



INCIDENT AND COMPLAINT SUMMARIES FOR FOURTH QUARTER 2012*

December 31, 2012

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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.shtml>

**Incident and Complaint Summaries
4th Quarter 2012**

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Incidents Opened Fourth Quarter 2012

I - 8993 - Possible overexposure - GCT Inspection, Inc. - Pasadena, Texas

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

File closed.

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

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

File closed.

Incidents Opened Fourth Quarter 2012

I - 8998 - Radiography Source Disconnect - METCO - Houston, Texas

On October 18, 2012, the Agency was notified of a source disconnect that occurred in a fixed bay after a large piece of equipment fell on the source guide tube and damaged the cable. The licensee was unable to retract a 56.8 curie iridium-192 source into the QSA 880F exposure device. Four company workers received dose to retrieve the source which required cutting the drive cable to remove the source. The highest dose received was 678 millirem whole body and 4.520 rem extremity dose to the hand. The radiography was being conducted on a large piece of pipe that was inadequately supported. This allowed the pipe to fall on the source cable and tube. The licensee conducted training on the proper support of heavy equipment and a notice was posted in each bay showing the proper set-up of supports and chocks. No violations were cited.

File closed.

I - 8999 - * - Christus Spohn Hospital Corpus Christi - Corpus Christi, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 9000 - Radiography Source Disconnect - Goolsby Testing Laboratory, Inc. - Humble, Texas

On October 18, 2012, the Agency received a reciprocity request from a source manufacturer to retrieve a 213 curie cobalt-60 source in a Spec 300 camera. The Agency then contacted the licensee. The licensee stated that it had been able to retract the source into the camera but it had not been able to disconnect the source pigtail. The manufacturer was unable to provide guidance over the phone so the decision was made for the manufacturer to come to the licensee's temporary work location to disconnect the source. The manufacturer found that the source drive cable had been snapped about 12 inches from the connection to the source and that the connectors were still inside the camera. The manufacturer removed the locking device and saw that the source was disconnected from the drive cable and the two connections were side by side in the outlet port of the camera and wedged tightly together (piggybacked). The manufacturer could not repair the camera so it was placed in a shipping container and sent to the manufacturer's facility. The manufacturer's inspection found that the connectors had been damaged and a misconnection had occurred allowing the source and drive cable connectors to piggyback and get wedged at the outlet port of the camera. The manufacturer repaired the connectors and returned the camera to the licensee. The licensee stated that no overexposure occurred as a result of this event. The licensee stated that it would perform a misconnect check of the camera and increase maintenance to prevent recurrence of the event. Three violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

I - 9001 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On October 18, 2012, the Agency was notified by the licensee that a dispensing error had occurred at one of its nuclear pharmacies. The pharmacy technician read a request for 5 millicuries of technetium-99m as 0.5 millicuries and created the unit dose. The error was caught by the customer when it assayed the unit dose. The unit dose was not administered to a patient. The licensee stated that it counseled all employees involved in the event and provided additional training on proper dispensing practices. No violations were cited.

File closed.

I - 9004 - Nuclear Pharmacy Error - Cardinal Health - Corpus Christi, Texas

On September 14, 2012, the Agency was notified by the licensee that an irregularity in the dispensing of a customer's order had occurred. The licensee reported that an order was requested for delivery on September 12, 2012. The order was to be calibrated and used on September 13, 2012; however, it was calibrated for use on September 12, 2012. No patient received the product. The licensee determined that the cause for the error was the pharmacist failed to recognize that the use date was different than the requested delivery date. The licensee has counseled all employees involved in handling customer orders to ensure that the product is properly prepared, dispensed, and delivered. No violations were cited.

File closed.

I - 9005 - Damaged Moisture/Density Gauge - Paradigm Consultants Inc. - Houston, Texas

On November 1, 2012, the licensee notified the Agency that one of its Campbell-Pacific Model MC-3 moisture/density gauges had been run over by a pickup truck at a temporary work site in Houston, Texas. The gauge contained one 10 millicurie cesium-137 source and one 50 millicurie americium-241/beryllium source. The sources were in the safe position when it was run over. The source rod was broken off at the top of the housing. The gauge was taken to a service company and it was determined that it was damaged beyond repair. There was no leakage of the source and no exposure to any individual as a result of this incident. The cause was attributed to a lack of attention to detail by the licensee's worker which allowed a nearby contractor's truck to run over the gauge. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

I - 9006 - Possible Overexposure - Desert NDT LLC - Abilene, Texas

On November 2, 2012, the Agency was contacted by the licensee's radiation safety officer (RSO) and informed of a possible overexposure. The licensee stated that its dosimetry processor had informed it that one of its radiographers had a badge reading of 21.6 rem for the exposure period of September, 2012. The RSO stated that a review of the daily records for the individual revealed no irregularities. The RSO stated that the radiographer had been interviewed and an explanation for the high dose could not be provided. The licensee sent blood samples from the radiographer to The Radiation Emergency Assistance Center Training Site in Oak Ridge, Tennessee. The results indicated that the radiographer had not received the exposure recorded on their badge. The licensee assigned a dose of 76 millirem to the radiographer based on the radiographer's daily self-reading dosimeter readings for the exposure period. No violations were cited.

File closed.

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

On Tuesday, November 6, 2012, the licensee notified the Agency that one of its employees discovered that a Troxler Model 3411B moisture/density gauge had been stolen from the company-owned vehicle while it was parked at his residence in Laredo, Texas, during the preceding weekend. The licensee reported that on Friday the employee had gone to his residence from a temporary worksite due to a family emergency and had failed to return the gauge to the licensed location. The employee stated he had forgotten the gauge was still in the truck. The gauge contained one 8 millicurie cesium-137 source and one 40 millicurie americium-241/beryllium source. The licensee notified local law enforcement, conducted physical searches of areas near where the theft occurred, notified local contractors and testing labs, alerted the nuclear gauge manufacturer and several service companies, and posted flyers on street corners offering a reward. The Agency notified the Texas Association of Pawnbrokers. The Agency's investigation revealed that not only did the licensee's employee fail to properly store the gauge, the licensee was not employing two independent barriers to secure the gauge as required. As corrective actions, the licensee retrained the employee and restricted his use of the company truck. The licensee held a safety meeting for all of its employees regarding the handling of gauges and they will attend a previously scheduled course for hazmat materials on nuclear gauges. The licensee stated it is having metal cages fabricated for all of its trucks in which to carry nuclear gauges to provide another barrier. The gauge has not been recovered as of January 7, 2013. Two violations were cited. Update: On February 2, 2013, the licensee notified the Agency that it had recovered the stolen gauge.

File closed.

I - 9008 - * - Baylor Medical Center at Grapevine - Grapevine, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

I - 9009 - Damaged Moisture/Density Gauge - ATC Associates, Inc. – Spring, Texas

On November 7, 2012, the Agency was notified by the licensee that one of its Troxler model 3411B moisture/density gauges had been damaged. The gauge contained one 8 millicurie cesium-137 source and one 40 millicurie americium-241/beryllium source. The operator had stepped off the distance to a nearby wall to get location information. A bulldozer operator assumed this meant the test was finished and drove into the area, impacting the gauge. The gauge suffered a bent top and damaged electronics. The licensee performed a survey and determined that the integrity of the sources and shielding were not affected. The licensee performed a leak test and returned the device to the manufacturer for replacement. No violations were cited.

File closed.

I - 9010 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On October 26, 2012 the Agency was notified by the licensee that on October 19, 2012 they sent the wrong form of technetium (Tc) to a customer. The customer had ordered a unit dose of technetium-99m sestamibi for a cardiac exam. However, the scan performed following administration of the unit dose presented primarily a bone image. An investigation by the licensee determined a syringe of Tc-99m medronate was labeled as Tc-99m sestamibi. The patient did not experience any adverse effects. In order to prevent recurrence of a similar event, the licensee counseled all employees involved in the prescription sorting and dispensing procedures. Procedures were modified on site to better distinguish labels for different radiopharmaceuticals. No violations were cited.

File closed.

I - 9011 - Medical Waste At Landfill - University Medical Center of El Paso - El Paso, Texas

On November 9, 2012, the Agency was informed by a landfill operator that a load of waste picked up from the licensee's facility for disposal had caused their radiation monitor to alarm. An Agency inspector went to the landfill and surveyed the container. The radioisotope was identified as technetium-99m. Investigation revealed that two licensees at the facility share the same waste compactors and both are licensed for this radioisotope. Therefore, it could not be determined from which licensee the material originated. To prevent recurrence, area radiation monitors are being purchased and installed at the loading dock door where all trash and linen for both licensees exits the facility and all appropriate staff will receive training. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

I - 9012 - Possible Overexposure - South Texas Radiology Imaging Services - San Antonio, Texas

On November 13, 2012, the Agency was notified by the registrant that one of its radiologists may have exceeded the annual Lens Eye Dose (LED) limit of 15,000 millirem by receiving 16,065 millirem for the current year. The registrant stated that the radiologist had lost his second quarter dosimeter. The radiologist found the dosimeter three months later in September 2012 and it was sent for processing. The licensee was unable to determine where the badge had been for the three months it was missing. That badge had a reading of 6,625 millirem LED which was higher than normal for the radiologist. An investigation was conducted by the registrant and an averaged quarterly reading of 3,404 millirem LED was assigned for the second quarter based on two years of quarterly data for the radiologist. The recalculated total LED for the year was 12,844 millirem. Additionally, the investigation determined that the radiologist, who had been performing fluoroscopy studies, had been wearing his collar badge closer to his shirt pocket which resulted in a higher level on the badge reading. He was directed to wear his badge at collar level. No violations were cited.

File closed

I - 9013 - Nuclear Pharmacy Error - Cardinal Health - Lubbock, Texas

On October 25, 2012, the licensee received a call from one of its customers reporting that 3 of 18 dosages of technetium-99m sestamibi were assayed and found to have activity 10 to 15 millicuries less than the dosage ordered at calibration. The customer used other unit dosages with higher activities that were calibrated for use later in the day to keep patients on schedule and the pharmacy sent replacement dosages for the later calibrated times. None of the unit doses found to have the incorrect activity were administered to any patient. The licensee conducted an investigation and believes that the pharmacy technician inadvertently dispensed less activity in 3 of 18 unit dosages than the amount ordered. To prevent recurrence, the licensee counseled all employees involved in the procedures for dispensing and assay prior to releasing dosages. These individuals will verify each dosage activity to ensure that the product is dispensed properly before being released. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

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

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

File closed.

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

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

File closed.

Incidents Opened Fourth Quarter 2012

I - 9016 - Radioactive Material Found - Sinclair Building Partner, LP - Fort Worth, Texas

On November 20, 2012, the City of Fort Worth Emergency Management Coordinator (EMC) notified the Agency that a police officer's personal radiation detector had alarmed in a privately-owned parking lot in downtown Fort Worth. Following the alarm, the EMC had used a radiological isotope identifier and identified the material as radium-226 in or under the asphalt. A hole was dug through the asphalt and the radiation readings jumped to 200 millirem/hour at near contact with the dirt under the asphalt. The EMC then called the Agency and investigators were dispatched to the scene. The radiation measurements and identification were confirmed and the property owner was notified. The property owner hired a company licensed for remediation to perform the cleanup. The Agency's investigation revealed that a hospital was on this site prior to the parking lot. However, no license for radioactive material has been located. The Agency's investigation into this event is ongoing.

File open.

I - 9017 - * _____ - Baylor Medical Center at Irving - Irving, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 9018 - Abandoned Well Logging Source(s) Down Hole - Schlumberger - Nueces County, Texas

On November 26, 2012, the licensee contacted the Agency to report that it was abandoning two well logging sources (16 curies of americium-beryllium and 1.7 curies of cesium-137) down hole in a well in Nueces County. On December 18th, it was reported by the licensee that the sources were abandoned at 12,658 and 12,670 feet respectively, with 381 linear feet of red-colored cement plug. A drill bit was set as a deflection device at 12,270 feet. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2012

I - 9019 - Lost Equipment Containing Radioactive Material - Houston Refining LP - Houston.

On November 19, 2012, the Agency was notified by the licensee that it could not locate a Thermo Niton model number XL-II x-ray fluorescence analyzer containing a 10 millicurie cadmium-109 source and a 20 millicurie iron-55 source. The radiation safety officer (RSO) thought the device had been shipped to the manufacturer; but, after he was unable to find any shipping papers for the device he determined the device was missing. On December 11, 2012, the licensee notified the Agency that the manufacturer had located the missing sources at its facility. The manufacturer provided documentation showing it had received the device with the sources on March 13, 2012. The licensee stated that it changed its procedure to require the RSO to complete shipments involving radioactive material. No violation was cited.

File closed.

I - 9020 - Abandoned Radioactive Material - Montgomery County Management Company, LLC – Conroe, Texas

On November 13, 2012, the Agency's Radioactive Materials Licensing Group requested assistance from the Incident Investigations Program to locate radioactive sources that had been owned or possessed by a licensee that was in bankruptcy. An investigation was conducted and it was discovered that the licensee had owned a number of calibration/reference sources, none of which were required to be listed on its license. The licensee had left approximately two-thirds of these sources in the nuclear medicine lab area of one of the leased facilities it vacated. A new medical group leased the space, found the sources, and was in the process of having them disposed of properly. The licensee had left the remaining one-third of its sources with the positron emission tomography (PET) machine at another leased facility it vacated. This piece of equipment was purchased by another licensee and the sources were transferred with the machine. No violations were cited.

File closed.

I - 9021 - Badge Overexposure - TC Inspection LLC - Oyster Creek, Texas

On October 30, 2012, the Agency was informed by the licensee that the badge reading for a previous employee had been reported to it by the badge processor as 19.911 rem. The badge had been issued to the employee for the March 2012 exposure period and was reported as lost. The licensee's radiation safety officer had found the employee's badge in a truck used by the employee and sent it for processing in October 2012. The licensee had already assigned a dose of 416 millirem to the employee for that exposure period. The licensee removed the 19.911 rem exposure from the individual's record. No violations were cited.

File closed

Incidents Opened Fourth Quarter 2012

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

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

File closed.

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

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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

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

File closed.

Incidents Opened Fourth Quarter 2012

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

*Health and Safety Code Chapter 241.051(d)

This was a non-cited severity level IV violation.

File closed.

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

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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

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

File closed.

I - 9028 - * - Methodist Health Care System of San Antonio, LTD LLP - San Antonio, Texas

*Health and Safety Code Chapter 241.051(d)

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

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2012

I - 8909 - Damaged Nuclear Gauges - Pasadena Refining Systems, Inc. - Pasadena, Texas

On December 12, 2011, the Agency was notified by a licensee that on Saturday, December 10, 2011, there had been a fire in the coker unit at their facility in Pasadena, Texas. The radiation safety officer (RSO) reported there were four Ohmart-Vega Model SH1G-1 fixed nuclear gauges each containing a 300 millicurie cesium-137 source mounted on 82 foot tall drums in the area of the fire. Two gauges were directly in the fire and were damaged. The other two gauges were shielded from the fire by the drum they were mounted on. There were no radiation levels above background found during initial surveys from the barricade line and subsequent surveys conducted under the drums on the ground level and second level. On January 3, 2012, the licensee was able to get closer to the gauges involved in the fire and determined that dose rates in the area of the gauges were elevated. Dose rates taken in uncontrolled areas near the gauges remained at normal background levels. The licensee arranged to have a service provider remove the four gauges. The gauges were removed on June 12, 2012, leak tested, and shipped to the service provider's location for disposal. On June 19, 2012, the service provider notified the Agency that while removing the source from one of the gauges damaged by the fire, a technician, the floor in the work area, and the work bench became contaminated. The technician was immediately decontaminated and the other areas were decontaminated to background that same day. The technician did not receive any significant dose from the contamination event. The service provider reported that the gauge with the leaking source was void of lead shielding because of the fire damage. After removal from the gauges, the service provider leak tested all four sources again. Only the source involved in the contamination event at the service provider's location was leaking. The service provider is attempting to send the three sources that were not leaking to a national laboratory for further evaluation. No violations were cited.

File closed.

I - 8946 - Access to Facility Denied - Fairmont Diagnostic and MRI Center - Pasadena, Texas

On April 10, 2012, the Agency was notified that a licensee's radiation safety officer (RSO) had been locked out of the licensee's facility by the landlord. The facility is licensed to possess unit doses of short-lived radiopharmaceuticals. The agent controlling access to the facility agreed to allow the RSO and this Agency access to the area if and when needed. The property was purchased by another licensee the first week of July 2012. The new licensee submitted an amendment to its license in mid- August 2012. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2012

I - 8957 - Medical Event - Texas Oncology PA - Dallas, Texas

On June 6, 2012, the licensee notified the Agency that a medical event had occurred at its facility on June 5, 2012. The therapists failed to insert a conical collimator prior to a stereotactic radiosurgery (SRS) procedure which resulted in a dose being delivered to a patient that varied greater than 10% from the prescribed dose. Investigation revealed the conical collimator being used with the accelerator for the therapy did not have an interlock as required by Agency regulations. Also, the therapists failed to follow the registrant's procedures that would have verified the conical collimator necessary for the SRS was in place prior to treatment. Two violations were cited.

File closed.

I - 8971 - Gauge Shutter Failure - Eastman Chemicals Company, Texas Operations - Longview, Texas

On July 24, 2012, the licensee notified the Agency that a shutter mechanism on an Ohmart SH-F2-45 gauge mounted on the side of a tank at the licensee's facility was broken and the shutter could not be closed. The gauge contained a 200 millicurie cesium-137 source. The 3/8 inch cast iron shutter rod broke approximately 1/4 inch below the top surface of the gauge. The licensee observed that only a small fraction of the handle's diameter was a fresh break and approximately 90% of the face of the break was rusted, indicating a crack in the casting had existed for some time. The licensee submitted the appropriate request to the Agency for the gauge to remain in operation until repairs were made. On October 4, 2012, the shutter assembly was replaced by a manufacturer's service representative. No violations were cited.

File closed.

I - 8981 - Stolen Moisture/Density Gauge - Henley-Johnston & Associates, Inc. - Lubbock, Texas

On August 30, 2012, the licensee notified the Agency that a Troxler model 3430 moisture/density gauge, containing a 40 millicurie americium-241/beryllium source and an 8 millicurie cesium-137 source, had been stolen out of the back of one of its trucks outside a hotel in Lubbock, Texas. The licensee's technician had gone inside to gather his belongings. When he came back outside approximately 20-25 minutes later, he found the chain securing the gauge had been cut and the gauge was gone. The local police department was notified by the technician. The licensee notified the manufacturer and other gauge service companies. The Agency notified the Texas Association of Pawn Brokers. The technician had failed to secure the portable gauge with two independent physical controls as required. The licensee reported that it is building an improved means of securing the portable gauges for all of its trucks. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2012

I - 8983 - Therapy Event - University of Texas Health Science Center at San Antonio - San Antonio, Texas

On August 31, 2012 the Agency was notified by the registrant that on August 30, 2012, it discovered a therapy event had occurred. A patient was prescribed 2,600 centigray to an area of a limb to be given in seven fractions. The error occurred when the therapist discovered that the patient would not fit into the treatment device head first and the patient was turned to enter the device feet first. Once the patient was turned, the area on the opposing limb was marked for treatment and treatment started. The patient received 1,880 centigray before the error was identified. The registrant's investigation determined that human error was the root cause for the event. Both the patient and the referring physician were notified of the error. The prescribing physician reviewed the treatment and determined that the medical event was of no clinical significance. The registrant conducted in-service safety training with all faculty and staff to review patient safety procedures. The registrant also created a new procedure designed to ensure the correct treatment location is identified prior to treatment. No violations were cited.

File closed.

I - 8984 - Gauge Shutter Failure - Weatherford Artificial Lift Systems, Inc. - Alice, Texas

On September 4, 2012, the Agency was notified by the licensee that the shutter on an Ohmart/Vega nuclear gauge, model SHLD-1 containing a 20 millicurie cesium-137 source, had been damaged and no longer functioned as designed. The licensee stated that the gauge was mounted on the side of a truck trailer. The licensee stated that the gauge operator wanted to close the gauge shutter and could not find the key to the lock for the gauge. The operator obtained a hammer and struck the lock and shutter mechanism. The four bolts holding the shutter mechanism in place snapped and the shutter fell off the gauge. The operator placed the shutter back on the gauge to provide shielding. The gauge was leak tested and determined to be satisfactory. The gauge was returned to the manufacturer and repaired. The licensee has provided additional training to all employees throughout its company. No violations were cited.

File closed.

I - 8985 - Stolen Radiation Generating Device - Corridor Medical Services, Inc. - Fort Worth, Texas

On September 6, 2012, the Agency was notified by the registrant that a mobile x-ray device was stolen from one of its mobile x-ray trucks. Shortly after the police were contacted to report the theft, the facility where the technician had worked earlier in the day called to report that he had left the unit. The x-ray unit was recovered and in good working order. The technician was counseled on attention to detail and tested for drugs. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2012

I - 8989 - Therapy Event - UT Southwestern Medical Center at Dallas - Dallas, Texas

On September 12, 2012, the Agency was notified by the registrant's radiation safety officer that it had treated a patient with the previous patient's treatment plan. Both patients' treatments were to be delivered to the same location of the body with the same total dose of 200 centigray. The incorrect treatment was stopped just short of completing the 200 centigray fraction. The registrant reported there were no adverse effects to the patient and the patient's total treatment plan was adjusted to account for the error. The facility conducted training on the incident and is installing an in-room monitor to show the treatment console display. Additionally, new verification procedures of patient's name and treatment plan have been added to operating procedures. No violations were cited.

File closed.

I - 8990 - Gauge Shutter Failure - Bayer Material Science, LLC - Baytown, Texas

On September 19, 2012, the Agency was notified by the licensee that during a routine inspection it discovered shutters on two Berthold Model LB-300L gauges were stuck in the open position. One gauge contained a 1.9 millicurie cobalt-60 source and the other a 1.68 millicurie cobalt-60 source. The gauge normally operates with the shutter in the open position. There was no increased risk of exposure to any individual. On October 5, 2012, the licensee reported that the gauge shutters had been repaired by the manufacturer. The licensee stated that a buildup of rust had prevented the shutter from operating. No violations were cited.

File closed.

I - 8991 - Veterinary Event - Texas A&M University - College Station, Texas

On September 20, 2012 the Agency was notified by the registrant that an inadvertent exposure occurred to a student's hand. The student was holding a kitten for an x-ray. Because it was difficult to hold the small kitten, a lead glove was placed on top of the student's hand to provide protection. When the film was reviewed, it was discovered that a portion of the student's hand was visible in the image. The individual was assigned a dose of 59 millirem for their hand. The registrant's radiation safety officer provided additional training for the two students involved in the inadvertent exposure. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth Quarter 2012

I - 8992 - Gauge Shutter Failure - Bayer Material Science, LLC - Baytown, Texas

On September 27, 2012, the Agency was notified by the licensee that the shutter on a Berthold nuclear gauge containing a 1.14 curie cobalt-60 source was found to be stuck in the open position during a routine inspection. The gauge normally operates with the shutter in the open position. The licensee stated that the gauge did not pose an increased exposure risk to any personnel. The gauge shutter was repaired on October 16, 2012. The manufacturer found a significant buildup of corrosion in the shutter operating arm area. The licensee instructed its inspectors to take corrective actions anytime a buildup of material is observed around the operating shaft by submitting a maintenance request to have the area cleaned. No violations were cited.

File closed.

I - 9002 - Nuclear Pharmacy Error - Cardinal Heath - Dallas, Texas

On September 6, 2012, the Agency was notified by the licensee that a dispensing error had occurred at its Dallas, Texas location. The licensee stated that on September 6, 2012, a unit dose of fluorine-18 fluorodeoxyglucose was sent to a customer containing a higher activity than requested. The customer found the error and adjusted the dose to the correct activity prior to administering it to the patient. The licensee stated that the technician who prepared the dose made an error when they withdrew the material to make the unit dose. The licensee stated that it counseled all employees involved in the event in the proper procedure for preparing a unit dose. No violations were cited.

File closed.

I - 9003 - Nuclear Pharmacy Error - Cardinal Heath - Dallas, Texas

On September 17, 2012, the Agency was notified by the licensee that a dispensing error had occurred at its Dallas, Texas, location. The licensee stated that a unit dose of technetium-99m was sent to a customer containing a higher activity than requested. The activity of the unit dose was adjusted and administered to the patient. The licensee counseled all applicable employees involved in the procedures for proper assay and labeling of the product prior to release. No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2012

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

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

File closed.

C - 2432 - Regulatory Violations - Lakeway Regional Medical Center LCC - Lakeway, Texas

On October 11, 2012, the Agency received an anonymous complaint alleging that the nuclear medicine department at a licensee's hospital was operating with multiple regulatory violations including public access to the hot lab, high dose rate levels in hallways, and lack of shielding for radioactive sources. An on-site investigation was conducted by the Agency on October 31, 2012. The licensee had added a lock on the hot lab. The dose rates were measured and were no greater than background in the hallways. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2433 – Unregistered Laser Facility - Luxe Body Spa - Austin, Texas

On October 15, 2012, the Agency received a complaint alleging laser procedures were being conducted at a body spa that was not registered with this Agency. A search of the Agency's database was unable to find a registration for the entity. The Agency contacted the entity and they stated they were not aware of the registration requirements. The owner agreed to obtain the appropriate registrations. The investigation into this event is on-going.

File open.

Complaints Opened Fourth Quarter 2012

C - 2434 - Inadequate Credentialing - Jack County Hospital District - Jacksboro, Texas

On October 17, 2012, the Agency received a report from an anonymous caller alleging that the registrant was allowing an individual to perform computerized tomography (CT) who was not qualified to do so. The Agency conducted an on-site investigation. X-ray and CT logs were reviewed and interviews were conducted. The Non-Certified Technician (NCT) named in the complaint and the radiation safety officer stated that the NCTs set up the patient and get everything ready, but a physician actually pushes the button to energize the machine. The investigation did not reveal any evidence to support the allegation. The complaint was not substantiated. No violations were cited.

File closed.

C - 2435 -Unregistered Use of Mammography Machine- Sierra Providence Total Care Imaging - El Paso, Texas

On October 19, 2012, the Agency received a complaint alleging that a facility was using a mammography machine for approximately one month without submitting a physics survey report to the Agency and accreditation body. The Agency sent an inspector on-site who determined that the timeline to transfer equipment from one registration to another, including submitting the physics evaluation to the Agency, was completed properly. The complaint was not substantiated. No violations cited.

File closed.

C - 2436 - * _____ - Community Hospital of Brazosport - Lake Jackson, Texas

*Health and Safety Code 241.051(d)

Complaint could not be substantiated. No violations cited.

File closed.

C - 2437 - Laser Regulation Violations - Aqua Medical Spa LLC - Dallas, Texas

On November 2, 2012, the Agency received a complaint alleging that the licensee was conducting business without a laser safety officer (LSO) and with non-registered technicians. Further, the complainant alleged that client forms were not documented correctly, as well as other health and safety concerns. The Agency's investigation revealed that facility was properly registered under the laser rules and was exempt from the laser hair removal rules. The registrant does have an LSO. The LSO was reminded to ensure that all activities required by regulations are completed and documented. The complainant was advised that the other health and safety concerns were not within the radiation regulations and was advised where they could be reported. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2012

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

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

File closed.

C - 2439 - Laser Injury - Beleza Med Spa - Austin, Texas

On November 14, 2012, the Agency received a complaint from an individual who alleged they had been injured on September 7, 2012, during a photo facial procedure performed using an intense pulsed light device. The Agency interviewed the physician assistant at the registrant's location who stated that the patient was diagnosed by them as having first degree burns and hyperpigmentation, which does not require reporting. Information provided by the complainant from their dermatologist stated that they had received burns, but did not state that the burns were second degree burns. No violations were cited.

File closed.

C - 2440 - * - Texas Health Presbyterian Hospital WNJ - Sherman, Texas

*Health and Safety Code Chapter 241.051(d)

The complaint was not substantiated. No violations were cited.

File closed.

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

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

File closed

Complaints Opened Fourth Quarter 2012

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

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

File closed.

C - 2443 - Unregistered Laser Hair Facility - The Ritz - Burlison, Texas

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

File closed.

Complaints Opened Fourth Quarter 2012

C - 2444 - Laser Hair Removal Regulation Violations - Ideal Image - San Antonio, Texas

On December 6, 2012, the Agency received an anonymous complaint alleging that a laser hair removal facility in San Antonio, Texas, was not registered, customers had received injuries, the facility was operating without a laser safety officer, all of the technicians performing laser hair removal were not registered with the Agency, the physician was not reviewing or signing incident reports (adverse reactions, blistering), and the lasers were not being maintained like they should be. During the Agency's investigation, it was found that the facility was properly registered with the Agency and technicians were also registered. The facility has a laser safety officer as required. It has contracts with the equipment manufacturers and the equipment is maintained and serviced according to their recommendations. In response to the allegations concerning adverse events, the registrant reported it had not had an adverse event as defined in the Agency's regulations and no evidence could be provided to the contrary. The complaint could not be substantiated. No violations were cited.

File closed.

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

*Health and Safety Code Chapter 241.051(d)

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

File closed.

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

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

File closed.

Complaints Opened Fourth Quarter 2012

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

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

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2012

C - 2393 - Laser Injury - Metropolitan Laser Institute - Houston, Texas

On April 5, 2012, the Agency received a complaint alleging an individual had received unspecified burns while receiving treatment at a laser facility. An on-site investigation was conducted by the Agency on August 1, 2012. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2411 - Patient Care Concern - Various Registrants - Dallas, Texas

On June 26, 2012 the Agency received a complaint alleging registrants were sending mammogram studies to him instead of the physician ordering the study. The complainant provided a list of patients involved. The complainant was concerned that patients needing immediate care may experience a delay in treatment or other action due to the results coming to him and not the prescribing physician. The registrants provided by the complainant were contacted by the Agency. Each registrant stated that the patients had requested the mammogram and had provided the complainant's name as their physician. The complainant was contacted and informed that the studies had been requested by the patient and that his name had been provided as their physician. The complaint was not substantiated. No violations were cited.

File closed.

C - 2418 - Regulatory Violations - Frisco Pain Center, LLC - Frisco, Texas

On July 25, 2012, the Agency received a complaint alleging that uncredentialed personnel at one office for a registrant were performing fluoroscopy. Additionally, it was alleged there may be C-arm units at two locations but the registration states there are two fluoroscopy units at one location. The Agency inspected both locations and determined that the registrant had units at two different facilities contrary to registration. Additionally, the registrant failed to establish public dose measurements at the unregistered location. The complaint that uncredentialed personnel were performing fluoroscopy could not be substantiated. The complaint was partially substantiated. Five violations were cited.

File closed.

C - 2420 - Not Registered for Laser Services - Laser Scientific - Round Rock, Texas

On July 30, 2012, the Agency received an anonymous complaint that a company in Round Rock, Texas, was making components for medical laser hair removal machines and providing services for laser hair removal machines and was not registered to do so. A review of records indicated that the company had applied for registration but had not completed the application process. The company was contacted and informed that they needed to complete the registration process to continue providing services. The company reapplied for registration on September 8, 2012. The complaint was substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Fourth Quarter 2012

C - 2421 - Personnel Exposure Monitoring Not Provided - PDQ Imaging Services, LLC – De Leon, Texas

On August 1, 2012, the Agency received a complaint alleging that a mobile radiographic services registrant did not monitor the complainant's radiation exposure during the approximate 12 months he was employed nor did it provide any protective devices (lead apron) for the complainant to use for himself or patients until approximately one month prior to the end of his employment. The Agency's investigation substantiated the allegation that the registrant had failed to provide personnel exposure monitoring for the complainant as required for the approximate 12 months he was employed. The Agency was unable to substantiate that a protective device was required. One violation was cited.

File closed.

C - 2428 - Regulatory Violations - Alamo Mobile X-Ray - San Antonio, Texas

On September 12, 2012, the Agency received a complaint alleging that the registrant was operating mobile x-ray units with various equipment problems that may affect their safe operation. The Agency conducted an inspection on November 28, 2012. The inspector found two of the machines in use failed the reference light test. One of the machines failed the technique factor test. The inspector found that equipment performance tests had not been completed every two years as required. The registrant took the two devices for repair and testing on November 28, 2012. The complaint was substantiated. Five violations were cited.

File closed.

C - 2430 - Regulatory Violation - Hammami Imaging and Associates MD PA - Edinburg, Texas

On September 18, 2012, the Agency received an anonymous complaint that the registrant was using a computed tomography (CT) scanner to perform routine x-rays. On October 30, 2012, the Agency performed an on-site inspection. The inspector found the registrant was using the device's scout mode to perform routine diagnostic medical radiography on patients. The complaint was substantiated. One violation was cited. The Agency reviewed the information obtained in the original investigation and searched other resources for information pertaining to the non-standard use of CT scout mode for diagnostic radiography. The Agency determined that in order to evaluate patient safety and regulatory compliance, the rules for regular x-ray machines, rather than the CT specific rules, would be the most applicable. An on-site investigation was conducted on July 16, 2013, in regard to the non-standard use of the CT. Five violations were cited.

File closed.