



INCIDENT AND COMPLAINT SUMMARIES FOR SECOND QUARTER 2012*

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Regulatory Services Division
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* Any complaints 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 2012

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Incidents Opened Second Quarter 2012

I - 8945 - Radioactive Material Found - MINCO Technology Labs LLC - Austin, Texas

On April 2, 2012, the Agency was notified that a semiconductor company in Austin, Texas, had accidentally received electronic components containing small amounts of krypton-85 (Kr-85) from a company in the Philippines. The Philippine company assembled and tested the components for the Austin company. The Kr-85 gas was used for leak detection in the hermetic electronic components. The Agency's investigation revealed that the Kr-85 was sent to the Austin company in the components by accident and was due to an apparent failure of a radiation detector in the Philippine company's testing equipment. No regulatory exposure limits were exceeded as a result of the incident. 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 investigation into this event is ongoing.

File open.

I - 8947 - Abandoned Well Logging Sources - Schlumberger Technology Corp. - Reeves County, Texas

On April 12, 2012, the licensee notified the Agency that it had abandoned three well logging sources down hole in Reeves County, Texas. The sources--two 16 curie americium-241/beryllium sources and a 1.7 curie cesium-137 source--were abandoned between 12,277 and 12,318 feet after multiple recovery attempts. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A 208-foot red-dyed cement plug was set with the top at 11,960 feet. A production liner was run above the abandonment and included a collar with a "no drill plate" at 11,953 feet which will serve as a mechanical deflection device. A plaque will be mounted at the well head as a warning that radioactive sources are abandoned in the well and to provide persons with the State of Texas radiation control program contact information. No violations were cited.

File closed.

Incidents Opened Second Quarter 2012

I - 8948 - Therapy Event - University of Texas M. D. Anderson Cancer Center - Houston, Texas

On April 13, 2012, the Agency was notified by the licensee that a therapy event had occurred on April 11, 2012. A patient was prescribed 105 grays using yttrium-90 microspheres. The patient received only 77.4 grays. The licensee stated that during the procedure the physician noticed a pressure release valve was activating and the fluid from the infusion syringe was flowing into the vented vial on the input side rather than through the output side and into the patient. The physician checked the output tubing and found a pinch clamp was not fully released. The physician fully released the pinch clamp, the infusion was continued, and flow appeared to be normal. The initial disturbance in the infusion process apparently either prevented some of the microspheres from exiting the dose vial or trapped some of the spheres along the output tubing, tubing/microcatheter junction and/or microcatheter. The licensee stated that there were no adverse effects on the patient. As corrective action, the licensee will review each technologist's proficiency for delivery system set-up, the interventional radiologist will confirm set-up prior to each infusion which will serve as a second check, and a check list has been developed and will be used for all future treatments to ensure specific steps have been completed prior to infusion. No violations were cited.

File closed.

I - 8949 - Abandoned Well Logging Sources Down Hole - Weatherford International - Moore County, Texas

On April 21, 2012, the Agency was notified by the licensee that after eight days of trying to retrieve a logging tool from a well in Moore County, Texas, they had decided to abandon the tool and sources down hole. The tool contained a 5 curie americium-241/beryllium source and a 1.5 curie cesium-137 source. The licensee stated the sources were abandoned at a depth below 3,400 feet. Two hundred feet of red-dyed cement and a deflection device were placed above the tool to prevent intrusion. A plaque was ordered to be placed at the well head as a warning that radioactive sources are abandoned in the well and to provide persons with the State of Texas radiation control program contact information. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 8950 - Gauge Shutter Failure - Formosa Plastics - Point Comfort, Texas

On April 25, 2012, the Agency received a reciprocity request from a nuclear gauge manufacturer to perform maintenance on a nuclear gauge at a licensee's facility in Point Comfort, Texas. The reciprocity request stated that it was to perform a shutter repair to a Ronan SA-1 nuclear gauge containing 50 millicuries of cesium-137. The Agency contacted the licensee and asked if it needed to report a stuck shutter. The licensee stated that the manufacturer was performing inspections of its gauges and found this shutter was stuck in the open position. This gauge normally operates with the shutter in the open position so there was no additional exposure hazard. The manufacturer returned to the licensee's facility on April 30, 2012 and cleaned and adjusted the gauge shutter. One violation was cited.

File closed.

Incidents Opened Second Quarter 2012

I - 8951 - Damaged Moisture/Density Gauge - Rone Engineering Services - San Antonio, Texas

On May 4, 2012, the licensee notified the Agency that one of its moisture/density gauges had been run over and damaged by a water truck on a temporary job site in San Antonio, Texas. The licensee's technician was utilizing the Troxler Model 3430 Plus gauge, which contained 8 millicuries of cesium-137 and 40 millicuries of americium-241, for density control on asphalt. At the completion of one test, he set the gauge down on the ground approximately 5 feet to his right. He marked the test spot and then was guiding the coring vehicle to the spot when a water truck began backing into the area from his left. The technician and another worker attempted to get the driver's attention but were unsuccessful. As the vehicle continued it ran over the gauge. At the licensee's request, the Agency responded to the incident to survey the gauge to determine whether the source was still fully shielded and the gauge was still safe. The licensee had also called a licensed service company from Austin. The Agency inspector and service company representative both surveyed the gauge and determined that the source was fully shielded. The service company packaged the damaged gauge and transported it to their facility. The gauge was not repairable. One violation was cited.

File closed.

I - 8952 - Abandoned Well Logging Sources Down Hole - Thru-bit LLC - Harrison County, Texas

On May 5, 2012, the licensee notified the Agency that it had abandoned well logging sources down hole in a well in Harrison County, Texas, after retrieval attempts had failed. The licensee abandoned a 1.61 curie cesium-137 source at 11,362 feet, an 18.9 millicurie californium-252 source at 11,351 feet, and also at that depth were two 100 nanocurie cesium-137 energy compensation sources. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A 500-foot red-dyed cement plug was set with the top at 4,570 feet with drill pipe that was also abandoned to serve as a means to prevent inadvertent intrusion on the source. An additional cement plug was set between 2,700 feet and 2,000 feet as the well will be sidetracked at approximately 2,155 feet. 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 State of Texas radiation control program contact information. No violations were cited.

File closed.

I - 8953 - Abandoned Well Logging Sources Down Hole - Baker Hughes Oilfield Operations, Inc. - Polk County, Texas

On May 8, 2012, the Agency was notified by the licensee they had abandoned a 15 curie americium-241/beryllium source at 14,906 feet and a 2.5 curie cesium-137 source at 14,922 feet. A 230-foot red-dyed cement plug, whipstock, and cast iron bridge device were placed above the tool string to prevent intrusion on the sources. 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 State of Texas radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

Incidents Opened Second Quarter 2012

I - 8954 - Nuclear Pharmacy Error - Cardinal Healthcare 414 LLC dba Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On May 9, 2012, the Agency was notified by the licensee that on April, 30, 2012, it had delivered a unit dose of technetium-99m to the wrong hospital. The licensee coordinated with its customers to provide corrected replacement unit dosages. No patients were administered an incorrect product. The licensee determined that the individual packaging the materials for transport inadvertently switched the unit dosages and the mistake was not realized upon verification. The licensee reported that its employees were counseled and retrained on the proper procedures. No violations were cited.

File closed.

I - 8955 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On May 15, 2012, the Agency was notified by the licensee that it had shipped the wrong form of technetium-99m to a hospital on May 2, 2012. The error was discovered when the hospital reviewed a patient's scan and found that it did not produce the image they had ordered. The hospital contacted the licensee and informed them of the error. The hospital reported that no adverse effects were experienced by the patient who had received the incorrect radiopharmaceutical. The individual dispensing the unit dosage inadvertently selected the incorrect drug vial and the pharmacist on duty did not catch the mistake during verification. The licensee counseled all employees involved in the error, conducted a staff meeting, and trained personnel on proper verification procedures. No violations were cited.

File closed

I - 8956 - * - The Methodist Hospital - Houston, Texas

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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. A technician failed to insert a conical collimator prior to a stereotactic surgery procedure which had resulted in a dose being delivered to a patient that varied greater than 10% from the prescribed dose. An investigation into this event is ongoing.

File open.

Incidents Opened Second Quarter 2012

I - 8958 - Nuclear Pharmacy Error – Cardinal Health 414 LLC dba Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On June 7, 2012, the Agency was notified by the licensee that on June 4, 2012, it sent four unit doses of technetium-99m that had expired on June 1, 2012, to a hospital. The error occurred when the technician dispensing the unit dose failed to recognize that the solution in the drug vial had expired and sent the unit dose created from it to the hospital. The error was not discovered until after a unit dose had been administered to two patients. The licensee stated that neither patient experienced any adverse effects and that the scan results were normal. The licensee counseled all employees involved in proper selection and product review procedures. No violations were cited.

File closed.

I - 8959 - Medical Event - Oncology Consultants - Houston, Texas

On June 7, 2012, the Agency was notified by the licensee that a medical event had occurred that day when a patient was administered the wrong form of fluorine (F)-18. The cause for the error was the technician marked F-18 Naf instead of F-18 Fdg on the order form sent to the pharmacy. The error was not discovered until after the unit dose was administered to the patient. The patient and the patient's physician were notified. The licensee reported that the patient did not suffer any adverse effects from the error. The F-18 Naf is rarely used at this facility so it was removed from the order form to prevent a recurrence of the error. No violations were cited.

File closed.

I - 8960 - Gauge Shutter Failure - Nucor Steel Texas Division - Jewett, Texas

On June 15, 2012, the Agency was notified by the licensee that the shutters on five Berthold Technologies Model LB300ML nuclear gauges, each containing a 4 millicurie cobalt-60 source, may have been damaged. The gauges are used in a steel mold and protected inside of the mold housing. An electrical power failure at the facility caused molten steel to pour onto the gauge protective housing and leak into the area around the gauges. The licensee contacted a service provider who inspected the gauges on June 15, 2012. The service provider stated that the shutters would not operate, but the sources did not appear to be affected. The licensee stated that there was no increased risk of exposure to their workers due to the failed shutters. The sources were leak tested on June 15, 2012, and the results for all sources were satisfactory. The licensee replaced the gauge housing using the sources from the damaged gauges. No violations were cited.

File closed.

Incidents Opened Second Quarter 2012

I - 8961 - Lost Equipment Containing Radioactive Material - Team Industrial Services - Robstown, Texas

On June 19, 2012, the Agency was notified by the licensee that one of its radiography crews reported it had lost a QSA Global model 880D camera containing 13.4 curies of iridium-192. The radiography crew stated that about 3.5 miles into the return trip to the office an individual in another vehicle motioned for them to pull over. The individual told them that the door to their dark room was open. The radiographer went to the back of the truck to close the door and discovered the radiography camera and transportation container were both missing. The radiographers went back to the work location and searched for the camera. The radiographers walked the road from the work location to where they had discovered the camera missing but did not find it. The radiographer stated that the source was locked in the fully shielded position and the result of the final survey of the camera was normal. The licensee notified local law enforcement and meet with them later that night. The licensee contacted the Agency at 0015 hours on June 20, 2012, and reported that the camera and source had been recovered. An individual had found the camera lying in the road and contacted the licensee. The transportation container was still locked and the camera was inspected and found to be undamaged. The licensee reported the event was caused by a failure of the radiographers to properly secure the transportation container to the vehicle. The licensee inspected all of its vehicles from this location and repaired or replaced any storage box not meeting the transportation requirements. The licensee conducted meetings with its employees to discuss the event and its procedures regarding the transport of these devices. The licensee and both radiographers were each cited for one violation.

File closed.

I - 8962 - Radioactive Material Identified at Landfill - Spectrum Tracer Services LLC - Odessa, Texas (San Angelo, Texas)

On June 14, 2012, Agency investigators responded to a technical assistance request at the San Angelo municipal landfill. A trailer of trash from an oil well site had caused the radiation monitor to alarm on June 11, 2012, and the landfill was unable to identify the isotope. Agency investigators identified the material as iridium-192. An investigation into this event is ongoing.

File open.

I - 8963 - Badge Overexposure - Midwest Inspection Services - Perryton, Texas

On June 20, 2012, the Agency was notified by the licensee that, upon processing, a badged worn by one of its radiographer trainees indicated a reading of 33,480 millirem. The dosimetry report stated that the image indicated an irregular exposure. The individual was interviewed and stated that he had not dropped or misplaced his badge at any time. He stated that he had not received any alarms on his alarming rate meter during the exposure period. Radiographers who had worked with the individual were also interviewed and they could not recall any instance that would have caused the high badge reading. The licensee determined that the dose was to the badge only. The licensee assigned 160 millirem to the individual for the exposure period, which was the total of the radiographer's self-reading dosimeter readings for that exposure period. No violations were cited.

File closed.

Incidents Opened Second Quarter 2012

I - 8964 - Lost Lasers - University of Houston - Houston, Texas

On June 27, 2012, the registrant notified the Agency that class 3b and class 4 lasers could not be located during an inventory. In February 2012, the registrant discovered and reported two missing lasers and a violation was cited for failing to conduct annual inventories (I-8933). The registrant conducted a full inventory in response to that Notice of Violation and as a required activity. The registrant discovered more lasers could not be accounted for. By the end of the inventory, the registrant determined that besides the two lasers unaccounted for in February, one more class 3b and one more class 4 laser were also unaccounted for. No further violations were cited.

File closed.

I - 8965 - Medical Event - Austin Cyberknife LLC - Austin, Texas

On June 26, 2012, the Agency was notified by the registrant that a medical event had occurred on March 22, 2012. The registrant stated that the patient was prescribed five fractions of 5 gray each to the treatment site. The treatment was inadvertently set in the exposure device to deliver the 25 gray in one treatment. The medical physicist stopped the treatment half way through to recheck the plan and discovered the error. The registrant determined that the treatment site had received 12.915 rad exposure. The registrant determined that the 12.915 rad exposure delivered to the treatment site would have nearly the same biological effects on the treatment site as the 5 fractions of five gray would have had, so no additional exposure was required. The patient and their physician were notified of the error. The registrant stated the effects to the patient from this event would be minimal. The registrant has implemented additional checks of equipment settings prior to the administration of a treatment to prevent a recurrence of this event. No violations were cited.

File closed.

I - 8966 - Abandoned Well Logging Source(s) Down Hole - Halliburton – Houston, Texas (Leon County)

On June 28, 2012, the Agency was notified that the licensee had abandoned a 2 curie cesium-137 source, a 135 nanocurie cesium-137 source, and a 230 nanocurie cesium-137 source down hole in a well in Leon County, Texas. The licensee stated that 348 feet of red-dyed cement along with 3,213 feet of drill pipe were in place above the sources to prevent intrusion into the sources. A plaque will be mounted at the well head as a warning that radioactive sources are abandoned in the well and to provide persons with the State of Texas radiation control program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

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

I - 8886 - Overexposure - Caribbean Inspection & NDT Services, Inc. - Port Lavaca, Texas

On September 19, 2011, the Agency received an email stating that a radiographer trainee (RTT) may have received an overexposure to one of his hands and was seeking medical attention in a Houston, Texas hospital. The RTT stated that he was performing radiography using an Amersham 660 camera containing 73 curies of iridium-192 on September 13, 2011. He stated that the last shot had been completed and he was removing the guide tube to move the camera when he saw the source was sticking out of the front of the camera about 2 inches. He stated that he immediately retracted the source to its fully retracted and locked position. He stated that he did not tell his trainer what had happened. On September 16, 2011, the thumb, index finger, and middle finger of his hand began to swell and turn yellow. At this point he began to seek medical attention that resulted in his admission to the hospital in Houston. The RTT was diagnosed with a radiation burn to his hand. The radiographer trainer (RT) stated that the RTT never had access to the camera while the source could be moved out of the camera. He stated that the RTT only took the camera from the truck to the work location and back to the truck after the source had been locked in the shielded position. Two trainees who had previously worked with the RT stated that they were allowed to crank the source in and out when they worked with the RT and one stated that the RT had left him unsupervised on at least one occasion when he was performing radiography. The licensee assigned a dose of 2,703 rem to the radiographer's finger. The licensee, radiographer, and radiographer trainee were all cited for multiple violations.

File closed.

I - 8917 Gauge Shutter Failure - Huntsman Petrochemical LLC - Port Neches, Texas

On January 6, 2012 the Agency was notified by the licensee that while conducting a routine maintenance check, the shutter on an Ohmart /Vega model SH-F2 was found to be stuck in the open position. The gauge contained 375 millicuries of cesium-137. The gauge normally operates with the shutter in the open position. The gauge did not pose an increased exposure hazard to the general public or to the workers. On February 3, 2012, the manufacturer representative attempted to close the shutter on the gauge but was unsuccessful. The licensee decided that the gauge and source were no longer needed and on April 5, 2012, the gauge and source were returned to the manufacturer. No violations cited.

File Closed.

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

I - 8925 - Radioactive Material at Scrap Yard - Tradewinds Aircraft Supply - San Antonio, Texas

On December 29, 2012, the Agency received a referral from the Texas Commission on Environmental Quality concerning an aircraft scrap yard in San Antonio. The scrap yard had numerous aircraft gauges that contained radium-226. A joint on-site investigation was conducted. The Agency's investigation of the radiological concerns revealed that most of the gauges were obtained prior to January 1, 1986, which by rule made the majority of the gauges exempt from regulation. The facility owner will ensure proper removal of the radioactive material. The Agency will conduct a follow-up investigation. No violations were cited.

File closed.

I - 8928 - Transportation Violation - RNLS, LLC dba Renegade Services - College Station,

On January 23, 2012, the Agency was notified that a licensee had improperly shipped a container that held radioactive material. The licensee was attempting to return an empty container to its radioactive tracer material manufacturer. Upon arrival, the manufacturer discovered that one can of the licensee's tracer material, containing 30 millicuries of antimony-124, was still inside the shipped container which had "empty" labels affixed to it and was not accompanied shipping papers indicating the container held radioactive material. The licensee's investigation determined that the employee who prepared and shipped the container had not properly surveyed the container and therefore failed to identify the material was present. The Agency's investigation revealed that the licensee had failed to train employees responsible for shipping as required. Three violations were cited.

File closed.

I - 8933 - Lost Lasers - University of Houston - Houston, Texas

On February 13, 2012, the registrant's Laser Safety Officer notified the Agency that they were unable to locate two Class 3B and one Class 4 lasers at their facility. The registrant's investigation into the event concluded that the devices were removed from the storage location prior to a renovation project conducted in the storage area and were unable to determine the current location of the devices. The registrant provided additional awareness training for all project managers involved in construction projects which included protocols for ensuring the safety of radiation devices during construction activities. One violation was cited.

File closed.

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

I - 8934 - Overexposure - Metco - Houston, Texas

On February 17, 2012, the licensee notified the Agency of an overexposure event involving one of its radiographers. The radiographer was working in a shooting bay at the licensee's facility and was using a QSA D880 radiography camera containing a 37 curie iridium-192 source. The radiographer was using her cell phone when she entered the bay to set up her next shot. Her head was about 12 inches beneath the collimator for about two and a half minutes. When she exited the bay she attempted to crank out the source but realized the camera was unlocked and the source was still cranked out and in the collimator from the previous shot. She did not perform a proper survey of the camera or the source guide tube after the previous shot. The shooting bay is equipped with an audible and visual alarm to indicate when a radioactive source is exposed. Another worker had opened a breaker that turned off ventilation fans in the building which also supplied power to the audible and flashing red light alarm for the fixed bay. An on-site investigation by the Agency was conducted on March 15, 2012. Based on two reenactments, it was determined that the radiographer received a whole body exposure to her head of 8.116 rem. Corrective action included properly labeling and locking the breaker panel for the alarm power, training all radiographers on the incident, and banning the use of cell phones during radiography. Three violations were cited.

File closed.

I - 8938 - Transportation Event - NDE Solutions LLC - Burleson County, Texas

On February 27, 2012, the Agency was notified that an industrial radiography truck belonging to the licensee had been involved in a single vehicle rollover accident on a rural road in Burleson County, Texas. The radiography camera, which contained 69.2 curies of iridium-192, remained secured inside the locked lockbox which was affixed inside the darkroom even though the darkroom separated from the vehicle. The Burleson County Emergency Management Coordinator (EMC) and the Snook Volunteer Fire Department responded to the scene followed by a licensee employee and the licensee's Radiation Safety Officer. The EMC and fire department conducted initial radiation surveys and determined there were no elevated radiation readings, which was confirmed by the licensee's staff. The driver was transported to a local hospital where he was checked for injuries and released. He suffered no major injuries. There was no damage to the camera and there was no exposure to any individual. The licensee's investigation revealed the accident occurred because driver had fallen asleep and had overcorrected the steering when he awakened. No violations were cited.

File closed.

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

I - 8939 - Stolen Radioactive Material - Fugro Consultants LP - Mont Belvieu, Texas

On March 5, 2012, the Agency was notified by the licensee that a moisture density gauge had been stolen from one of its vehicles. The gauge was a Troxler Model 3430 containing a 8.0 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source. The gauge was recovered by the licensee later that same day. The investigation conducted by the licensee found that the technician had driven away from the job site with the gauge sitting unsecured on the tailgate of the truck. A member of the general public saw the gauge fall out of the truck and informed another technician sent to replace the first technician. The gauge was recovered with the sources in the shielded positions. A survey of the gauge and the surrounding area was conducted by the licensee and dose rates were found to be normal. The licensee stated that due to the shielded position of the sources, the location where the gauge was found, and the results of the dose rate survey, exposure to any individual was not likely. The gauge was sent to a service company for inspection and repair. The licensee terminated employment of the employee who lost the source. The licensee reviewed the event and the company's procedure for handling and transporting nuclear gauges with all of its technicians. One violation was cited.

File closed.

I - 8941 - Lost Source of Radioactive Material - Probe Technology Services Inc. - Houston, Texas

On March 22, 2012, the Agency was notified by a licensee that a 350 millicurie americium-241/beryllium source was lost during shipment. Investigation of the incident revealed that the licensee in Fort Worth, Texas, that was shipping the source had inadvertently switched the billing address (Houston, Texas) and shipping address (Corpus Christi, Texas) on the bill of lading that was provided with the source package to the common carrier. The common carrier attempted to deliver the source package to the Houston address but the receiving licensee rejected delivery as it was not licensed to receive radioactive material at that address. The source package was taken to the common carrier's Houston service center. The carrier contacted the shipping licensee and then created a new bill for the source package to be delivered to the correct address in Corpus Christi. The source package was transported by the common carrier to its service center in San Antonio for distribution to Corpus Christi. When the source package was scanned in San Antonio, the original label was scanned instead of the new one. The source package was taken back to the Houston service center and became lost after its arrival. The common carrier reported it searched its service center facilities extensively and repeatedly and contacted customers it delivered to immediately following the disappearance of the package. The source package was not located. The shipping licensee, receiving licensee, and common carrier will notify the Agency if new information is received or the source package is located. No violations were cited.

File closed.

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

I - 8943 - * - CHCA Clear Lake LP - Texas City, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 8944 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On March 23, 2012, the Agency was notified by the licensee that it had shipped the wrong form of technetium-99m to a hospital. The error was discovered when the hospital reviewed a patient's scan and found that it did not produce the image they had ordered. The hospital contacted the licensee and informed it of the error. The hospital reported that no adverse effects were experienced by the patient who had received the incorrect radiopharmaceutical. The licensee stated the error occurred when a unit dose prescription for technetium-99m oxidronate was placed within a stack of technetium-99m sodium pertechnetate and the technician failed to catch the error. The prescription was filled with technetium-99m sodium pertechnetate. The licensee counseled all employees involved in the error. No violations were cited.

File closed.

Complaints Opened Second Quarter 2012

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

On April 5, 2012, the Agency received a complaint alleging the an individual had received unspecified burns while receiving treatment at a laser facility. The investigation into this event is ongoing.

File open.

C - 2394 - Regulatory Violations - Premier Dental Seguin PLLC - Seguin, Texas

On April 17, 2012, The Agency received a complaint alleging that employees at a registrant's dental office are required to hold the head of an x-ray device while taking x-rays. The Agency conducted an on-site investigation on May 24, 2012. The investigation found that a technician had held the x-ray receptor in the patients' mouth on a few occasions when a patient was not able to hold the receptor in position on their own. The technician stated they had not held the x-ray device head on any occasion. The registrant's Operating and Safety Procedure allows for holding of the receptor in a patient's mouth when necessary. No violations were cited.

File closed.

C - 2395 - Unregistered Use of X-ray Machines - The GEO Group, Inc. - Karnes City, Texas

On April 17, 2012, the Agency received a complaint that a civil detention center in Karnes City, Texas, did not have required radiation-related signage posted, did not have personal dosimetry for staff operating x-ray machines, and was possibly not registered with the Agency. The Agency conducted an on-site inspection and investigation. The investigation revealed that the company managing the facility had installed an x-ray machine and had been using it since March without registering with the Agency. Employees were not provided with personal dosimetry and required signs were not posted. The facility's health services administrator stated she had only been in the position a short time and had recently become aware of the registration and dosimetry issues. The administrator had begun taking action to correct these issues prior to the investigation. The complaint was substantiated. Six violations were cited.

File closed.

C - 2396 - Naturally Occurring Radioactive Material - Firefish Group - Burleson, Texas

On April 27, 2012, the Agency received a complaint alleging that a facility was handling naturally occurring radioactive material (NORM) in a manner which may violate Agency rules. An on-site investigation was conducted on May, 15, 2012 and May 22, 2012. The investigation determined that the pipe was being collected at this facility and then sent to other locations for reprocessing into other forms of usable steel. The facility was not performing decontamination of the pipe. The company's Chief Executive Officer stated that they had discussed their business model with both state and federal agencies. An investigation into this complaint is ongoing.

File open.

Complaints Opened Second Quarter 2012

C - 2397 - * - Transitional Hospitals Corp. of Texas, Inc. dba Kindred Hospital Tarrant County, Southwest Campus - Fort Worth, Texas

*Health and Safety Code Chapter 241.051(d)

Seven violations were cited.

File closed.

C - 2398 - Regulation Violation - Careers in Dental Assisting - Royse City, Texas

On May 2, 2012, based on information collected in a previous investigation, the Agency opened a complaint against this entity for allowing students to x-ray other students for training purposes. An on-site investigation was conducted on May 15, 2012 by an Agency inspector. The inspector found that the registrant was allowing students to perform x-rays on other students for training purposes. The complaint was substantiated. One violation was cited.

File closed.

C - 2399 - Regulation Violation - Dental Career Center of Texas - Rockport, Texas

On May 2, 2012, based on information collected in a previous investigation, the Agency opened a complaint against this entity for allowing students to x-ray other students for training purposes. An on-site investigation was conducted on May 9, 2012 by an Agency inspector. The inspector found that the registrant was allowing students to perform a set of x-rays for diagnostic purposes under his direct supervision on students. The complaint was not substantiated. No violations were cited.

File closed.

C - 2400 - Regulation Violation - Milan Institute - Amarillo, Texas

On May 2, 2012, based on information collected in a previous investigation, the Agency opened a complaint against this entity for allowing students to x-ray other students for training purposes. On May 23, 2012, the Agency conducted an on-site investigation of the complaint. The inspector determined that the entity was allowing students to take x-rays on other students for training purposes. The entity has provided documents to the Agency indicating that they will not allow this practice to continue. The complaint was substantiated. One violation was cited.

File closed.

Complaints Opened Second Quarter 2012

C - 2401 - Regulation Violation - VIP Dental Training Center - Flower Mound, Texas

On May 2, 2012, based on information collected in a previous investigation, the Agency opened a complaint against this entity for allowing students to x-ray other students for training purposes. On May 21, 2012, an Agency inspector performed an on-site investigation at the registrant's facility. The inspector was able to substantiate the allegation. One violation was cited.

File closed.

C - 2402 - Uncredentialed Technicians - San Antonio Diagnostic Imaging Inc.- San Antonio, Texas

On May 2, 2012, the Agency received a complaint alleging that uncredentialed personnel at three of a registrant's facilities were conducting fluoroscopy and other x-ray examinations. A recent inspection had been conducted at one of the facilities on April 20, 2012, and on May 16, 2012, inspections were conducted at the other two facilities. Additionally, two recent inspections had been conducted at facilities in Houston that were owned by the same doctor. The complaint could not be substantiated. One unrelated violation was cited.

File closed.

C-2403 - Regulatory Violations - Rodeo Dental - Ft. Worth, TX

On May 17, 2012, the Agency received an anonymous complaint that dental staff were performing x-rays on children and the operator was not moving 6 feet away from the x-ray machine while in operation. It was also alleged that staff were pressured to hold the patient if needed to complete the x-ray. The investigation into this complaint is ongoing.

File open.

C-2404 - * _____ - Vibra Specialty Hospital - DeSoto, TX

*Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Complaints Opened Second Quarter 2012

C-2405 - Regulatory Violation - Lake Pointe Cancer Center - Rowlett, TX

On June 4, 2012, the Agency received an anonymous complaint alleging that the Radiation Safety Officer (RSO) listed on the registration for the cancer center quit working at the facility in December 2011, and no one had been selected as the new RSO. On June 8, 2012, the Agency conducted an on-site investigation and interviewed several employees. The employees reported that a new doctor had been the RSO since January 2012. The RSO name had not been updated on the license. A full inspection of the facility was conducted and no other violations were noted. The complaint was substantiated. One violation was cited.

File closed

C – 2406 - Radiation Exposure to Member of the General Public - Texoma Pulmonary & Sleep Specialist - Sherman, Texas

On June 5, 2012, the Agency received a complaint stating that individuals working adjacent to the registrant's facility were concerned about the exposure to radiation they were receiving from the registrant's x-ray device. An Agency inspector performed an on-site inspection at the registrant's location. The inspector found that the registrant had failed to perform surveys to demonstrate compliance with rules regarding exposure to members of the general public and failed to provide personal monitoring devices for their employees performing operations with an x-ray device. The complaint was substantiated. Two violations were cited.

File closed.

C - 2407 - Public Safety Matter - Janex Integrity Group - Catarina, Texas

On May 23, 2012, the Agency received a phone call from an individual who stated he had worked as a radiographer trainee in the Catarina, Texas, area and had observed actions by the radiography company that concerned him. The caller alleged the licensee was taking multiple shots of the same weld and assigning new numbers each time. The individual stated that he had a video on his cell phone that showed them doing this. The Agency contacted The Texas Commission on Environmental Quality and the Railroad Commission of Texas, but both stated that they did not have any jurisdiction. The licensee and the general contractor were both contacted by the Agency and both stated they were aware of the allegations. They both stated they had conducted an investigation into the allegations. They stated that all of the film produced at the project had been reviewed by a level three inspector and one weld was determined to have a small flaw and was replaced. The complainant was contacted and asked for a copy of the video. The complainant stated that he had dropped his phone in water and the video could not be retrieved. The Agency informed the complainant that there was no violation of its rules, but the information gathered during the investigation would be forwarded to the United States Environmental Protection Agency (USEPA). Region 6 of the USEPA was provided a copy of the information on July 31, 2012. No violations were cited.

File closed.

Complaints Opened Second Quarter 2012

C - 2408 - Regulatory Violations -TECHCORR USA LLC - Pasadena, Texas

On June 13, 2012, a welder working at a refinery reported seeing radiography operations in progress close to other workers and that no 2 mrem/hr boundary had been established. On August 2, 2012, the Agency conducted an on-site investigation including monitoring one radiography company that normally operates at the refinery. Additionally, the Agency discovered that the welding company, the refinery, and the radiography company involved in the complaint conducted an investigation on the day of the alleged incident. The Agency reviewed the survey report for the radiography area. The radiographers had appropriate boundaries established. The complaint was not substantiated. No violations were cited.

File closed.

C - 2409 - Unregistered Use of X-ray Machines - Texan Urgent Care - Waco, Texas

On June 21, 2012 the Agency received a complaint that a registrant had opened a new facility and had not registered it with this Agency. The complaint also alleged that the required "Notice To Personnel" was not posted on the wall and that the light used to define the exposure field on the machine was not working. An on-site investigation was conducted by the Agency on June 26, 2012. The registrant provided a copy of their request for an amendment to their registration adding this location and device. A copy of the "Notice To Personnel" was posted on the wall in the x-ray room. A copy of the technique chart was in a book located at the x-ray operator's table. The light indicating the exposure field for the machine operated properly. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2410 - Unregistered Laser - Not Just Ink - Belton, Texas

On June 20, 2012, the Agency received information from one of its inspectors that a facility in Belton, Texas, advertised and possessed equipment for laser tattoo removal and did not appear to be registered with the Agency. The inspector also reported that the facility advertised on its webpage that it performs laser hair removal and laser teeth whitening. An investigation into this complaint is ongoing.

File open.

C - 2412 - * - CHCA Woman's Hospital LP dba Woman's Hospital of Texas - Houston, Texas

*Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

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

C - 2368 - No Radiation Safety Officer - Open MRI and Digital Imaging, LLC - Spring, Texas

On December 2, 2011, the Agency received a phone call from an individual who alleged that the Radiation Safety Officer (RSO) on a facility's registration left the facility about two years previously and had not been replaced. The Agency conducted an on-site inspection and investigation. The investigation revealed the RSO listed on the registration was still coming to the facility on a regular basis but the inspection revealed he was not performing activities required of an RSO. The complaint was substantiated. Seven violations were cited.

File closed.

C - 2381 - Unregistered Dental Radiographic - Joe Schmidt, DDS - West Lake Hills, Texas

On February 17, 2012, the Agency received an anonymous complaint that a dentist was not registered with the Agency. On March 12 and May 15, 2012, the Agency conducted an on-site investigation at two facilities operated by the dentist. At one site, the Agency found an expired registration belonging to a previous dentist and a search of Agency records revealed the registration had been terminated in April 2008. The dentist did not register with the Agency for the use of dental radiographic machines, as required, when he took over the practice. The investigation further revealed that the dentist did have a registration for the use of dental radiographic machines for the other site, but he failed to amend his registration when he added machines. The complaint was substantiated. Two violations were cited.

File closed.

C - 2386 - Inadequate Credentialing - Eves Breast Center- Southlake, Texas

On March 8, 2012, the Agency received a complaint alleging that the registrant was allowing individuals who do not hold the appropriate credentials to provide mammography services. It also alleged that the registrant was not performing quality control tests on the mammography units. An on-site inspection was conducted by an Agency inspector on June 7, 2012. The inspector did not find any items of non-compliance. The complaint could not be substantiated. No violations were cited.

File closed.

C- 2387 - Uncredentialed Technicians - Southmore Medical Clinic - Pasadena, TX

On March 9, 2012 the Agency received an anonymous complaint that a medical facility was allowing uncredentialed technicians to take x-rays. The complainant reported multiple x-ray violations about the facility. On March 15, 2012 an on-site investigation was completed by the Agency. The complaints could not be substantiated. No violations were cited.

File closed.

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

C - 2390 - Inadequate Credentialing - Greenhill Clinic PA - Frisco, Texas

On March 22, 2012, the Agency received a complaint alleging that a registrant was allowing individuals who are not credentialed to perform x-rays. An on-site investigation was completed on May 14, 2012. The inspector found that only qualified individuals or individuals under direct supervision of the doctor had performed x-rays. The complaint could not be substantiated. No violations were cited.

File closed.