



# **INCIDENT AND COMPLAINT SUMMARIES FOR THIRD QUARTER 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.shtm>

## **Incident and Complaint Summaries**

**3rd Quarter 2012**

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## Incidents Opened Third Quarter 2012

### I - 8967 - Nuclear Pharmacy Error - Cardinal Health - Austin, Texas

On July 5, 2012, the Agency was notified by the licensee that on July 2, 2012, it received a report from a hospital stating a study it had performed using a unit dose provided by the licensee produced unexpected results. The licensee determined that its pharmacist used a vial of technetium-99m Sestamibi instead of technetium-99m Medronate to produce the unit dose. The licensee reported that the patient did not experience any adverse medical reactions due to the error. The licensee counseled all individuals involved in the error on the proper procedure for selection and review of unit dose production. No violations were cited.

File closed.

### I - 8968 - Abandoned Well Logging Sources Down Hole - Schlumberger Technology Corporation - Upton County, Texas

On July 14, 2012, the Agency was notified by the licensee that it was abandoning a 1.7 curie cesium-137 and two 16 curie americium-241/beryllium sources down hole in a well in Upton County, Texas. The licensee stated that the source tool was stuck at a top of tool depth of 11,300 feet. A 155-foot cement plug with red color dye was placed above the tool from 11,300 feet to 11,145 feet. A deflection device was placed above the cement plug. As required by rule, a plaque was ordered for placement at the well head as a warning that radioactive sources were abandoned in the well and to provide 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 Third Quarter 2012

### I - 8969 - Therapy Event - Corpus Christi Precision Cancer Center - Corpus Christi, Texas

On July 17, 2012, the Agency was notified by the registrant that it had treated a patient with a treatment plan intended for a different patient. The patient and the patient's physician were notified of the event. The treatment site and dose for the two patients were similar. The event occurred when therapist #1 escorted a patient into the treatment room. Therapist #2, who was stationed at the treatment console, moded up the next patient on the treatment schedule and reviewed the patient's photo in the chart and compared it with the patient being escorted into the treatment room. The photo appeared to therapist #2 to be a match with the patient in the treatment room. After therapist #1 had completed the patient set-up in the treatment room, she left the treatment area to use the restroom. Cone-beam computerized tomography (CT) localization was performed initially and the patient was quite close in shape and volume to the incorrect patient's reference CT, so therapist #2 believed this to be the correct patient and set-up. After couch correction, which was within tolerance, therapist #2 proceeded with treatment delivery. After therapist #1 returned to the console, she recognized that the incorrect treatment plan was being delivered to the patient and the treatment was stopped. A dose of 115 centigray had been delivered. The registrant determined the error occurred due to the failure of the therapist in the treatment room to verify the identity of the patient being setup. To prevent a recurrence of this event, therapists bringing a patient into the treatment room must verbally verify the patient's identity, then communicate with the therapist at the console so that the appropriate treatment plan is used. The registrant stated the error would not have a measurable effect on the patient's treatment outcome or risk of complication. No violation was cited.

File closed.

### I - 8970 - Lost Source of Radioactive Material - Weatherford International Inc. – Snyder, Texas

On July 20, 2012, the Agency was notified by the licensee that one of its crews had lost a calibration source containing three stainless steel tubes with 1.73 microcuries of natural thorium inside each one. The source was lost between Odessa and Snyder, Texas. Later that day, the licensee reported finding the source at a road intersection outside of Snyder. The container and the sources were not damaged. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2012

### 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 200 millicuries of cesium-137. 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 - 8972 - Stolen Radioactive Material - Apex Geoscience, Inc. - Paris, Texas

On July 26, 2012, the Agency was notified by the licensee that one of its employees had been missing all day with a company truck and a Humboldt Scientific Inc. model 5001 moisture/density gauge containing 10 millicuries of cesium-137 and 40 millicuries of americium-241. Local law enforcement was notified. On July 27, 2012, the employee who had been missing contacted the licensee and reported that the truck and gauge were at his residence. The licensee picked up the gauge and conducted an inspection and leak check. The gauge was in good condition. The licensee terminated the individual's employment. No violations were cited.

File closed.

### I - 8973 - Gauge Shutter Failure - Westlake Longview Corporation - Longview, Texas

On August 7, 2012, the licensee notified the Agency that on August 6, 2012, the shutter on a Ronan Model SA-1 fixed nuclear gauge, containing 100 millicuries of cesium-137, at its facility in Longview, Texas, was found to be stuck in the open position. The gauge normally operates with the shutter in the open position so there was no increased risk to any individual. The licensee contacted the manufacturer to schedule repairs, notified employees of the gauge's status, and implemented administrative controls to restrict access until repairs were completed. The gauge was repaired by the manufacturer on August 28, 2012. The repair technician found that a buildup of debris around the operating mechanism prevented the gauge shutter from closing. The mechanism was cleaned and the gauge was returned to service. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2012

### I - 8974 - Abandoned Well Logging Source Down Hole - Thrubit LLC - Wise County, Texas

On August 7, 2012, the licensee reported to the Agency that it was abandoning a 1.6 curie cesium-137 source down hole in a well located in Wise County, Texas. The licensee was unsuccessful in retrieving the tool string with the density skid containing the source after it became lodged in the hole wall in a curve at 5,522 feet. Also abandoned were two 100 nanocurie cesium-137 energy compensation sources in the detectors. Abandonment procedures were completed in accordance with the Agency and Texas Railroad Commission regulations. Approval was granted and production casing was run inside the bore. Red dyed cement was pumped across and 712 feet above the source, sealing it off from the open wellbore. Standard cement was pumped from below the source to total depth. The 5.5 inch casing will serve as a permanent deflection device. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well, specifically that they are "behind production casing and cemented in place. No perforating, exiting or expanding casing in interval between 5,122 feet and 5,922 feet. Do not re-enter this well before contacting Texas Department of State Health Services Radiation Control Program [and] Texas Railroad Commission." No violations were cited.

File closed.

### I - 8975 - Badge Overexposure - Professional Service Industries Inc. - Houston, Texas

On August 3, 2012, the Agency was notified by the licensee that it had received an exposure report from its dosimetry processor that indicated a radiography trainee had received a higher than expected reading. The badge reading for the trainee was 4,700 millirem for the May 25 to June 24, 2012, exposure period. The radiographer trainee's self-reading pocket dosimeter readings for the exposure period totaled 159 millirem. The licensee interviewed the trainee as well as radiographers the trainee had worked with and was not able to determine how the trainee could have received the exposure. The dosimetry processor reported that the energy of the radiation the badge was exposed to was 60 kiloelectron volts, well below the energy of the gammas emitted by iridium-192. The licensee determined that the exposure was to the badge only. The licensee assigned a dose of 159 millirem to the radiographer for the exposure period. No violations were cited.

File closed.

### I - 8976 - Equipment Malfunction - TAMKO Building Products, Inc. - Dallas, Texas

On August 8, 2012, the licensee notified the Agency that it had experienced an equipment malfunction on an NDC Model 301 scanner that contained a 10 millicurie strontium-90 source. The licensee had attempted to close the shutter and the shutter would not close by normal means. The licensee disconnected the air supply from the machine and the shutter closed. The licensee found the source of the problem was a bad solenoid. The solenoid was replaced and the shutter functioned properly. Because the shutter was able to be closed using the secondary system, this event did not meet the criteria as a reportable event. No violations were cited.

File closed.

## **Incidents Opened Third Quarter 2012**

### I - 8977 - Abandoned Well Logging Sources Down Hole – ThruBit,LLC - Cherokee County, Texas

On July 15, 2012, the Agency was notified by the licensee that a 1.61 curie and two 100 nanocurie cesium - 137 sources were abandoned downhole in a well in Cherokee County, Texas. The sources were abandoned at a depth of 8,216 feet measured depth. A cement plug of 500 feet of red dye cement and 200 feet of conventional cement was placed above the sources. A whipstock was placed above the cement plug to prevent intrusion. The licensee stated that the well will be sidetracked. A plaque will be placed at the well head as a warning that radioactive sources are abandoned in the well and to provide persons with the Radiation Control Program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

### I - 8978 - Nuclear Pharmacy Error - Cardinal Health - Lubbock, Texas

On July 25, 2012, the Agency was notified by the licensee that it was notified by two of its customers that images taken after the administration of technetium-99m Sestamibi were unclear. A third customer who received product from the same lot did not administer the dose. The licensee conducted an investigation into the event and discovered that this lot had failed its quality control test, but the test results were not reviewed prior to these dosages being sent out. The licensee reviewed its policies regarding the required reviews and product testing procedures prior to releasing its product with the employees involved in the error. The licensee stated that no adverse patient reactions occurred due to the error. No violations were cited.

File closed.

### I - 8979 - Stolen Radiography Camera - Eagle X-ray, Inc. - Baytown, Texas

On August 15, 2012, the Agency was notified by the licensee that one of its radiography cameras was stolen out of the dark room on one of its trucks that was parked at its office. A QSA Global model 880 D radiography camera with an 81 curie iridium-192 source was stolen by a relative of an employee. The camera was recovered the next day. On August 23, 2012, the Agency conducted an on-site investigation. Contrary to company policy, the radiographer decided to leave the camera in the truck overnight instead of locking the camera in the vault. No person was present to monitor for the audible alarm when the thief broke open the door and cut the chain that was used to lock the camera into place. The licensee terminated the radiographer's employment and conducted training with all of its workers. Two violations were cited.

File closed.

## Incidents Opened Third Quarter 2012

### I - 8980 - Abandoned Well Logging Sources Down Hole – Thrubit, LLC - Glasscock County, Texas

On August 21, 2012, the Agency was notified by the licensee that a 1.7 curie cesium-137 source was abandoned down hole in a well in Glasscock County, Texas. On September 18, 2012, the licensee reported that the source activity was 1.64 curies of cesium-137 and that two 100 nanocurie cesium-137 sources were also abandoned down hole. The sources were abandoned at a depth of 11,415 feet. A non-drillable plate was set in the well at a depth of 10,496 feet. A 1,970 foot red-dyed cement plug was placed above the drill plate. A plaque will be placed at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the Radiation Control Program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

### 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.

### I - 8982 - Lost Radioactive Material - Imaging Associates of Abilene - Abilene, Texas

On August 30, 2012, a company contracted by a licensee to conduct a closeout of an imaging facility notified the Agency that the licensee had sold an ADAC Gamma/PET Camera early in July 2011 without proper shipping and transfer paperwork and with a 20 millicurie cesium-137 sealed source located inside the PET scanner. The PET scanner was brokered/sold four times and finally a company in Staten Island, New York, purchased and removed the PET machine. The company in New York provided a letter to the Agency stating that it did not transport the PET machine with a source nor did it remove the source. The last radiation safety officer and nuclear medicine technician left the licensee's company in December 2010. During 2011 and 2012 there was no one assigned at the licensee's facility to conduct weekly surveys, conduct a closeout survey, or inventory the sources. Without supervision of the radioactive material, the source went missing and is presumed lost. A formal closeout of the facility was completed by a hired consultant. One violation was cited.

File closed.

## Incidents Opened Third 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 to receive 2,600 centigrays 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 centigrays 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 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 violation was cited.

File closed.

## Incidents Opened Third Quarter 2012

### I - 8986 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On September 5, 2012, the Agency was notified by the licensee that on August 28, 2012, the licensee had sent a unit dose labeled as 15 millicuries fluorine-18 that was assayed by the receiving customer at zero millicuries. The customer returned the unit dose to the licensee. The licensee's investigation determined that the technician preparing the unit dose became distracted during the dispensing of the dose and failed to fill the syringe. The syringe was capped, labeled, packaged and sent out empty. The licensee counseled all individuals involved in the event. A staff meeting was held by the licensee to review the event and stress the importance of using proper dispensing practices. No violations were cited.

File closed.

### I - 8987 - Nuclear Pharmacy Error - Cardinal Health - Dallas, Texas

On September 5, 2012, the Agency was notified by the licensee that on August 29, 2012, they had sent a unit dose to a customer which contained a higher activity than ordered. The licensee notified the customer of the error before the unit dose was administered to the patient. The customer adjusted the dose to use only the activity needed for the study. The licensee's investigation determined that the technician preparing the unit dose inadvertently drew up a higher activity in the syringe than had been requested by the customer. The licensee counseled all individuals involved in the event. A staff meeting was held by the licensee to review the event and stress the importance of using proper dispensing practices. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2012

### I - 8988 - Lost Source of Radioactive Material - Halliburton Energy Services, Inc. - Pecos, Texas

On September 11, 2012, the Agency was notified by the licensee that a 15 curie americium-241/beryllium (Am-Be) source could not be located. The source had been used earlier that day at a well site near Pecos, Texas. The well logging crew left the Pecos site and went about 130 miles to a well site south of Odessa, Texas. When the crew went to remove the Am-Be source they discovered the source transport container lock and plug were not in place and that the source was missing. The crew returned to the well site near Pecos and searched for the source but did not find it. A search along the route traveled by the licensee's vehicle was conducted by this Agency and the 6 Civil Support Team (6CST) the week of September 13, 2012, using radiation detection instrumentation. The source was not recovered. On September 14, 2012, the Environmental Protection Agency's Airborne Spectralphotometric Environmental Collection Technology airplane flew over the route. The flight returned two possible locations that were searched by the Agency and 6CST. The source was not recovered. The licensee continued daily searches for the source using radiation detection instruments. On October 4, 2012, the source was found by a member of the general public. The individual contacted the licensee and the licensee recovered the source from the individual. The source was visually inspected and leak tested and the source was found not to be damaged. The individual was interviewed by this Agency on October 12, 2012. The individual stated that he found the source at a location 8 miles from the well site where the licensee had been working but in the opposite direction from the path driven by the crew. Several scenarios were explored to determine how the source could have been left where it was found, but none proved feasible. It was determined that the individual who recovered the source had received more than 2 millirem in one hour during his/her possession of the source. On May 2, 2013, the Agency met with the licensee. The licensee addressed all the concerns the Agency had identified during the investigation of the event. Five violations were cited.

File closed.

### 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. 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 the patient's name and treatment plan have been added to operating procedures. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2012

### 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 had 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 too difficult to hold the kitten while wearing a lead glove, a lead glove was placed on top of the student's hand instead. 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 licensee's Radiation Safety Officer provided additional training for the two students involved in the inadvertent exposure. No violations were cited.

File closed.

### 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 1.14 curies of cobalt-60 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.

## Incidents Opened Third Quarter 2012

### I - 8995 - Nuclear Pharmacy Error - Cardinal Heath - Dallas, Texas

See I-8986

### I - 8996 - Nuclear Pharmacy Error - Cardinal Heath - Dallas, Texas

See I-8987

### 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 activity prior to administering it to the patient. The patient administered the corrected dose did not experience any adverse medical effects. The licensee stated that the technician preparing 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.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2012

### I - 8910 - Gauge Shutter Failure - Sherwin Alumina LP - Corpus Christi, Texas

On December 14, 2011, the Agency received a report from the licensee that the shutter on a Kay-Ray Model KR7062P fixed density gauge containing a 100 millicurie cesium-137 source had failed in the open position. The gauge shutter is open during operation so the failure did not create an exposure hazard. The licensee contacted the manufacturer and it replaced the gauge May 10, 2012. On July 31, 2012, the manufacturer stated that product must have built up around the hexagon shaft which then got bound up when the handle was moved to close the shutter. This caused the shaft to shear off at the handle. No violations were cited.

File closed.

### I - 8942 - Overexposure and Radiography Source Disconnect - Non-Destructive Inspection Corporation - Pasadena, Texas

On March 24, 2012, the licensee notified the Agency that one of its radiography teams had experienced a disconnect of a 65 curie iridium-192 source on a QSA Delta 880 radiography camera at a temporary work site in Pasadena, Texas. The crank out drive cable had broken at the pigtail and the source had disconnected. After an authorized individual performed the source retrieval, the licensee's RSO learned that the radiographer trainer disconnected the source guide tube from the camera and had carried the source guide tube around his neck while he climbed down the ladder of the scaffold. The source was still in the source guide tube at this time. When the radiographer trainer reached the platform he removed the source tube from his neck and laid it on the platform. The licensee and the Agency conducted an investigation, including reenactment, into the event. The licensee performed dose assessment calculations and estimated the radiographer received 29.32 rem (whole body, deep dose equivalent) during this event. Most of this dose would have been to the radiographer trainer's left upper thigh area. The licensee arranged for medical surveillance on the radiographer trainer. Blood tests returned negative results and no symptoms of local radiation injury ever manifested. The investigation revealed that the drive cable had not been properly inspected and maintained by the licensee and had failed due to a combination of wear, corrosion, and lack of lubrication, according to the manufacturer's evaluation. Also, the radiographer trainee failed to perform the daily equipment check prior to using the equipment. The radiographer trainer stated he performed the required survey prior to removing the source guide tube and observed normal readings. The survey meter was checked by the licensee's Radiation Safety Officer and by the manufacturer and was found to be operating correctly. A proper survey would have detected that the source was not back in its fully shielded position inside the camera. The licensee was cited for two violations. The radiographer trainer was cited for two violations.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2012**

### 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.

### 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 it was returning to its office and had traveled about 3.5 miles when an individual in a 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 the local law enforcement and met 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 cited for the violation.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2012**

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

On June 20, 2012, the Agency was notified by the licensee that, upon processing, a badge 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 he 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.

### 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 had discovered and reported two missing lasers and a violation was cited for failing to conduct annual inventories (Incident I-8933). In response to that Notice of Violation, and as a required activity, the registrant was conducting a full inventory when it 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 - 8966 - Abandoned Well Logging Sources Down Hole - Halliburton – Leon County, Texas

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 17,240 feet 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 of the sources and the well will be sidetracked above that. A plaque will be placed at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the Radiation Control Program contact information. The sources were abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

## **Complaints Opened Third Quarter 2012**

### C - 2414 - Regulatory Violations - Open MRI of McAllen - McAllen, Texas

On July 11, 2012, the Agency received a complaint that a facility that performs mammography in McAllen, Texas, had not completed the required equipment systems testing prior to mammograms being sent to and read at a remote work station. The Agency's investigation revealed that the facility was in compliance with the Agency's regulations for the machines being used. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2415 - Uncredentialed Technologists - Family Medical Clinic - Houston, Texas

On July 17, 2012, the Agency received an anonymous complaint that a chiropractic office was using an unregistered x-ray machine and uncredentialed technicians were operating the device. On August 1, 2012, the Agency conducted an investigation of the facility. The building was shared between the chiropractic office and a family medical clinic which has a registered x-ray machine. Both facility doctors initialed the x-ray log after use. The Agency registration manager reported that both doctors could operate the x-ray device. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2416 - Unregistered Laser Hair Facility - Bella Kara - McAllen, Texas

On July 17, 2012, the Agency received a complaint that an individual was performing laser hair removal at a facility in McAllen, Texas, and neither the individual nor the facility was registered with the Agency. The Agency's investigation substantiated the complaint. One violation was cited for the individual and one violation was cited for the facility.

File closed.

## Complaints Opened Third Quarter 2012

### C - 2417 - Regulatory Violations - Lorenzo Kunze - Golden, Colorado

On July 17, 2012, a complaint was received by the Agency with the following allegations: an individual had taught laser hair removal (LHR) courses using a laser college's name to students within the state of Texas and gave out the laser training college's certificates of completion without the college's knowledge or consent and without the students attending college; that the individual backdated LHR training course certificates to allow the supposed graduates to be grandfathered when the new Texas LHR rules took effect; that laser spas in Texas helped the individual in the backdating scheme; and, that laser spas within Texas have conducted laser training with the individual as the instructor who do not have approval from Texas Workforce Commission. A written request was sent to the complainant to provide more specific information and names so that an investigation could be conducted. There was no response. Complaint was not substantiated.

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 its registration. Additionally, the registrant failed to establish public dose measurements at the unregistered location. The allegation that uncredentialed personnel were performing fluoroscopy could not be substantiated. The complaint was partially substantiated. Five violations were cited.

File closed.

### C - 2419 - Response To Public Concern - University Cancer Center - Huntsville, Texas

On July 25, 2012, the Agency received a written complaint alleging that the therapy machine used to administer dose to cancer patients was in need of repairs and that the device may have parts in it that are not intended for the device. The complaint alleged that patients have expressed concern over the operation of the device. An on-site investigation performed on August 21, 2012 was unable to substantiate the allegations. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2012

### 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. No violations were cited.

File closed.

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

On August 1, 2012, the Agency received a complaint that a mobile radiographic services registrant did not provide personnel exposure monitoring for the complainant 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 - 2422 - Uncredentialed Technologists - Texas Institute of Chest and Sleep Disorders - Houston, Texas

On August 2, 2012, the Agency received an anonymous complaint that uncredentialed technicians were taking x-rays at the registered facility. On August 23, 2013, the Agency conducted an on-site investigation. The office manager was interviewed and admitted to taking x-rays on occasion although she was not certified to take x-rays. The complaint was substantiated. Two violations were cited.

File closed.

## Complaints Opened Third Quarter 2012

### C - 2423 - Regulatory Violations - Kids Dental and Orthodontics - San Juan, Texas

On August 8, 2012, the Agency received information that a dental facility in San Juan, Texas, was using a dental x-ray unit from China that was not in compliance with Food and Drug Administration (FDA) regulations. The complaint also alleged that the Radiation Safety Officer (RSO) was no longer employed there and his absence may exceed the 30-day notification requirement to the Agency. The Agency conducted an on-site investigation in conjunction with the facility's initial inspection. Further investigation revealed that the x-ray unit is an FDA approved make/model. Also, the registrant stated that even though the RSO was no longer working within the office, he remained as the RSO. The registrant changed its RSO to a dentist working at the facility. The complaint was not substantiated. As a result of the inspection, five violations were cited.

File closed.

### C - 2424 - Unregistered Laser Facility - Revitalize Laser and Aesthetics Clinic - Denton, Texas

On August 2, 2012, the Agency received a complaint that a facility in Denton, Texas, was performing laser hair removal and other aesthetic procedures using lasers and it was not registered with the Agency. The Agency's investigation revealed that the facility had been using a laser without being registered. In response, the facility submitted an application to the Agency in August 2012 for the appropriate laser registration. The complaint was substantiated. No violations were cited.

File closed.

### C - 2425 - X-ray of an Individual For Training Proposes - Eastex Dental Academy - Longview, Texas

On August 16, 2012, the Agency received a phone call alleging that the registrant, a dental training school, was allowing students to x-ray an individual for training purposes. The Agency's investigation revealed that the owner of the school, who is qualified to operate the x-ray machine, had contacted her dentist and requested to bring her own FMX series of x-rays (which requires up to 18 films) to her scheduled appointment. The dental office approved the request. The owner of the school allowed each of 7 students to perform two x-rays for training but the films were taken for healing arts purposes. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2012

### C - 2426 - Regulatory Violation - J Z Russell Industries, Inc. - La Porte, Texas

On August 17, 2012, the Agency received an allegation that the licensee was storing radiography cameras containing radioactive sources at a location not approved on its license. On August 28, 2012, the Agency conducted an on-site investigation. The investigation found that the licensee began storing sources at the location in mid-June 2012. The complaint was substantiated. One violation was cited.

File closed.

### C - 2427 - Unregistered Use of X-ray Machines - K-Spinal Rehab Center - Garland, Texas

On August 27, 2012, the Agency received information that the registrant had moved and failed to notify the Agency, that the registrant should have terminated one registration and applied for a new one due to business change, and the registrant had begun performing x-rays at a second site that was not on any registration. The Agency's investigation revealed that a new registration application had been submitted in March 2012 but it was incomplete. The registrant had failed to respond to letters and phone calls from the x-ray registration group concerning the application and the termination of the old registration and it continued to be unresponsive during the investigation. Therefore, an on-site investigation was conducted and at that time the registrant provided the necessary documents to complete the application and termination. The registrant had opted not to use the second location. The complaint was substantiated. 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 test 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.

## Complaints Opened Third Quarter 2012

### C - 2429 - Unregistered Laser Facility - Skin Care, LLC - McAllen, Texas

On September 18, 2012, the Agency received a complaint that a facility registered for laser use on humans had moved and not amended its registration, that the Laser Safety Officer was no longer associated with the facility, and that the facility was performing laser hair removal and had not registered as a laser hair removal facility. After extended communications with the registrant concerning compliance and receipt of another complaint, the Agency conducted an on-site investigation. During the on-site investigation, an Agency inspector found the registrant possessed one laser unit that was not fully assembled and was not in operation and two intense pulsed light machines. The registrant stated she was still seeking a doctor to oversee operations as required and would submit the proper application as soon as she could meet rule requirements. The complaint was substantiated. Since the registrant ceased operations until compliance could be attained, no 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.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2012**

### C - 2364 - Regulation Violations - Texas A&M University, College Station, Texas

On November 7, 2011, the Agency received a complaint that keys to the cyclotron building at a university had been missing since January 2011 and the building's locks had not been re-keyed, thus creating a breach in the security of the cyclotron. During the Agency's investigation, the registrant provided information that there were adequate methods in place to secure the accelerator from unauthorized use by interlock systems and access control. The complaint was not substantiated. No violation was cited.

File closed.

### C - 2376 - Regulation Violation – 96 Named Dental Schools - Various Locations In Texas

On January 23, 2012, the Agency received a complaint alleging that dental schools were allowing students to perform x-rays on other students for training purposes. The Agency was provided a list of locations that were alleged to allow this to occur. The Agency sent a request to each of the entities listed in the complaint requesting information on their training, including whether or not students were allowed to take x-rays of other students for training purposes. Of the 96 schools questioned, four stated that students were allowed to take x-rays of other students for training purposes. The Agency performed on-site investigations at these four schools. Of these four schools, two were cited for the violation. The complaint was partially substantiated.

File closed.

### C - 2379 - Laser Injury - R U Hairy, Inc. – Houston, Texas

On February 13, 2012, the Agency received a complaint from an individual alleging she had received burns and hyperpigmentation as the result of a laser hair removal procedure at a facility in Houston in October 2011. The Agency's rules govern only the reporting of adverse effects. The registrant provided copies of documentation supporting that this did not meet the criteria of a reportable adverse effect. The complaint was not substantiated. No violation was cited.

File closed.

### C - 2382 - Regulation Violation - ATI Enterprises, Inc. - Dallas, Texas

On February 22, 2012, the Agency received a complaint that a laser hair removal and training facility had failed to provide copies of records to the complainant as required by rule. The Agency's investigation revealed that the procedures the complainant was requesting records for would not have been applicable toward her certificate with the Agency as they were performed prior to the complainant applying for and receiving her apprentice certificate from the Agency. The facility was contacted and is aware they must produce procedure records upon written request. The complaint was not substantiated. No violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2012**

### C - 2392 - Laser Injury - Tri-City Med Spa - Willow Park, Texas

On March 26, 2012, the Agency received a complaint concerning an injury received during a laser hair removal procedure. The complainant alleged he/she had developed clear blisters that burst and became infected and the injury may result in scarring. The Agency's investigation revealed that the complainant was seen and treated by a physician. The complainant was diagnosed as having a medical condition, but not second degree burns. The adverse effect did not meet the reporting requirement in the Agency rules applicable to this facility. The complaint was not substantiated. No violation was 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 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 had established a limit of 200 microrem per hour for the pipe it received and pipe with readings above that would not be accepted. The company's Chief Executive Officer stated that they had discussed their business model with both state and federal agencies. A radiation survey conducted on the site did not identify any area with a radiation measurement above 120 microrem per hour. A contamination survey of the facility indicated they were not conducting pipe descaling at this location. No violations were cited.

File closed.

### C - 2397 - \* – Kindred Hospital Tarrant County, Southwest Campus – Fort Worth, Texas

\*Health and Safety Code Chapter 241.051(d)

Seven violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third 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-2403 - Regulatory Violations - Rodeo Dental - Ft. Worth, TX

On May 17, 2012, the Agency received an anonymous complaint that dental staff were conducting x-rays on children and the operator was not moving six 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 Agency performed an on-site investigation into the allegations. The Agency was not able to substantiate the allegation. No violations were 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 facility. 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 employees performing procedures with an x-ray device. The complaint was substantiated. Two violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2012**

### 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 licensee's 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 from a consulting firm hired by the contracting company 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 its investigation would be forwarded to the United States Environmental Protection Agency (USEPA). USEPA Region 6 was provided a copy of the information on July 31, 2012. No violations were cited.

File closed.

### 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 millirem per hour boundary had been established. On August 2, 2012, the Agency conducted an on-site investigation which included 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.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2012**

### 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 its request for an amendment to its 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. The owner of the company was contacted and stated that they did perform laser tattoo removal using a class 4 laser. The owner applied for laser registration and the registration was granted on August 7, 2012. No violations were cited.

File closed.

### C - 2412 - Laser Regulatory Violations - Woman's Hospital of Texas - Houston, Texas

On June 25, 2012, the Agency was notified that a hospital in Houston, Texas, had failed to remove the laser safety officer (LSO) from its registration in August 2010 when the LSO's employment ended and failed to update the registration with a new LSO. The Agency contacted the hospital and determined that since August 2010 the facility had several acting LSOs but they never requested an updated registration. A new LSO started work at the facility in July 2012. The complaint was substantiated. One violation was cited.

File closed