



**INCIDENT AND COMPLAINT SUMMARIES
FOR THE
SECOND QUARTER 2009***

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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 Chapter 241.051(d). These summaries will not appear in this report.

Incidents Opened Second Quarter 2009

I - 8625 - Failure of a Device Shutter to Close - Flint Hills Resources - Odessa, Texas

On April 9, 2009, the Agency was notified by the licensee that a 120 millicurie cesium (Cs) -137 source, used in an Ohmart\VEGA model SHLM level gauge, would not fully retract into the source holder. The source would retract into the sleeve between the vessel and the gauge, but not into the gauge. The dose rates in the accessible area were found to be minimal. On May 13, 2009, a manufacturer representative arrived at the facility to inspect, repair, and remove the gauge. At that time, it was found that a small roll pin connecting the source rod to the source carrier was protruding about 0.25 inches preventing the source from retracting. The roll pin was tapped into place and the source was fully retracted into the gauge. The gauge was then removed from the vessel and packaged for shipment and disposal. A leak test of the source was performed and the results were within regulatory limits. During the investigation of this event, the licensee determined that it had not verified the operation of the shutter for this gauge. The licensee has removed all nuclear gauges and is in the process of license termination. No violations were cited.

File closed.

I - 8627 - Impersonating a State Employee - National Inspection Services - Crowley, Texas

On April 3, 2009, the Agency received a call from the licensee's Radiation Safety Officer (RSO). The RSO stated that he had been informed by one of his radiography crews that, while they were driving to a location, a car pulled up along side of their vehicle and the driver started waving at them. The radiographer pulled over to see if there was a problem with his truck. The individual from the car told him that he was employed by the State of Texas. The individual attempted to open the door to the truck's dark room, and began asking questions about the source he was carrying. When asked for his credentials, the individual stated that he did not have them with him. The radiographer gave him his supervisor's name and number. The individual called the office of the licensee and stated he was a certified radiographer in Texas, and asked if they were hiring. The RSO stated that they were not and got his name and contact phone number in case of a job opening. An individual from the Agency called the numbers provided. One was not in service, the other reached a recorder. When the individual contacted the Agency, he stated that he was not the individual they were looking for and did not know anything about the licensee. The Agency could not find sufficient evidence to pursue a charge of impersonating a public servant. No violations were cited.

File closed.

I - 8628 - Source Abandonment - Schlumberger - San Patricio County, Texas

On April 17, 2009, the Agency was notified by the licensee that a logging while drilling tool containing a 1.7 curie cesium (Cs) - 137 source, and a 10 curie americium (Am) - 241 source was stuck in a well at 12,311 feet. Several unsuccessful attempts were made to retrieve the tool. A 439 foot cement plug containing red dye was placed above the tool. The casing liner left in the hole above the tool will act as a mechanical deflection device. A plaque was ordered and will be placed at the well head. No violations were cited.

File closed.

Incidents Opened Second Quarter 2009

I - 8629 - Incorrect Treatment Energy Used - University of Texas M D Anderson Cancer Center - Houston, Texas

On April 22, 2009, the registrant's Radiation Safety Officer notified the Agency that they had treated a patient for two therapy fractions at an energy setting of 6 MV instead of the 18 MV that was prescribed, which qualifies as a medical event according to Agency regulations. The written report was received by the Agency on May 11, 2009. The patient and doctor were both notified of the error. The remaining eight fractions were given at the correct energy. The error was found during a quality assurance review conducted by the facility. The registrant determined that the error occurred because the individuals involved did not comply with the current procedures. The event was reviewed with the individuals involved and additional training was provided to them. The Radiation Oncology Quality and Safety Council will also review the event to determine if any additional corrective actions should be implemented. No violations were cited.

File closed.

I - 8630 - Exposure to Eye from Laser, - University of Texas at Austin - Austin, Texas

On April 24, 2009, the Agency was notified that a researcher received three burns to the macula of the left eye while making a close adjustment to a crystal on a Type IV Ti: Sapphire laser. The device was operating at 800 nanometers wavelength, 10 Hertz repetition rate, approximately 10 millijoule/pulse output energy and approximately 600 picoseconds pulse length. At the time of the accident, the worker was wearing the proper protective eyewear designed to fit over prescription glasses. While leaning over the apparatus to inspect the crystal for condensation, the goggles slipped from his head allowing a gap between his face and the goggles. The researcher then noticed a bright flash and when standing up sensed some compromised peripheral vision in his left eye. Upon seeing a physician, it was confirmed that three burns had occurred on his retina but this did not appear to compromise the individual's vision. The Laser Safety Officer had all protective equipment checked and provided supplemental training to all staff and students who worked with lasers. No violations were cited.

File closed.

I - 8631- Erroneous Badge Reading - Radiographic Specialist Inc. - Houston, Texas

On April 24, 2009, the licensee informed the Agency that one of their employees had received 1,500 millirem during an exposure period, which was much higher than normal. An investigation into the exposure found that the employee had removed the film from its holder and carried it in his wallet until he exchanged it for a new badge. The film processor stated that the increased pressure and heat on the film would have caused the film to read high. The licensee assigned a dose of 417 millirem to the employee for the exposure period. No violations were cited.

File closed.

Incidents Opened Second Quarter 2009

I - 8632 - Badge Overexposure - General Electric Healthcare - Houston, Texas

On April 21, 2009, the Agency was notified by the licensee that notice was received from their dosimetry processor that one of their employees had received 16,033 millirem exposure for the first quarter exposure period of 2009. The licensee conducted an investigation and found that the individual involved had performed testing on a fluoroscopy machine and had inadvertently left his monitoring device on the table of the device. The dosimetry processor stated that the dose indicated on the badge was static and did not appear regular. The individual was assigned a dose equal to the average dose they had received over the last three exposure periods. The employee received additional instruction on the requirements for wearing his dosimeter. No violations were cited.

File closed.

I - 8633 - Gauge Shutter Failed To Close - Union Carbide Corporation - Port Lavaca, Texas

On May 4, 2009, the Agency received a report from the licensee stating that during a routine six-month inspection, the shutter would not properly close on a Ohmart/VEGA level gauge model SH-F2, containing a 200 millicurie cesium (Cs) - 137 source. Radiation levels in the area were found to be normal. The licensee lubricated the operating mechanism on the gauge and tried to close the mechanism, but was unsuccessful. The licensee continued to lubricate the mechanism periodically and on April 29, 2009, was able to close and operate the shutter normally. There was no apparent damage to the shutter operating mechanism, and there were no significant exposures to personnel involved. No violations were cited.

File closed.

I - 8634 - Radioactive Material Lost - Presbyterian Hospital of Allen - Allen, Texas

* Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

Incidents Opened Second Quarter 2009

I - 8635 - Gauge Shutter Failure - The Dow Chemical Company - Freeport, Texas

On May 21, 2009, the Agency received a report from the licensee that, while performing the biannual test on a Ronan Engineering nuclear gauge, the shutter failed to close. The gauge was a model SA-1, containing a 100 millicurie cesium (Cs) - 137 source. A dose rate measurement taken at the gauge was 0.03 millirem per hour, and the device posed no risk to the workers. The manufacturer was contacted to provide corrective maintenance on the shutter. The gauge was repaired and returned to normal service. An investigation by the Agency determined that the licensee had documented that the gauge had failed two previous biannual shutter checks which were not reported to the Agency. The licensee was cited for the failure to report the events.

File closed.

I - 8636 - Source Abandonment - Baker Hughes Oil Field Operations - Houston, Texas

On May 21, 2009, the Agency was notified by the licensee that they had abandoned a 5 curie americium – 241/beryllium (AmBe) source downhole. The licensee was running the tool down to find the bottom of the a salt dome. The tool broke and the source and most of the tool fell into the salt dome. The area is a large open space without any lining making retrieval of the source virtually impossible. A plaque was placed at the well head. No violations were cited.

File closed.

I - 8638 - Wrong Patient Treated - The Methodist Hospital - Houston, Texas

* Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

Incidents Opened Second Quarter 2009

I - 8639 - Equipment Malfunction - The Dow Chemical Company - Freeport, Texas

On June 11, 2009, the shutter of a Ronan Engineering gauge, Model SA-1 containing a 3 Curie cesium (Cs) - 137 source would not close during testing. The serial number is M7844 for both device and source, and the source model is 3M 4D6L. The exposure rate in the area was 1.5mR/hr and the gauge was located forty feet above the ground on a vessel which was in process which prohibits entry by personnel into the vessel. The licensee is planning to have the gauge repaired during a three day outage in July. No violations were cited.

File closed.

I - 8640 - Radioactive Material at a Landfill - VHS San Antonio Partners LLC - San Antonio, Texas

* Health and Safety Code Chapter 241.051(d).

The licensee was cited for the violation.

File closed.

I - 8641 - Inability To Retract Source - METCO - Houston, Texas

On June 19, 2009, the Agency was notified by the licensee that, on June 10, 2009, while performing radiographic operations using a SPEC 150 radiography camera, two radiographers found they were unable to retract a 35.6 curie cesium (Cs) - 137 source into the shielded position. An approved Source Retrieval Supervisor (SRS), who was at the jobsite grading film, was contacted. The SRS found that the source tube was positioned with a sharp bend which he felt may have put the drive cable in a bind. He repositioned the exposure device, attempting to reduce the source tube's bend, but this action had no effect. The SRS determined that the crankout device could be the problem, so he and one of the radiographers, disassembled the crankout and pulled the drive cable, returning the source to the shielded position. After ensuring the source was in the shielded position, the crankout was further disassembled and disconnected from the source pigtail, the exposure device was locked and the source guide tube removed. The highest exposure received during this operation was 7 millirem. The licensee's investigation concluded that debris in the cranking device prevented the device from operating normally. The crankout was removed from service, disassembled, inspected, reassembled, and satisfactorily tested. No violations were cited.

File closed.

Incidents Opened Second Quarter 2009

I - 8642 - Gauge Shutter Failure - Flint Hills Resources - Odessa, Texas

On June 25, 2009, the Agency was notified by the licensee that, while looking for information requested by the state for a gauge failure, the licensee discovered an additional event. This event occurred in early September 2008, and had not been reported to the Agency, as required. The event involved an Ohmart/VEGA Model SH-F2 level gauge containing a 300 millicurie (228 millicurie calculated current activity) cesium (Cs) - 137 source. The gauge shutter would not close due to a sheared shutter rotor. The manufacturer was notified and a technician arrived at the facility on September 30, 2009. The technician replaced the rotor, cleaned and lubricated the gauge which allowed the gauge to operate normally. The technician found that a great deal of material had collected in the source holder, causing the failure. Because licensee had removed all of their nuclear gauges and was in the process of terminating their license, no violations were cited.

File closed.

I - 8644 - Loss of Brachytherapy Seeds - Las Palmas Medical Center - El Paso, Texas

* Health and Safety Code Chapter 241.051(d).

File closed.

Complaints Opened Second Quarter 2009

C - 2185 - Failure to Provide Mammography Films - North Texas Imaging Hampton Center Inc - Dallas, Texas.

On March 27, 2009 the registration program received a phone call from a complainant who stated that she had made several unsuccessful requests by telephone to obtain her mammography records from the registrant. She asked the Agency to aide her in finding her mammography records. The complaint was forwarded to the mammography inspection manager on March 30, 2009. On April 2, 2009 another complainant contacted the incident investigation program regarding the registrant. The complainant stated that she had requested her mammography films sent to another facility and the registrant had refused her request. The complaint was also forwarded to the mammography inspector manager. An unannounced investigation was performed by a regional inspector on April 3-4, 2009. The complaint was substantiated. The registrant was cited for the described violation.

File Closed.

C - 2186 - Regulatory Violations - Pantel Ranjit MD - Webster, Texas

On April 16, 2009, the Agency received a complaint alleging that the registrant had not posted applicable registration forms. An inspection conducted by a regional inspector found that the required documents were properly posted at the facility. The complaint could not be substantiated. The registrant was cited for two unrelated violations.

File closed.

C - 2187 - Unregistered Veterinary Clinic - Happy Ending Dog Rescue - Hewitt, Texas

On April 15, 2009 the agency received an email complaint alleging that a veterinary clinic was using a radiographic machine without being registered by the agency. The agency was unable to determine if the facility was registered with the Agency based on the information provided. On May 28, 2009, an agency inspector performed an unannounced inspection of the facility. The Agency determined there was no registration for the operation of the radiation machine. The registrant was cited for the violation.

File Closed.

Complaints Opened Second Quarter 2009

C - 2188 - Unqualified PET Technologists - Desert Imaging - El Paso, Texas

On April 22, 2009 the Agency received a letter from a technologist that had been discharged from a positron emission tomography mobile coach scanner alleging that the imaging company was employing technologists that did not have training, as required by licensing standards. The technologist had taken a leave of absence due to an automobile accident and was subsequently terminated. Utilization logs were reviewed by an Agency inspector and the complaint was not substantiated. No violations were cited.

File closed.

C - 2189 - Regulations Violations - Cook Children's Medical Center - Fort Worth, Texas

* Health and Safety Code Chapter 241.051(d).

A violation was cited for the failure to perform the evaluation as required.

File closed.

C - 2190 - Misuse of Diagnostic Radioactive Material - Temple Imaging Center - Lufkin, Texas

On April 29, 2009 the Agency received an e-mail from a regional inspector stating that a licensee was accused of misusing radioactive material during an attempted medical diagnostic procedure. The uptake detection device used for quantifying radioiodine in a patient's thyroid allegedly was improperly used and the setup information, which is specific to a particular dose, was not saved. Thus, when the patient had returned for the completion of the procedure, it was unable to be performed. The event was investigated and found to be a procedural error which is beyond the scope of the Agency's jurisdiction. No violations were cited.

Complaints Opened Second Quarter 2009

C - 2191 - Failure to Provide Records - Doctor Allen Kapilivsky - McAllen, Texas

On May 7, 2009, the Agency received a complaint alleging that a patient was unable to obtain her mammography records. She had requested the records on May 4, 2009, and her doctor had informed her that the records were no longer retrievable. The registrant was contacted by the Agency on June 24, 2009. He stated that the facility where the records were stored had been damaged and the records were no longer in any type of order to allow for easy retrieval. The registrant was informed that he was still obligated to provide the records when requested. The registrant had the files straightened out and the complainant received the requested files during the first week of August 2009. The complaint was substantiated. A notice of violation was issued for failing to provide the records within the required time.

File closed.

C - 2192 - Personnel Monitoring Violations - Twin Lakes Pet and Bird Clinic - Aubrey, Texas

On May 7, 2009, the Agency received a complaint stating that the registrant had reissued a personnel dosimetry device to a second user. The complainant also stated that not all individuals who operated the x-ray device had received personnel dosimetry. An Agency investigator determined that in the year 2008, at least one individual wore an exposure device not assigned to them, and the individual was not assigned any monitoring devices for the year 2008, even though exposed to radiation during occupational duties. The registrant has implemented new procedures and training to prevent a reoccurrence. The complaint was substantiated. The registrant was cited for the two violations.

File closed

C - 2193 - Inadequate Laser Protection - American Laser Centers - Austin, Texas

On May 15, 2009, the Agency received a complaint alleging the registrant was treating patients without providing the patient with required eye safety equipment. The complainant also alleged that the facility allowed the use of cracked safety goggles, and allowed unqualified individuals to operate the equipment. Two Agency inspectors performed an on-site investigation on June 4, 2009. The Inspectors found that the 12-month protective eyewear exams were not conducted as required, and that damaged eyewear had been used. It was also determined that the registrant had allowed lasers or intense-pulsed light devices to be used on humans without the supervision of a licensed practitioner of the healing arts. They could not substantiate the allegation that unqualified individuals were operating devices. The complaint was partially substantiated. The registrant was cited for three violations.

File closed.

Complaints Opened Second Quarter 2009

C - 2194 - Allegation of Abandoned Radioactive Material - Trace Life Sciences Inc. - Denton, Texas

On April 16, 2009, an email complaint was received by the Agency alleging the licensee had abandoned radioactive material at their facility. A regional inspector was sent to the facility to determine if there were any potential risks to the health and safety of the public. The inspector found that the facility was adequately secured and ascertained there was no eminent threat to the public. The Agency learned that the licensee has been experiencing financial difficulties and is seeking additional financial investment.

File open.

C - 2195 - Regulations Violations - Halliburton Energy Systems - Alvarado, Texas

On June 3, 2009, the Agency received a complaint alleging that the licensee was violating several regulatory requirements. The allegations included failure to: conduct adequate inventories, provide adequate fume hoods, perform adequate bioassay sampling, or keep proper records. An on-site investigation was conducted on June 8, 2009, by the Agency. The investigator found that inventories of radioactive sources and leak test of those sources were conducted and documented as required. The investigator also found that all individuals in the facility were in the bioassay sample program and the results for the year 2009 were all within regulatory limits. The licensee provided manufacturer's specifications on their fume hoods and the testing data provided indicated that they were within regulatory requirements. The complaint was not substantiated. No violations were cited.

File closed.

C - 2196 - Unauthorized use of X-ray Device - El Paso Healthcare System - El Paso, Texas

On June 15, 2009, the Agency was notified by a regional inspector that he had observed several commercial advertisements stating that osteoporosis screening would be provided at a woman's health fair at the El Paso Convention Center scheduled for June 27, 2009. The test procedure for this screening process normally involves the use of a bone densitometry machine which uses ionizing radiation in the evaluation and imaging of the area of interest. The regional inspector contacted the registrant to determine if the screening service would violate any state regulations during its use. The inspector was informed that the registrant intended to use an ultrasound imaging machine which dose not generate any ionizing radiation. No violations were cited.

File closed.

Complaints Opened Second Quarter 2009

C- 2197 - Failure to Provide Records - Rio Grande Regional Hospital - McAllen, Texas

* Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

C - 2198 - Regulation Violations - Southwest X-ray - El Paso, Texas

On June 23, 2009 the Agency received a complaint from an anonymous source. The complaint was forwarded to an investigator on June 24, 2009, and it alleged that several regulation violations were made by the licensee/registrant. The alleged violations enumerated by the complainant included: failure to perform weekly wipe tests and surveys, failure to provide personnel monitoring reports to all technologists, failure to properly designate a Radiation Safety Officer, failure to properly maintain and provide dose and calibration information at all sites, manipulation of doses and calibration sources by technologists, and allowing uncredentialed personnel to perform work beyond their scope. The complaint also implied that the licensee is using nuclear medicine at a location that has registered x-ray equipment but is not authorized by their license for the use of radioactive materials. The complaint was forwarded to the regional inspector on June 25, 2009. The inspector performed a full inspection at all three sites and found most of the complaint to be substantiated, along with several other regulation violations. The licensee was cited a total of nine violations.

File closed.

C - 2199 - Unregistered Laser - Bella Fontana Spa, Ltd. - Sherman, Texas

On June 25, 2009, a telephone complaint was received to the registration program alleging that a spa was using lasers without being registered with the Agency, and that clients of the facility had suffered burns from the lasers. An initial search of the Agency's database did not yield a certificate of registration for the facility. The complaint was forwarded to the x-ray inspection unit for further review. A regional inspector performed an inspection and found that the lack of registration with the Agency was substantiated, but the alleged burns from the laser could not be substantiated. One violation was cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2009

I - 8206 - Abandoned Sources - Advanced Active Care - Houston Texas

On February 16, 2005, an Agency inspector went to the licensee's facility to complete a final close out survey for radiation and contamination. The inspector determined that no contamination was present, but a positron emission tomography scanner containing three germanium/gallium sources with a total activity of 12.93 millicuries (assayed in July 2002) was still located in the facility. The facility was locked and the building manager notified. The machine was purchased by a company in California, and later moved to a facility in that state. A notice of violation was issued to the building management company for being in possession of radioactive material without a license.

File closed.

I - 8601 - Source Found at a Recycling Facility - Newell Recycling of San Antonio - San Antonio, Texas

On January 20, 2009, the Agency was notified by a recycling company that they had found a source of radiation in a load of scrap steel. The company believed the material came from El Paso, Texas. An Agency inspector went to the facility on January 21, 2009. The inspector was able to identify the radioisotope as sodium (Na) - 22. The recycler stored the source in a remote location of their facility. The source was removed from the facility by the Agency on March 25, 2009, and the remaining material was disposed of as waste. No violations were cited.

File closed.

I - 8614 - Source Disconnect - Desert Industrial X-Ray - Abilene, Texas

On March 5, 2009, the Agency was notified by the licensee that a source disconnect had occurred. The source had been returned to the camera and was shielded. In this case, the connector crimp that is fitted on the source pig tail had separated from the source cable. Neither the individual who retrieved the source nor the individual who operated the camera during the source retrieval exceeded any exposure limits. The device was returned to the manufacturer located in the State of California, and the Agency notified the State of California Radiological Health Branch of the event. The manufacturer inspected the devices and could not determine the cause for the failure. They also tested all of their connector assemblies they had in inventory and no others failed. As the cause for the failure could not be identified, no corrective action could be taken. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2009

I - 8616 - Badge Overexposure - Shannon Medical Center - San Angelo, Texas

* Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

I - 8617 - Stolen Equipment - Radiology Associates of San Antonio PA - San Antonio, Texas

On March 11, 2009, the Agency was notified by the registrant that a GE MST 625 II x-ray device had been stolen. The company had relocated to a new building and left the device at the original location for storage. The device had not been used for over a year. The Radiation Safety Officer stated that they had determined a time frame when the device could have been removed, but not a specific date. No radioactive material had been left in the room with the device. The area where the device had been stored was being remodeled for a new tenant. Interviews with the workers did not provide any information about the disappearance of the device. Local law enforcement was notified of the event. The registrant has added a procedure to their radiation protection plan to provide guidance and controls for devices in storage. No violations were cited.

File closed.

I - 8618 - Lost Sources - Dr. Pepper Bottling Co. - Irving, TX

On February 20, 2009, during an internal audit/inspection, it was discovered that two Filtec Model FT 50 level detection devices each with a 100 millicurie of americium (Am) - 241 were missing and had been removed from the facility as scrap metal. The investigation determined that the metal scrap, along with these devices, was subsequently shipped on December 8, 2008 to a mill in Nhava Sheva, India where it was melted. The company was cited for failure to maintain control of licensed material.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2009

I - 8619 - Sources Seized by Property Owner - Network Cancer Care - Corinth, Texas

On March 30, 2009, the Agency was notified that the property and assets of a medical business in Corinth, Texas, had been seized by the property owner for overdue rent. Included in the assets were two nuclear medicine scanners with installed radioactive sources used for attenuation correction. Other assorted sources typically found in a nuclear medicine clinic were also discovered unsecured. At a later date and with the permission of the owner, the sources were impounded and secured in safe storage. Prior to the contents of the office being auctioned, the Agency provided the property owner with a complete inventory of the sources impounded and those removed from the devices by an authorized firm. The information was provided to the licensing branch so that the license could be properly terminated since the licensed entity was in bankruptcy. No violations were cited as the licensed persons were no longer available.

File closed.

I - 8620 - Inability to Close Nuclear Gauge Shutter - Union Carbide Corporation - Seadrift, Texas

On March 18, 2009, the Agency was notified that while attempting to close the shutter on an Ohmart/Vega SH-F1 level detection gauge, the handle shaft broke separating it from the shutter closure device. The gauge contained a 10 millicurie cesium (Cs) - 137 source. Dose rates were taken in the area and were found to be normal for a closed shutter. A technician from the manufacturer installed a shield over the shutter. The gauge was then moved to a storage area and packaged for return to the manufacturer. Operations at this facility have ceased and they are currently preparing for demolition. No violations were cited.

File closed.

I - 8622 - Overexposure - Weld Spec. Inc. - Beaumont, Texas

On March 25, 2009, the Agency was informed by the licensee that they had been notified by their dosimetry processor that one of their employee's thermoluminescent dosimeter badge read greater than 1,000 rad Deep Dose Equivalent, exceeding the annual limit. The licensee's Radiation Safety Officer (RSO) had contacted the individual and sent her to have complete blood count done. The worker stated that she had only performed work nine days in the month of February, and all of that work was done in the dark room. She stated that she was in control of her badge at all times from the time she picked it up for the first time in her company mail box in mid February, until it was turned back in. The results of the blood work were normal. The licensee removed the recorded dose from the individual's dose history and assigned a dose of 416 millirem for the exposure period. The RSO conducted safety training with all of their technicians and informed them of the consequences of exposing an individual's dosimeter as a trick or to seek revenge. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2009

I - 8624 - Unaccounted for Iodine Seed During Patient Treatment - Scott And White Hospital - Temple, Texas.

* Health and Safety Code Chapter 241.051(d).

No violations were cited.

File closed.

I - 8626 - Lost Source - Edward W. Leahey MD, PA - Baytown, Texas

On April 15, 2009, the Agency received a letter from the licensee stating that they had lost a 206.8 microcurie cesium (Cs) - 137 source. The source was used for dose calibrator accuracy and consistency evaluations. The licensee's facilities had been heavily damaged by Hurricane Ike in September of 2008. The licensee looked for the source after the hurricane, but could not find it. They believed that after all the debris was removed, they would be able to locate the source. They completed repairs to the facility and began nuclear operations in late February 2009, when it was determined that the source was still missing. The licensee performed radiological surveys using a scintillation detector, but were not able to locate the source. The licensee is now storing all sources in a lead pig to prevent a reoccurrence of this event. The licensee received a notice of violation for failure to make a phone notification within 30 days of the event to the Agency.

File closed.

I - 8637 - Contaminated Drilling Mud from Mexico - Weathordford International - Edinburg,

On February 13, 2009, the Agency received a phone call from Customs Border and Protection Agents in Edinburg, Texas, indicating that small quantities of radioactive material were detected in a roll off container filled with drilling mud that was destined for disposal at a hazardous waste disposal facility. Radioisotope identification and quantification revealed the presence of microcurie quantities iridium-192 and Scandium-46 which are commonly used in the well logging industry. Under international agreement, waste materials originating from American industries located in Mexico must be disposed of in the United States. Thus, the contaminated mud was held at a licensed disposal facility to allow the radioactive material to decay. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2009

C - 2166 - No Physician Oversight - The Valentine Foundation - Houston, Texas

On October 23, 2008, the Agency received a complaint stating that the registrant was performing laser treatments without physician oversight. The DSHS Drugs and Medical Devices (DMD) group was contacted to determine whether a joint inspection should be conducted. The DMD group stated that since there were already actions being taken against the registrant, a letter requesting the required information should be sent. A letter was sent on January 14, 2009. The letter was returned on January 30, 2009, by the postal service stating that the letter could not be delivered and that no forwarding address was available. A second letter was sent to a different address, but there was no response to it. This complaint is closed and is being pursued under complaint C-2151.

File closed.

C - 2167 - Regulation Violations - CONAM Inspection & Engineering Inc. - Texas City, Texas

On November 4, 2008, the Agency received a complaint stating that the licensee was allowing various regulatory violations to occur without taking any corrective actions. The complainant alleged that the security systems were broken on three out of five trucks, maintenance of cameras was inadequate, collimators were not used properly, trucks/sources were left unattended, surveys were not performed, and a transport box was loose on a truck used to transport radioactive materials in excess of the Quantities of Concern. An on-site investigation was conducted on June 10, 2009, by the Agency. The workers were informed of the inspector's presence before he could observe their work in progress. The investigation found that while two out of three trucks alarm systems failed to alarm properly, the trucks were never without observation by an employee of the licensee. The transport boxes for the sources were bolted to the frame of the trucks. All individuals interviewed had appropriate dosimetry. A review of truck and camera records did not find any discrepancies. The complaint was not substantiated. No violations were cited.

File closed.

C - 2168 - Poor ALARA Practices - QC Laboratories Inc. - Houston, Texas

On November 14, 2008, the Agency received a complaint stating that personal dosimetry is not being used or issued to workers, technicians are being exposed to radiation due to poor ALARA practices and that collimators are not used during radiography operations. An investigation done at the licensed facility found all individuals were wearing appropriate dosimetry. In the shooting bays, they found two valves set up for radiography, and both installations included collimators. Both the Radiation Safety Officer and the Chief Operating Officer (COO) stated that performing radiography operations outside of the shooting bays did not occur very often. The last time it occurred, the COO stated that he personally performed boundary surveys to verify dose rates were within acceptable limits. The complaint was not substantiated. The licensee was cited for three violations found during the investigation.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2009

C - 2174 - Regulation Violation - Ashtead Technology - Pasadena, Texas

On February 3, 2009, the Agency received a complaint stating that the registrant was leasing radiation generating devices to individuals who are not registered to use them. A review of rental records obtained from the registrant by the Agency was conducted and indicated that each entity who had rented a device was correctly registered with this Agency. The complaint was not substantiated. No violations were cited.

File closed.

C - 2175 - Uncredentialed Technologists - Red Oak Cardiovascular Center PA - Houston, Texas

On February 3, 2009, the Agency received a complaint alleging that the registrant was laying off qualified technicians and hiring unqualified personnel to perform x-rays. An Agency inspector performed an investigation at the facility on March 31, 2009. The inspector determined that only credentialed individuals were operating the x-ray equipment. The complaint was not substantiated. No violations were cited.

File closed.

C - 2179 - Failure to Provide Records - Advanced Radiology Associates - Edinburg, Texas

On March 10, 2009, the Agency received a complaint from a husband alleging that the registrant had refused to provide his wife's mammogram records as requested until the patient received additional testing. The husband stated that they had requested copies of a mammogram on February 19, 2009, and again on March 2, 2009. He stated that the doctor had stated that the patient needed an MRI, and that they would not release his wife's mammogram records until the MRI was done. The husband had his local doctor fax a copy of the request to the mammogram facility on March 26, 2009. On March 27, 2009, the Agency contacted the mammogram facility to confirm that the facility had not released the records. The response to the call indicated no request had been received, but that the records were being faxed at the time of the call. The records were delivered to the requested location prior to the required 30 day timeline. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2009

C - 2182 - No Physician Supervision - Venus Day Spa - Austin, Texas

On March 11, 2009, the Agency received a letter from an anonymous source claiming that the facility was using lasers on humans for hair removal without physician supervision. On April 2, 2009, an Agency investigator performed an unannounced investigation at the facility. The investigation determined that the laser device being used was registered. The operator provided numerous examples of patients health information sheets being reviewed by a practitioner of the healing arts. The complaint was not substantiated. No violations were cited.

File closed.

C - 2184 - Uncredentialed Technologists - Lone Star Pediatrics - Kaufman, Texas

On March 19, 2009, the Agency received a complaint alleging that the registrant allowed Non Credentialed Technologists (NCT) to perform tasks beyond their abilities. The complainant alleged that the physician was not at the facility on Fridays, and that the Nurse Practitioner was required to perform unauthorized x-rays under the NCT. In a previous response to violations, the registrant had committed to send staff to training, but did not do so. An Agency inspector performed an unannounced inspection at the facility on April 3, 2009. The inspector found that on several occasions NCTs had operated the x-ray equipment. The physician stated that he had instructed all personnel that only properly credentialed individuals were to operate the device. The NCTs stated that they felt compelled to perform the operations due to time constraints and patient load. Disciplinary actions were taken for the individuals involved, the operating procedures for the facility have been updated, and the facility has hired a consultant to review their operations on a quarterly timeframe. The complaint was substantiated. Two violations were cited against the registrant.

File closed.

C - 2185 - Failure to Provide Mammography Films - North Texas Imaging Hampton Center Inc - Dallas, Texas.

On March 27, 2009, the registration program received a phone call from a complainant who stated that she had made several unsuccessful requests by telephone to obtain her mammography records from the registrant. She asked the Agency to aide her in finding her mammography records. The complaint was forwarded to the mammography inspection manager on March 30, 2009. On April 2, 2009, another complainant contacted the incident investigation program regarding the registrant. The complainant stated that she had requested her mammography films sent to another facility and the registrant had refused her request. The complaint was also forwarded to the mammography inspector manager. An unannounced investigation was performed by a regional inspector on April 3-4, 2009. The complaint was substantiated. The registrant was cited for the described violation.

File Closed.