fitness Center - Dallas, Texas

On May 29, 2014, the Agency received a letter alleging an individual was operating a class 3B laser at a facility and was not registered with this Agency. The investigation into this complaint is ongoing.

File open.

Complaints Opened Second Quarter 2014

C - 2569 - Registration Fraud - Applus RTD USA, Inc. - Houston, Texas

On June 2, 2014, the Agency was contacted by the radiation safety officer (RSO) for an industrial radiography registration. During a recent inspection by the Agency, it was noted that on March 18, 2014, a change to the registration was submitted by someone pretending to be the new RSO. The Agency approved the new RSO name and physical address on the registration. An Agency investigation revealed that one of the company's employees had thought he had to apply to the Agency for an RSO license when he applied for his job with the company. During a discussion with the Agency investigator, the individual understood this had been a mistake and stated he would not do it again. The registrant's human resources department is also investigating the individual's actions. The complaint was substantiated. No violations were cited.

File closed.

C - 2570 - Failure to Provide Exposure Record - IDEV Technologies Inc - Webster, Texas

On June 3, 2014, the Agency received a complaint that a former employee had not received his radiation exposure record from the registrant as requested. The Agency's investigation found that the record had not been sent by the registrant. The record was subsequently sent by certified mail and received by the former employee. The complaint was substantiated. One non-cited severity level IV violation was noted.

File closed.

C - 2571 - Dose to Public and Safety Concerns - AGD Inspection Services - Houston, Texas

On June 3, 2014, the Agency received information from the U.S. Customs and Border Protection (CBP) that some of its officers had detected radiation while driving near the port area of Houston, Texas, and the officers were concerned that a radiography source may have been used with improper safety controls. CBP had identified one licensee working within the area of concern. The Agency conducted an investigation which included an on-site investigation. The investigation revealed that there were several facilities in that area where industrial radiography licensees were routinely performing radiographic operations. The Agency identified and contacted 5 licensees, including the one identified by CBP. The Agency asked the licensees to reinforce with all of their radiographers the importance of performing required surveys ensure compliance with exposure limits. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2014

C - 2572 - Regulatory Violations - University of Texas M. D. Anderson Cancer Center - Nassau Bay, Texas

On June 18, 2014, the Agency received a complaint that the staff in the radiation therapy area (linear accelerators) at the facility were not wearing individual exposure monitoring devices (dosimetry badges). In response to the patient complaint, the site radiation safety officer (SRSO) made an unannounced visit to the site on June 25, 2014. The SRSO noted that all pertinent staff were wearing dosimetry badges and occupational dose records for the nursing and radiation therapy staff showed that there were no exposures exceeding regulatory limits. The SRSO completed a public dose assessment during patient treatments and observed that therapy staff followed appropriate radiation safety protocols. The results of the public dose assessment verified that it would not be possible for a member of the public to exceed the general public annual dose limit of 100 millirem/yr. The complaint was not substantiated. No violations were cited.

File closed.

C - 2573 - Working Without Reciprocity - Eagle NDT LLC - Orla, Texas

On June 20, 2014, the Agency received a complaint alleging a Texas licensee was performing radiography work in the State of New Mexico without receiving reciprocity from that state. The Agency contacted the State of New Mexico's Radiation Control Bureau (NMRCB) and informed it of the complaint. The NMRCB stated it would investigate the allegation. The NMRCB contacted the contractor using the Texas licensee and was informed that the Texas licensee was traveling through the State of New Mexico to get to work sites in Texas. The contractor stated the Texas licensee was not performing any work in the State of New Mexico. The NMRCB was not able to substantiate the allegation. No violations were cited.

File closed.

C -2574 - * - Parkview Regional Hospital - Mexia, Texas

*Health and Safety Code Chapter 241.051(d)

The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2014

C - 2575 - Uncredentialed Radiography Trainee - Weld Spec - Lumberton, Texas

On June 23, 2014, the Agency received a complaint alleging the licensee was not properly credentialing its industrial radiography trainees. It was also alleged that the forty hour safety training was not provided by an entity approved by the Agency for industrial radiography safety training. An investigation into this complaint is ongoing.

File open.

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

C - 2490 - Unregistered Laser Facility - Kaaya Salon and Spa - Katy, Texas

On August 5, 2013, the Agency received a complaint alleging that the facility may be operating without safety signs or registration. The Agency's investigation revealed the owner of the facility did not own a laser at the time and was in the process of certification. The owner stated she plans to work under the practice of a physician at another site until obtaining a facility registration. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2493 - Regulatory Violation - NQS Inspections - Corpus Christi, Texas

On August 15, 2013, the Agency was notified by the licensee's current radiation safety officer (RSO) they were not able to locate various records required by this Agency. The RSO stated they noted the records were missing while conducting a record review in response to their previous RSO leaving their employment. The Agency's inspector who had conducted the last inspection at the licensee's facility stated many of the required records they had reviewed were kept on a portable storage device. The Agency contacted the previous RSO who agreed to contact the licensee and provide the whereabouts of the storage device. The licensee was able to locate the storage device. The Agency performed an on-site investigation on September 17, 2013. The licensee was only able to provide some of the missing records. The current RSO stated he needed additional time to look through the hard drive to find the missing records. The Agency made several requests for the missing documents and on March 6, 2014, it performed a second investigation at the licensee's facility. The licensee was able to produce all but three required documents. Three severity level four violations were identified.

File closed.

C - 2505 - Regulatory Violations - Fox NDT, LLC - Abilene, Texas

On September 30, 2013, the Agency received a complaint alleging the licensee had 13 regulatory violations including trainees transporting cameras, trainees working without the supervision of a trainer, and inadequate daily paperwork including increased controls documentation. On October 21, 2013, the Agency conducted an on-site investigation at the licensee's Abilene site office. A spot check of equipment maintenance, qualification of radiographers, survey records, and the increased control program was completed. On October 22, 2013, a radiography spot check at a temporary field site was conducted. No violations were noted. An interview with the licensee's radiation safety officer was conducted to discuss the alleged violations. The complaint could not be substantiated. No violations were cited.

File closed

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

C - 2515 - Regulatory Violations - Arends Inspections, LLC - Wheeler, Texas

On October 25, 2013, the Agency received a complaint from a radiographer from the State of Illinois alleging the licensee's employees working near Wheeler, Texas, were performing unsafe activities. The Agency attempted to find the radiographers working near Wheeler on November 5, 2013, but did not locate them. The Agency attempted to contact the complainant but the complainant did not respond. A second attempt to locate the radiographers was conducted on December 3, 2013, but the inspector could not locate them. The licensee was contacted and the radiation safety officer stated they had ceased work in the area to resolve some issues that had come up with the company who had contracted them. A third attempt to observe the licensee's radiographers in the Wheeler area was conducted on April 14, 2014, but they were not located either in the field or parked in the town they were reported to be staying in. The Agency will continue its attempts to observe the licensee's radiographers during its industrial radiography temporary work site inspections throughout the state. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2525 - Unregistered Laser Hair Removal Facility - Lookin Good Spa - Wichita Falls, Texas

On November 26, 2013, the Agency received a complaint that the entity was engaged in laser hair removal services without a registered facility or registered technicians. The Agency's investigation found that the facility was not registered. The facility has submitted an application and fees to the Agency for the appropriate registration. The complaint was substantiated. No violations were 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.

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

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.

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 - 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.

File closed.

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.

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

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.

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 - 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.

Complaints Opened in a Previous Quarter and Closed in Second 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.