



# **INCIDENT AND COMPLAINT SUMMARIES FOR THE FIRST QUARTER 2011\***

Prepared by:  
Art Tucker, Ray Jisha, Chris Moore, and Karen Blanchard

Texas Department of State Health Services  
Regulatory Services Division  
Inspections Unit  
Radiation Branch

- 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.

**Incident and Complaint Summaries**  
**1<sup>st</sup> Quarter 2011**

**Table of Contents**

Incidents Opened in First Quarter 2011 .....	3
Incidents Opened in a Previous Quarter and Closed First Quarter 2011 .....	13
Complaints Opened in First Quarter 2011 .....	17
Complaints Opened in a Previous Quarter and Closed First Quarter 2011 .....	26

## Incidents Opened First Quarter 2011

I - 8806 - \* - University Medical Center - Lubbock, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8807 - Abandoned Radioactive Material - OKO/MED Downtown Imaging Center - Houston, Texas.

On January 5, 2011, the Agency was notified that a licensee had vacated a location which contained sources of radiation. An Agency inspector went to the location later that day and impounded the material: one 216.5 microcurie cesium (Cs)-137 dose calibrator source, two 1.3 millicurie germanium (Ge)-68 rod sources, and one 500 nanocurie Cs-137 check source. The licensee's Radiation Safety Officer (RSO) responsible for the material could not be located so the Notice of Impoundment was provided to the building manager. Repeated attempts to contact the owner and RSO were unsuccessful. Three violations were cited.

File closed.

I - 8808 - Abandoned Well Logging Source Downhole - Trubit LLC - McMullen County, Texas

On January 7, 2011, the Agency was notified that a 1.64 curie Cesium (Cs) – 137 source was abandoned downhole at a McMullen County well at a depth of 10,700 feet. A 750 foot red-dyed cement plug was placed above the logging tool to protect the source. A whipstock was placed above the tool to act as a deflection device. A plaque was placed at the well head as required. The source was abandoned in accordance with the Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

## **Incidents Opened First Quarter 2011**

### I - 8809 - Equipment Malfunction - Steris Isomedix Operations - El Paso, Texas

On January 11, 2011, the Agency received a report from the licensee that on January 10, 2011, it had experienced a drive mechanism failure on one of two source racks. This caused the 1.2 megacuries of cobalt - 60 (Co-60) to fail to descend into the pool. The source rack remained in the lifted position for approximately one hour until the operators discovered that a spool valve was stuck. A piece of pipe was removed to allow the piston to vent, thus bypassing the valve. The source rack returned to the pool in a controlled, normal descent. The spool in the malfunctioning control valve was found to have cracked o-rings which prevented the spool from shifting to the exhaust position. Immediate corrective action was to rebuild the control valves for both racks. The long-term corrective action is to add an annual preventive maintenance requirement to disassemble, inspect, clean and rebuild, as necessary, the pneumatic control valves for each source hoist cylinder. As all response activities occurred outside the primary shield walls; no individual received any additional radiation exposure as a result of this event. No violations were cited.

File closed.

### I - 8810 - Badge Overexposure - Maxum Health Services Corporation - Fort Worth, Texas

On January 4, 2011, the Agency was informed by the licensee that their dosimetry processor had reported that an employee's thermoluminescent badge reading was 58,118 millirem shallow dose equivalent which exceeds the annual limit. The licensee's Radiation Safety Officer (RSO) stated that based on his initial investigation, he believed the dose was to the employee's badge only. The badge report from the dosimetry processor stated that the exposure was irregular with a partially visible filter pattern. The employee had only handled fluorine (F) -18 during his employment there. During the licensee's investigation of the event, it was discovered that the employee had contaminated his glove and ring badge and had not reported it. The licensee assigned a dose of 109 millirem for the exposure period, which is based on an average of previous exposure period readings. The licensee instructed the employee to perform thorough surveys following the handling of any radioactive material and to notify the RSO if any contamination is detected. The employee will be observed performing injection techniques by his supervisor to determine if any additional corrective actions are required. No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

### I - 8811- Abandoned Radioactive Material - Schlumberger Technology Corporation - Houston, Texas

On January 12, 2011, the Agency was notified that a 16 curie americium (Am)-241/beryllium (Be) source and a 1.7 curie cesium (Cs)-137 source were abandoned downhole at depths of 12,213 feet and 12,226 feet in Limestone County. The tool containing the source became stuck on December 12, 2010, and attempts to retrieve the source were unsuccessful. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A 332 foot red-dyed cement plug and deflection device were placed above the logging tool. 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 the radiation control program contact information. No violations were cited.

File closed.

### I - 8812 - Nuclear Pharmacy Error - Cardinal Health - Austin, Texas

On January 4, 2011, the Agency was notified by a nuclear pharmacy that a hospital had ordered a unit of technetium (Tc) - 99m labeled medronate, but the pharmacy erroneously shipped Tc - 99m mertiatide. The hospital did not catch the error until after it was administered to the patient and they observed an uptake to the wrong organ. The prescribing physician was notified of the error and the test was repeated using the correct form of Tc - 99m. The patient did not experience any medical reaction as a result of this event. The nuclear pharmacy determined that the error was caused by a miscommunication between the individual receiving the order and the individual filling the order. All employees involved in the event were counseled on the use of proper procedures for product selection and required reviews. No violations were cited.

File closed.

### I - 8813 - Equipment Malfunction - IRISNDT, Inc. - Deer Park, Texas

On January 20, 2010, the Agency was notified by the licensee that while performing radiography operations at a field location, a radiography camera containing 29 curies of iridium (Ir)-192 fell approximately six feet to a concrete surface. The camera's source release plunger was the first part of the camera to hit the concrete. The radiographer attempted to retract the source, but it would not move out of the collimator. The licensee contacted the manufacturer and discussed a plan to free the drive cable so the source could be retracted. The licensee manipulated the locking mechanism until the cable was freed from the locking device and the source was returned to the shielded position. The source was secured in the shielded position and the camera and source were returned to the manufacturer for inspection. The manufacturer determined that the force of the fall had caused the source cable to become jammed in the device used to release the source cable from the locking device. The source was leak tested and the results were satisfactory. The camera was repaired by the manufacturer and returned to the licensee. The licensee provided additional training to all of its radiographers on how to properly secure a radiography camera during use and reviewed the event with all of their staff. No violations were cited.

File closed

## **Incidents Opened First Quarter 2011**

### I - 8814 - Therapy Event - University of Texas Health Science Center - San Antonio, Texas

On January 25, 2011, the registrant's Radiation Safety Officer reported to the Agency that on January 24, 2011, a patient had received treatment of approximately 100 centigrays, delivered via linear accelerator, to the incorrect site. The patient was scheduled to receive treatment to two sites. Following delivery of treatment to the first site, the patient was re-set for treatment to the second site. The system alerted the therapist that the couch was not in the correct location. The therapist adjusted the couch and patient manually and started the treatment. This was in conflict with the facility's departmental policy that requires that any override must be verified and co-signed by another therapist or member of the medical physics team. After the treatment began, the therapist told the second therapist about the physical repositioning. The second therapist determined the repositioning was incorrect and stopped the treatment. Internal notifications were made and a determination was made by appropriate staff to continue treatment to the correct site and that the event is of no clinical significance in terms of complications. The patient was properly notified. The facility's investigation indicated the error primarily resulted from an improper and unplanned physical patient shift. Corrective actions include: the addition of setup notification alerts by their record and verify system for the therapists when shifts of more than five centimeters long have to be applied to the patient's positioning prior to treatment; this additional alert window will have to be acknowledged by the therapist and the acknowledgments will be recorded in the system; the system will now include a 3-dimensional image to assist the therapists; and the staff's failure to follow policy will be addressed. No violations were cited.

File closed.

### I - 8815 - Found Radioactive Material - Weatherford International - Benbrook, Texas

On January 19, 2011, the Agency was notified by a scrap yard that three sealed cesium (Cs) -137 sources were detected in a load of scrap stainless steel. A picture of one of the sources showing the manufacturer's name and source serial number was provided to the Agency. The manufacturer of the sources was contacted and stated that the source was one of seven sold to a Texas licensee in May 2005. The Agency contacted the licensee and inquired about the sources. The licensee's Radiation Safety Officer (RSO) stated that he was unaware of any missing sources and that he would look through the licensee's records to determine if the found sources belonged to them. The RSO contacted the Agency and stated that the sources did belong to the licensee and that the three sources had been retrieved. The licensee conducted an inventory of all sources of this type and no additional discrepancies were identified. The licensee determined that the cause for the event was a failure in its chain of custody system. The sources had been taken to its warehouse where they were to be segregated from other material and delivered to the RSO, but instead they were placed in a dumpster for recycling. The licensee has changed its disposal procedure to prevent a recurrence of this event. All dumpsters on site were surveyed for radioactive material and no material was found. One violation was cited for failing to secure the sources unauthorized removal.

File closed.

## Incidents Opened First Quarter 2011

### I - 8816 - Stolen Radioactive Material - Century Geophysical Corporation - Tulsa, Oklahoma

On February 1, 2011, the Agency was notified by a licensee operating with reciprocity in the State of Texas that a well logging tool containing a 125 millicurie cesium (Cs) - 137 source was stolen from a company vehicle in Henderson, Texas. The source was installed in a ten foot long mineral logging tool and was locked in its shield mounted underneath a swamp buggy used for performing surveys. The locking device had been broken off of the storage device and the tool and source removed as one piece. The licensee conducted a visual search for the device in the area, but did not locate the tool or source. On the afternoon of February 1, 2011, a security guard for the facility noticed a vehicle leaving the area and stopped it. An officer from the local sheriff's office arrived and arrested the individual for charges relating to the theft. The sheriff's department questioned the individual and was told that the stolen device had been sold at a scrap yard in Longview, Texas, but he would not give a specific location. The Agency began calling scrap yards in the Longview area. A scrap yard stated that they had taken in a device the day before that matched the description of the tool. The licensee was notified of the information and location of the scrap yard. The licensee went to the scrap yard, verified that it was the stolen device, and that the source was still attached to the tool. The licensee took possession of the device. Dose evaluations for the individuals involved in this event did not exceed any regulatory exposure limits. The licensee will no longer leave sources stored at work locations. No violations were cited.

File closed.

### I - 8817 - Gauge Shutter Failure - Chevron Phillips Chemical Company - Orange, Texas

On February 2, 2011, the Agency was notified by the licensee that the shutter on a Ronan model SA1-F37 nuclear gauge was stuck in the open position. The gauge contains a 100 millicurie Cesium (Cs) - 137 source. The gauge is mounted on a vessel 100 feet above the ground and did not present an exposure risk. The licensee contacted the manufacturer and the manufacturer's technician arrived at the licensee's facility later that day. The technician and a licensee employee went to the gauge and the employee tried to close the shutter. The shutter closed only 95%. The manufacturer's technician then attempted to close the gauge shutter, and the shutter closed fully. The technician cycled the shutter open and closed several times and the shutter operated correctly. A dose rate survey was performed at the gauge and the readings were normal. It was determined that a buildup of ice around the shutter mechanism was the cause for the failure. No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

### I - 8818 - Stolen Self-Luminous Exit Signs - AMC American Multi-Cinema, Inc. - Houston, Texas.

On February 2, 2011, the Agency was notified that four self-luminous exit signs were noted as missing at a Houston-area movie theater. The notification stated that it appeared that the devices were forcibly removed from the wall without the use of tools and was an apparent act of vandalism. The notification came from the theater's corporate office in Kansas City, Missouri. The Assistant Director for Facilities explained that the devices were installed above doors, approximately 7.5-8 feet high, and secured with safety caps over the mounting screws. He stated that the devices were installed throughout the company's entire movie complex, with a total of approximately 100 at each facility. The company reported the incident to local law enforcement. No violations were cited.

File closed.

### I - 8819 - \* - Memorial Health System of East Texas - Lufkin, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 8820 - Nuclear Pharmacy Error - Cardinal Health - Houston, Texas

On February 8, 2011, the Agency was notified by a nuclear pharmacy that it had sent the wrong activity of fluorine (F) - 18 to an end user, a hospital. The hospital had been made aware of the error, but chose to use the unit dose anyway. The patient did not experience a medical reaction to the pharmaceutical. The licensee's investigation into the event determined that the error occurred because the unit dosages were prepared out of order and then packed in the order received. All employees involved were counseled and the licensee changed its procedure to facilitate verification of labels. The licensee held a meeting with its staff to review the event. No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

### I - 8821 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On January 12, 2011, the Agency was notified by the licensee that a dispensing error had occurred. The licensee stated that Customer-A had contacted them and informed them that they had received a properly labeled package, but it contained unit doses labeled for Customer-B. The licensee immediately contacted Customer-B and provided notification of the error, instructing them not to use the doses. The licensee went to both facilities and retrieved the material. The licensee determined that the error was due to a failure of personnel to verify the contents of the packages prior to shipping. The licensee counseled the employee who packaged the shipments and held staff meetings to discuss the event. No violations were cited.

File closed.

### I - 8822 - Medical Event - The University of Texas Southwestern Medical Center at Dallas - Dallas, Texas

On February 15, 2011, the Agency was notified by the licensee that during an internal investigation it was discovered that two young adult patients were administered 88% (565 gray) and 153% (506 gray) over the prescribed dose of phosphorus (P)-32 chromic phosphate colloid. These procedures were performed in July and September of 2010, with an ordered activity of 0.2 and 2.5 millicurie for a prescribed dose of 200 gray and 300 gray, respectively. The incidents were discovered when the authorized user (AU) noticed an area of inflammation surrounding the treatment site and along the track of the drainage catheter where the drug was administered. According to the AU, both patients have managed the treatment successfully without any other adverse reactions. The referring physicians and patients were notified of the event. To prevent recurrence, the licensee will perform a verification assay at its facility as well as assess the dose volume for calculating the specific activity. No violations were cited.

File closed.

### I - 8823 - Found Tracer Material - Frac Tech Services - Pleasanton, Texas

On February 15, 2011, the Agency was notified by a landfill operator that a roll-off container delivered to the landfill had caused the radiation monitor at the gate to alarm. As the readings were higher than typically seen (~9 millirem/hr) and the landfill operators were unable to identify the radionuclide, an Agency investigator was dispatched. Due to the shielding from the steel container and the material within, the source of the material could still not be determined. As the readings were highly localized and the company that generated the waste was only licensed for sealed sources, it was suspected that the material may have been a sealed source. The waste material was then carefully laid down on a clean, flat, and secure area of the landfill. As a precaution, a berm was constructed around the small portion of the pile where the radiation was emanating. The investigator identified a few microcuries of some material that appeared to be sand. Subsequent analysis identified the source as scandium (Sc) - 46 and antimony (Sb) - 124. These materials are commonly used as radioactive tracers by well service companies. The material was removed by the companies involved. No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

I - 8824 - \* - Houston Northwest Medical Center - Houston, TX

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8825 - Damaged Device Containing Radioactive Material - Trican Well Service LP - Longview, Texas

On February 25, 2011, the Agency received a copy of a notice to work in Texas under reciprocity to repair a shutter on a nuclear gauge. The licensee was contacted and asked about the broken gauge shutter. The licensee stated that while a work crew was placing a Berthold Technologies densitometer containing a 20 millicurie cesium (Cs) - 137 source on a well, the gauge was dropped and the roll pin that attached the handle to the gauge broke. The gauge handle then separated from the gauge. The gauge was taken back to the licensee's facility and a radiation survey of the gauge was conducted. The survey confirmed that the shutter was fully closed. A service company was called and the gauge was repaired on March 1, 2011, and returned to service. Safe and careful handling of the device was discussed with the operations management of the company. No violations were cited.

File closed.

I - 8826 - \* - Guadalupe Regional Medical Center - Sequin, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed

I - 8827 - \* - Texas Children's Hospital - Houston, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

### I - 8828 - Stolen Radiation Generating Device - Alec H. Jaret DMD PA dba Lonestar Dental Group - Austin, TX

On March 18, 2011, a registrant notified the Agency that a hand-held dental x-ray device had been stolen from an employee's vehicle in Dallas on February 12, 2011. The registrant had reported the theft to local law enforcement at the time of the theft. As of April 26, 2011, the Dallas Police Department has not been able to recover the device or catch the thief. The police department's investigation will remain open. The prescription device is considered a low-threat to the public health so the Agency has closed its file on the incident. No violations were cited.

File closed.

### I - 8829 - Abandoned Well Logging Sources Downhole - PSI Wireline Inc. - Edwards County,

On March 22, 2011, the licensee notified the Agency that on March 4, 2011, a 2 curie cesium (Cs)-137 source and a 5 curie americium (Am)-241/beryllium (Be) source were abandoned at 3,578 feet downhole at an Edwards, Texas, well site. The well bore was plugged with 478 feet of red dyed cement and 275 feet of cement. A drill bit was placed above the second plug to act as a deflection device. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. No violations were cited.

File closed.

### I - 8831 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services - Houston, Texas

On March 28, 2011, the Agency was notified by the licensee that a hospital had ordered a unit of indium (In)-111, but the pharmacy erroneously shipped technetium (Tc) - 99m exametazine. The incorrect radionuclide was administered to a patient for a diagnostic test; however, no adverse medical reactions occurred as a result of this event. The radiopharmacy conducted counseling and training with all of their employees to ensure diligence and proper procedures were followed when preparing and dispensing products. No violations were cited.

File closed

### I - 8833 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services - Houston, Texas

On March 25, 2011, the Agency was notified by the licensee that it had received notification from one of its customers that two studies using technetium (Tc)-99m had unexpected results. The studies were to image hepatobiliary and the lungs; instead, the study imaged the liver, spleen, and bones. A sample of the Tc-99m supplied to the hospital was tested by the licensee and found to be within acceptable standards. A second hospital, which received material from the same bulk lot, was contacted and it reported normal images. The licensee believes that the error was in the tagging of the Tc - 99m by the hospital and not in the production. The licensee conducted meetings with its staff to review the event. No violations were cited.

File closed.

## Incidents Opened First Quarter 2011

### I - 8834 - Radioactive Material Identified at Landfill - Accord Medical Management LP - San Antonio, Texas

On March 23, 2011, the Agency was notified by a landfill operator that a load of waste had caused the landfill's gate radiation monitor to alarm. The radionuclide was identified as technetium (Tc)-99m. The waste manifest indicated that the material was picked up at the licensee's location. The licensee's Radiation Safety Officer (RSO) stated that the material was a diaper from a cardiac stress test patient. The diaper was inadvertently disposed of in the trash. The licensee retrieved the diaper from the landfill and stored it for decay. The RSO stated that corrective actions included an inventory of the licensee's sealed sources and radiopharmaceutical doses and additional instructions to the nuclear medicine technologist on the proper handling of this type of material. The inventory did not identify any discrepancies. The event will also be a topic at the health system's next Environment of Care committee meeting. One violation was cited for the event.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2011

### I - 8779 - Gauge Shutter Failure - Chevron Phillips Chemical Company LP - Borger, Texas

On September 3, 2010, the Agency received a phone call from the licensee reporting that on September 2, 2010, while conducting routine gauge inspections, the shutter on a nuclear gauge failed to close. The gauge contains two millicuries of cesium (Cs)-137. The gauge normally operates in the open position. Radiation surveys in the area of the gauge were conducted and were normal. The licensee unsuccessfully attempted to free the shutter operating mechanism using light oil. The licensee stated that the gauge is 11 feet above the ground, is not accessible without the use of scaffolding, and therefore did not pose a risk of unintentional exposure to anyone. The licensee submitted a request to the Agency for a waiver to continue operations. The licensee contacted a service company for repairs. Gauge repair was attempted on October 18, 2010, but it was unsuccessful. A determination was made to replace the gauge with a new one. The waiver to continue operations was extended until the new gauge was installed on January 7, 2011. Inspection of the gauge by the service company indicated that the rotor seal had been compromised, thereby allowing moisture to be drawn into the source holder. To prevent recurrence, the source holder mounting orientation was changed to place the rotor seal on the bottom to reduce the potential for liquids to collect on top of the source holder and penetrate the rotor seal. A silicone sealant was applied to the rotor seal as well. No violations were cited.

File closed.

### I - 8783 - Badge Overexposure - Fugro Consultants Inc. - Pasadena, Texas

On September 13, 2010, the Agency received a phone call from the licensee's Radiation Safety Officer (RSO). The RSO stated that a radiographer declared pregnancy on August 18, 2010. The RSO stated that after she declared pregnancy he ordered a fetal monitoring badge for her, and then he received her badge reading for the month of July 2010. The radiographer's badge read 2,800 millirems (mrem) whole body dose for the month of July. The RSO stated that he asked the individual if she could explain why the badge reading was high and the individual stated she did not know. The radiographer stated that she was always in control of her badge and doesn't remember inadvertently leaving it near an exposed source. The Agency provided the RSO with guidance as to how to determine if the exposure was to the badge only. Since the radiographer did not declare her pregnancy until August 18, 2010, and the high badge reading was for the July monitoring period, the exposure was not reportable. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in First Quarter 2011**

### I - 8798 - Radiography Source Disconnect - Team Industrial Services - Alvin, Texas

On November 22, 2010, the Agency received notice from the licensee that it had experienced a radiography source disconnect on November 21, 2010. The equipment was reportedly inspected prior to use and passed all checks including tolerance testing of the connector mechanism on the drive cable. On the 25th exposure, after two and a half hours of work, the drive cable and source assembly failed to retract into the camera. Multiple attempts to retract the source were unsuccessful as evidenced by mechanical indications and radiation surveys. Barriers were established at a 2 mR/hr dose rate, shielding was stacked on the source, and an individual authorized for source retrieval was contacted. The source was retrieved. No exposure limits were exceeded during the event. The radiography camera, guide tube, and cranking device were sent to the manufacturer for inspection, but no cause was determined for the failure. No violations were cited.

File closed.

### I - 8800 - Transportation Event - Protechnics Division of Core Lab - La Salle County, Texas

On November 26, 2010, the Agency was notified that a well-logging truck had been involved in a traffic accident which resulted in the death of the driver. The radioactive material onboard the vehicle included 240 millicuries of iridium (Ir) -192, 160 millicuries of scandium (Sc) - 46, and 320 millicuries of antimony (Sb) - 124, stored in DOT Type A containers inside an overpack. The overpack was thrown from the vehicle and the lid opened up several inches. U.S. Border Patrol personnel who responded to the accident performed an initial survey and determined there was no radiation hazard. The licensee responded and verified there had been no release of radioactive material. The licensee transported the material to their licensed facility in Alice, TX. It was determined there had been no threat to public health as a result of the incident. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2011

### I - 8801 - Damaged Device Containing Radioactive Material - Bed Bath and Beyond - Austin, Texas

On November 19, 2010, the Agency was contacted by a contractor licensee from California requesting reciprocity to work at a store in Austin to remove and dispose of a tritium exit sign (TES). The store was contacted by the Agency and questioned about the work involving the TES. The store manager stated that the exit sign was mounted on a pole coming down from the ceiling. An employee was working on the top of a storage rack in the area of the sign and knocked it loose from the pole and it fell to the floor. The employee picked the sign up, placed it into plastic bags, took the sign to a storage locker, and locked the door. A contractor was contracted to clean up any contamination and dispose of the sign. The contractor stated that two tubes had broken in the sign. It was estimated that a maximum of 1.5 - 2.0 curies of tritium would have been released. The contractor prepared the sign for shipment and disposal. The contractor surveyed appropriate areas of the store and the highest removable tritium contamination levels found were 214 dpm/100 cm<sup>2</sup>. Bioassay samples were collected from the two store employees involved in the event. Both samples indicated that the committed exposure was less than 1 millirem. The personnel received additional training on the proper handling of TES and a company wide inventory of TES was conducted. No discrepancies were reported. No violations were cited.

File closed.

### I - 8802 - Patient Treatment Error - Oncology Hematology Consultants PA dba Center for Cancer and Blood Disorders - Fort Worth, TX

On December 16, 2010, the Agency was informed by the registrant's Radiation Safety Officer (RSO) that the registrant had inadvertently failed to administer treatment to an intended area. While the disease had been noted on both sides of a specific region in the patient, only one side was treated. The error was caught on a routine follow-up visit and the patient was informed at that time. Although there was no evidence of recurrence, the physician decided to complete treatment of the other side as originally intended. The RSO had all staff review responsibilities for identifying the correct area to be treated for external beam therapy. No violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in First Quarter 2011

### I - 8803 - Equipment Malfunction - H & H X-Ray Services Inc - Flint, Texas

On December 17, 2010, the Agency was notified by the licensee that on December 10, 2010, the locking device on a QSA model 880 camera containing 97 curies of iridium (Ir) – 192 failed to activate. The radiography crew (Crew-A) had completed operations on one location at a site near Lufkin, Texas, and was moving to a new location at the same site. The radiography camera, with the cranking device and guide tube still attached, was placed in the dark room of the radiographers' truck. The licensee stated that a survey was conducted to verify the source was in the fully-shielded, locked position. As the radiographer was driving to the new location, he passed about 5 feet from another group of radiographers (Crew-B) from the same licensee. As Crew-A passed by Crew-B, Crew-B's alarming dosimeters alarmed. Crew-B stopped Crew-A and told them that their alarms had gone off. Crew-A went to the camera, picked up the crank for the camera, and found that the source had moved from the locked position approximately one quarter of a turn. The radiographer cranked the source back to the fully-shielded position and secured the camera for transportation. The Agency conducted an on-site investigation at the licensee's facility. The investigation determined that the locking device operated for the six days between the event and the day the Radiation Safety Officer for the licensee was informed of the event. The licensee tested the camera and found the locking device to be operating properly. The locking device was dismantled and all parts were found to be in good working order. It was determined that the radiographers had not properly retracted the source to the locked position. The radiographers' dosimetry was processed and neither had exceeded a dose limit. The radiographer was cited for four violations.

File closed.

### I - 8805 - Badge Overexposure - Midwest Inspection Services - Perryton, Texas

On December 28, 2010, the Agency was notified that a radiographer working for the licensee had exceeded an annual exposure limit. The licensee's Radiation Safety Officer (RSO) stated that the exposure was to the badge only. The RSO stated that he had interviewed the radiographer involved. The radiographer stated that he had dropped his badge while conducting radiography at a location and completed an examination of between 20 to 25 welds before he observed his badge on the ground. The RSO stated that the average exposure to the radiographer in the previous 6 months was 343 millirem and that his work load had not significantly changed. The licensee has assigned a dose to the radiographer of 343 millirem. The RSO stated that the radiographer received additional training on the proper location and method of wearing his dosimetry. The RSO stated that the event was discussed with all company radiographers. No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2300 - Inadequate Credentialing - Stone Oak Center for Angiography and Intervention - San Antonio, Texas

On January 7, 2011, the Agency received an anonymous complaint alleging that technologists were performing fluoroscopy procedures without having the proper credentials. The Agency performed an on-site inspection on March 22, 2011. The investigation did not identify any instances where individuals operating the device did not have the appropriate credentials. The complaint could not be substantiated. Two related violations were cited.

File closed.

### C-2301- Regulatory Violations - Aviles Engineering Corp.- Houston, Texas

On January 10, 2011, the Agency was notified that a Texas licensee had allegedly used a moisture density gauge on federal property without obtaining proper reciprocity from the Nuclear Regulatory Commission (NRC). On January 18, 2011, the Agency contacted the licensee, a sub-contractor, and determined it had been using the gauge without NRC's approval for several weeks. When the issue was brought to the licensee's attention, it immediately stopped work and removed the gauge from federal property. The licensee obtained permission 5 days later from the NRC to work on federal property and then recommenced work. The Agency forwarded the complaint to the NRC. It was finally determined that "proprietary jurisdiction" was applicable at this facility and therefore a Texas license was adequate. The complaint was not substantiated. No violations were cited.

File closed

### C - 2302 - \* - Methodist Healthcare System of San Antonio - San Antonio, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2303 - Alleged Radiation Poisoning - Member of the Public - Dallas, Texas

On January 14, 2011, the Agency was contacted by a member of the public who alleged that she was poisoned by a hair application product she had used to attach hair pieces. The basis for her radiation concern was detectable amounts of thorium in a hair analysis report. Her physician had diagnosed her for various allergic sensitivities, some of which may have been related to the chemical adhesive that had been applied to her scalp for approximately three years. The Agency informed her that major national organizations have discounted hair analysis as a credible indicator for determining allergic disorders and that urinalysis for thorium is the chosen method for determining exposure to that element. She was referred to the Food and Drug Administration for filing complaints on cosmetic products and made aware of credible testing laboratories in her area should she choose to have herself properly evaluated for exposure to thorium. The complaint could not be substantiated. No violations were cited.  
File closed.

### C - 2304 - \* - Renaissance Hospital Terrell Inc - Terrell, Texas

\* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

### C - 2305 - Radioactive Material Found - Mount Pleasant Recycling & Scrap - Mount Pleasant, TX

On January 25, 2011, a member of local law enforcement in Mount Pleasant notified the Agency that an individual related to a worker at the facility stated that there was a "hot spot" at the facility that could be detected with hand-held geiger counters. The Agency conducted a survey of the facility on March 21, 2011. One small area of ground was found that had a reading of five microrem per hour greater than background. The investigation concluded that this was not a significant increase over background and it was not a health risk. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2306 - Uncredentialed Technologist - Richard E Jones MD - Dallas, Texas

On January 25, 2011, the Agency received an anonymous complaint stating that a technologist was performing x-rays without the proper credentials. The Agency conducted an on-site investigation on February 11, 2011. The technologist had finished an x-ray training program and an application was submitted for her Non-Certified Technician license on January 31, 2011. The facility manager stated that the technologist had practiced conducting x-rays with supervision but is not performing x-rays alone until she is issued a license. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2307 - Regulatory Violation - Diamond Shamrock Refining Company LP - Three Rivers, Texas.

On February 1, 2011, the Agency received a phone call from an individual stating that a licensee had tried to dispose of a device containing radioactive material. The complainant stated that the device was sent to a scrap yard for recycling and was rejected. The licensee's Radiation Safety Officer was contacted and the device was identified as an x-ray fluorescence device. The device did have a trefoil label on it warning of the radiation hazard for x-rays, but it did not contain any radioactive material. The disposal of this type of device is not regulated by this Agency. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2308 - Unregistered Laser - Shiller Surgery Center Inc. - Palestine, Texas

On February 2, 2011 an Agency inspector followed up on information given to them and discovered that a physician was in possession of a Class IV laser with a long expired permit. The investigation into this event is ongoing.

File open.

### C - 2309 - Naturally Occurring Radioactive Material - Clay County, Texas

On January 24, 2011, the Agency received a complaint that there were several citizens in Clay County concerned about an individual who was selling pipe that contains naturally occurring radioactive material (NORM) by the foot and in cattle panels that he built. The Agency conducted an on-site investigation. The individual was aware of the NORM and issues related to its presence. He stated that most of the pipe he gets has been surveyed before being released to him by his supplier, but he does get some with NORM. Radiation surveys were performed by the inspector which revealed radiation levels higher than background in several smaller pieces that had been rejected by the scrap yard and one of several large rolls of pipe. There were no radiation levels that would pose a health risk to any individual. Following the inspector's visit, the individual removed the NORM contaminated sections from the large roll of pipe and returned them to the supplier. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2310 - Naturally Occurring Radioactive Material - DFW Midstream Services LLC - Arlington, Texas

On February 8, 2011, the Agency received a complaint alleging that a well drilling company was storing old drilling pipe in a residential area, contaminating local residential areas with naturally occurring radioactive material (NORM.) The complainant requested a radiological survey to ensure there was no risk to the students attending school near the location. The Agency performed an on-site investigation on February 21, 2011. Radiation surveys were conducted at the well site near the school and at the storage location indicated by the complainant. The dose rates in both surveys were indistinguishable from background. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2311 - Unregistered X-ray Service Provider – TriMedx LLC - Indianapolis, Indiana.

On February 8, 2011, the Agency received a complaint alleging that a company was providing x-ray services in the State of Texas without Texas registration. The complainant provided the name of a hospital to which the company was providing services. This hospital had received a scheduled inspection on February 10, 2011, and the Agency inspector stated that services on the hospital's x-ray devices were conducted by qualified personnel. The Agency contacted the hospital and the hospital's radiation safety officer stated that the company in question did not provide services to them, but provided management of the x-ray service program. The actual service was performed by qualified hospital employees. The service company was contacted and confirmed that they managed the hospital employee's and scheduling of the services, but did not provide the actual service. On March 23, 2011, the service company provided copies of the application for registration for providing services for industrial radiation machines in the State of Texas. The complaint was not substantiated. No violations were cited.

File closed

### C - 2312 - Laser Injury - Medi-Bella, LLC - Buda, Texas

On February 8, 2011, the Agency received a complaint that on January 20, 2011, an individual had received second and third degree burns during a procedure for wrinkle reduction. The Agency's investigation revealed that the complainant received first and second degree burns during a procedure performed using a radio-frequency (RF) device. RF devices do not fall under the scope of the radiation rules. The complaint and investigation information was forwarded to the Agency's Drugs and Medical Devices Group. The investigation did reveal that the facility had been using a Class 4 laser without being registered with the Agency. One violation was cited.

File closed.

## Complaints Opened First Quarter 2011

### C-2313 - Regulation Violations - Castle Dental Centers - Austin, Texas.

On February 9, 2011, the Agency was forwarded a complaint form filed with the State Board of Dental Examiners which alleged that the registrant was needlessly irradiating the public and failing to use protective equipment. An investigation into this complaint is ongoing.

File open.

### C - 2314 - Laser Injury - Somabel Spa - Edinburg, TX

On February 15, 2011, the Agency received an anonymous complaint concerning individuals receiving second and third degree burns during hair removal and other treatments using an intense pulsed light (IPL) device at the facility. The complainant also alleged that the technicians using the devices weren't certified and did not know how to use the devices. The Agency conducted an on-site investigation. The facility admitted one client injury that resulted in a scar for which they were coordinating and paying for treatment with a dermatologist. They had not reported the injury to the Agency, they stated, because they were not aware of the requirement. Technicians employed during the time of the complaint were no longer employed at the facility and current technicians had received training in the use of the devices. The investigation revealed the facility had been using a Class 4 laser without a current certificate of registration. Corrective actions of obtaining a current certificate of registration and submitting an injury report to the Agency were completed by facility. The complaint was substantiated. Two violations were cited.

File closed.

### C- 2315 - Regulations Violations - Sightline West Houston IMRT - Houston, Texas

On February 15, 2011, the Agency received an anonymous allegation that the authorized physician user for a high dose rate therapy device (HDR) was not present during treatments as required at the licensee's facility. Agency rules for HDRs require that the Licensed Medical Physicist (LMP) and the Authorized User (AU) to be physically present during the initiation of all patient treatments; however, a trained physician under the supervision of the AU may be present instead of the AU for the remainder of the treatment. An Agency inspector performed on-site inspection that was due and an Agency investigator conducted an on-site investigation on separate dates. Information obtained by the two supported the licensee's attestation that an authorized physician was always present during the initiation of patient treatments as required. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2316 - Laser Injury - U. Boutique & Med Spa - Plano, TX

On February 17, 2011, the Agency received a complaint concerning burns received during a photofacial treatment using an intense pulsed light (IPL) device at a spa. On March 10, 2011, the Agency conducted an on-site investigation of the facility. The investigation revealed the facility was not registered with the Agency to possess and use a Class 4 laser for laser hair removal and vein treatments, nor did it report the IPL injury to the Agency. Documentation from the spa supported the allegation that the patient was burned. The facility had the manufacturer recalibrate the machine, but it was only reading 5% high, which was within tolerance. The manufacturer reported the burn to the FDA and stated that the most probable cause was improper assessment of skin type and failure to adjust settings when treating the forehead, in contradiction to device training and common medical practices. Supporting documentation from a physician confirmed that there were burns present. The complaint was substantiated. Three violations were cited.

File closed.

### C - 2317 - Regulatory Violation - Unknown - Fort Worth, Texas

On February 22, 2011, the Agency received a letter from an anonymous source alleging that staff at an unspecified facility were inattentive to their work while treating patients "while the beam is on." No specific violation of this Agency's rules were alleged. The complaint could not be investigated due to insufficient information. No violations were cited.

File closed.

### C - 2318 - \* - CHCA Bayshore LP - Pasadena, Texas

\* Health and Safety Code Chapter 241.051(d)

No violation were cited.

File closed.

## Complaints Opened First Quarter 2011

C - 2319 - \* - The Hospital at Westlake Medical Center - Austin, Texas

\* Health and Safety Code Chapter 241.051(d)

Two violations, not directly related to the complaint, were cited.

File closed.

C - 2320 - Uncredentialed Technologist - Vanguard Urology Institute - Houston, Texas

On February 25, 2011, the Agency received a complaint stating that a technologist, nurses, and other office staff were performing x-rays without the proper credentials. The Agency performed an on-site inspection on March 4, 2011. The inspector determined that only properly credentialed individuals had operated the x-ray device. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2321 - Public Irradiation - Rockport Landing Apartment - San Antonio, Texas

On February 28, 2011, the Agency received a complaint referral from the Texas Commission on Environmental Quality. The complainant alleged that her upstairs neighbor was irradiating her with iodine (I) -131 and cobalt (Co) - 60. The Agency contacted the complainant. The complainant could not provide any specific observations or reasonable basis for her beliefs. The complaint could not be substantiated.

File closed.

C - 2323 - Uncredentialed Technician - Luis Delgado Jr. - McAllen, Texas

On March 11, 2011, the Agency's Incident Investigation Program was provided a field report from a regional inspector that stated that an individual was conducting x-rays as a Limited Medical Radiologic Technologist (LMRT), but had not met the requirements to do so. An investigation into the allegation revealed that the individual had received a LMRT license. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2324 - No Physician Supervision for Laser Treatment - The Valentine Foundation, Inc. - Houston, TX

On March 3, 2011, information was shared within the Agency that the registrant did not have supervision of laser treatments by a practitioner of the healing arts. A complaint file was opened. However, since the Agency's Drugs and Medical Devices Group is pursuing the same violation under its rules, it was decided that the Radiation Incident Investigations Group would not conduct a separate investigation.

File closed.

### C - 2325 - Naturally Occurring Radioactive Material - Formosa Plastics - Point Comfort, Texas

On March 22, 2011, the Agency received a complaint alleging that the licensee was not performing radiation surveys on process lines when they were breached, exposing their workers to radiation from Naturally Occurring Radioactive Material (NORM). The complaint also stated that none of the nuclear gauges at the facility had shutters on them. The Agency performed an on-site investigation on April 11, 2011. The licensee's Radiation Safety Officer (RSO) stated that only six gauges, which were mounted on small vessels, did not have shutters on them. He stated that they were purchased from the manufacturer that way and, because of the vessel size, the only portion of a worker that could enter the vessel is their hand. The RSO stated that surveys for line breaches were conducted by "NORM Monitors", workers trained to perform radiation surveys. The RSO stated that surveys they had conducted for sample line breaches in the past had not shown any radiation levels above background. He stated that they had a recent incident with an individual who requested a survey on a quarter-inch line prior to opening it and the individual did not believe that the survey was done correctly. The RSO stated that he went with the individual and performed additional surveys. This did not appease the individual. The RSO stated that their workers can request a survey from the NORM Monitors any time they wish. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2326 - Laser Injury - Renew Beauty Med Spa - Dallas, Texas.

On March 22, 2011, the Agency received a phone call from an individual stating that he/she had received burns to the face during laser vein treatments at a facility in Dallas.

On April 13, 2011, the Agency conducted an on-site investigation of the facility. The investigation revealed the facility was not registered with the Agency to possess and use Class 4 lasers for laser hair removal and vein treatments, nor did it report the injury to the Agency. Supporting documentation from a physician confirmed that there were burns present. The complaint was substantiated. Four violations were cited.

File closed.

## Complaints Opened First Quarter 2011

### C - 2327 - Potential Exposure to Individual - Tejas Oilfield Services - Cleburne, Texas

On March 22, 2011, the Agency received a complaint referral from U.S. Department of Labor-OSHA involving an oil and gas well pipe inspection company operating in Cleburne, Texas. The original complainants had concerns over radiation levels from stacks of pipe that they believed contained naturally occurring radioactive material (NORM) and lack of personal protective equipment for employees working on scale removal. An on-site inspection was conducted in conjunction with OSHA on March 25, 2011. The investigator was able to determine that the facility was not de-scaling pipe at this location and that the facility did not routinely survey pipe prior to working on it until March 9, 2011. On January 26, 2011, the facility conducted a survey of all pipe located on the site and found 19 pipe sections reading greater than 50 microrem/hour. The facility's operations manager stated that they had not worked on any of this pipe and that it was removed from their site by a contractor. The investigation found that appropriate protective clothing was available for the workers. Dust masks were also available for the workers' use. The facility's safety coordinator stated that after they received their training the first week of March 2011 all individuals who had worked on the pipe were sent for bioassay samples. The doctor who screened all of the individuals' medical reports indicated that he did not find "any ill effects" from the exposure to the individuals involved. However, the samples were not analyzed for radioactivity. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2011

C - 2273 - \* - Triumph Hospital of North Houston - Houston, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2283 - Inadequate Credentialing - Alamo Heights Surgicare LP - San Antonio, Texas

On October 6, 2010, the Agency received an allegation that inadequately credentialed registered nurses and/or physician assistants were performing fluoroscopic procedures. The Agency conducted an on-site investigation on October 26, 2010. The investigation revealed that only physicians were performing fluoroscopic procedures. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2286 - Unregistered Laser - Clearstone Laser Hair Removal - Houston, Texas

On November 5, 2010, the Agency received an anonymous complaint stating that a provider of laser procedures for hair removal was operating without proper registration with the Agency and without proper posting of warning signs on the laser treatment room. Additionally, the complainant believed he/she had received excessive burns from treatment at the facility. Follow-up communications with the complainant revealed there had been no medical treatment for the alleged burns and no photographs had been taken. On December 15, 2010, the Agency conducted an on-site investigation. The investigation revealed there were Class 4 lasers in use since January 2010 and the facility was not registered with the Agency. Additionally, the facility was using improper warning signs and four pair of protective eyewear were cracked. During the investigation, the owner admitted that one patient had received burns on October 5, 2010, that required medical attention from a physician. The owner would not give the Agency records related to the burn during the on-site investigation. The facility filed its injury report with the Agency on January 5, 2011. Portions of the complaint were substantiated. Two violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in First Quarter 2011**

### C - 2288 - Regulatory Violations - Woodlake Imaging and Diagnostics - Houston, Texas

On November 16, 2010, the Agency received a complaint alleging that a facility was using an unregistered x-ray machine and committing numerous additional violations. An on-site investigation was conducted on December 14, 2010, subsequent to an inspection five days earlier. Neither the inspection nor the investigation could substantiate any of the allegations. No violations were cited.

File closed.

### C - 2289 - No Physician Supervision for Laser or Intense Pulsed Light Treatment - Natural Skin Creations Day Spa - Houston, TX

On November 16, 2010, the Agency received an anonymous complaint stating that a provider of laser and intense pulsed light (IPL) procedures for skin treatment and hair removal was operating without proper registration with the Agency, without licensed medical practitioner supervision, without properly trained technicians, and without proper posting of warning signs on the IPL/laser treatment room. The Agency conducted an on-site investigation on December 14, 2010. The investigation revealed the facility did not have a contract with, or supervision by, a licensed practitioner of the healing arts. In addition, hazard warning signs were not posted and the facility possessed and used a Class 4 laser for which it was not registered with the Agency. The technicians' training did meet the current training requirements. The complaint was substantiated. Two violations were cited.

File closed.

### C - 2293 -Inadequate Credentialing - Emergency Medicine Specialist LLP - Richardson, Texas

On December 14, 2010, the Agency received a complaint stating that individuals performing x-rays for the registrant are not credentialed. The Agency conducted an inspection at the facility on January 11, 2011, and the operators were verified as having proper and current credentials. The complaint was not substantiated. Three non-related violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2011

### C - 2294 - Radiation Exposure to Member of General Public - Houston Medical Clinic - Houston, Texas

On December 15, 2010, the Agency received an anonymous complaint alleging that an individual had received excessive radiation exposure from an x-ray machine located in a room adjacent to her work station. The Agency conducted an on-site investigation. The investigation revealed that the x-ray machine had not been used since approximately October 2010. The investigation also revealed that due to the type of machine and its positioning in the room, the beam could not have been directed toward the area where the individual worked. In addition, distance from the work station and building structure would have reduced any scatter radiation from the use of the machine to levels below regulatory limits. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2295 - Inadequate Credentialing - Family Medicine Rural Health Clinic PA - Copperas Cove, Texas

On December 16, 2010, the Agency received an anonymous complaint alleging that the registrant was allowing two employees who were not properly credentialed to take x-rays. The Agency conducted an on-site investigation. Required certifications were current for technicians performing x-ray procedures. The complaint was not substantiated. Three violations, unrelated to the complaint, were cited.

File closed.

### C - 2296 - Unregistered X-ray Equipment - Integrated Pain Associates - Killeen, Texas

On December 20, 2010, the Agency received a complaint stating the facility was operating a C-arm machine for exposures on humans without proper registration. An Agency investigator found that an application for a certificate of registration from the facility was received by the Agency on December 31, 2010. An on-site investigation was conducted on March 8, 2011. The investigation revealed that the facility had submitted a request for registration on December 6, 2010. The C-arm device was received in early January 2011, but had not been operated until January 13, 2011. The C-Arm was surveyed by a licensed medical physicist on January 17, 2011, and required no adjustments. The area where the machine was used was properly posted and current procedures were available. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened in a Previous Quarter and Closed in First Quarter 2011

### C-2297 - Inadequate Credentialing - Injury Medical Clinic - El Paso, TX

On December 21, 2010, the Agency received a complaint alleging that staff at a medical clinic were improperly calibrating x-ray equipment and the staff at the facility were not adequately trained. On January 27, 2011, an Agency inspector performed an on-site inspection at the registrant's facility. The inspector found that the equipment performance evaluations had been completed as required and the inspector was not able to identify any instances where non-credentialed personnel performed a procedure. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2298 - Regulatory Violations - Wilson Inspection X-Ray Services - Corpus Christi, Texas

On December 15, 2010, the Agency received a complaint alleging that a radiography company was performing radiography work at a temporary job site without setting up proper barriers. On December 16, 2010, two Agency investigators performed an on-site investigation. The investigators interviewed the complainant and were informed that the radiography crew were no longer performing radiography for them, but were still on site working for a subcontractor. He also stated that he had observed a second crew performing radiography work about a mile from this location. The investigators found the first radiography crew on the east end of the facility. They were sitting in their truck and did not appear as though they were about to perform any work that the investigators could observe, so the investigators drove to the second location where they found a second truck from the licensee sitting on the side of the road. As they drove past, they saw two individuals sitting in the cab of the truck. A radiography camera and drive cables were sitting on the tailgate of the truck. No one had direct control of the camera. The investigators found that neither radiographer had an electronic alarming dosimeter, that both self-reading dosimeters were off scale, the trainee did not have a copy of his credentials, radiation surveys had not been conducted during radiography operations, and the radiographer trainer was not providing supervision of the trainee as required. The original complaint was not substantiated. The radiographer trainer and the licensee were cited for the violations that were observed.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in First Quarter 2011**

### C-2299 - Uncredentialed Technologist and Other Regulation Violations - Family Medicine Clinic - Lampasas, TX

On December 16, 2010, the Agency received a complaint alleging that non-certified technicians were being required to take x-rays of minors, that no technique chart was available for children, and that x-rays were being ordered not only by the doctor and nurse practitioner but also by nurses and medical assistants. The complaint further alleged the exposure to patients was uncertain, the films and cassettes don't match, the exposure settings were being doubled to take x-rays, and the staff was working with three or more technique charts to take x-rays. The agency conducted an on-site investigation. The investigation revealed that a Non-Certified Technologist (NCT) had taken x-rays of a minor that were outside the scope of her certification. It was also found that entrance exposures to the chest exceeded regulatory limits. The issues of films and cassettes not matching, practice of simply doubling settings, and multiple technique charts being in the control room were addressed with the registrant in regard to best practice. The complaint was substantiated. Three violations were cited.

File closed.