



**INCIDENT AND COMPLAINT SUMMARIES
FOR THE
SECOND QUARTER 2010***

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* Any complaint and/or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & the Health and Safety Code Chapter 241.051(d). These summaries will not appear in this report.

Incident and Complaint Summaries
2nd Quarter 2010

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Incidents Opened Second Quarter 2010

I - 8728 - Radiography Truck Accident - Team Industrial Services, Inc - Kosse, Texas

On April 7, 2010, the Agency received a telephone call from the Radiation Safety Officer (RSO) of the licensee. The RSO stated that two industrial radiographers employed by the licensee had been involved in a traffic accident on State Highway 7, approximately eight to ten miles east of Kosse, Texas. The RSO stated that one of the radiographers had been fatally injured and the other had been rushed to the hospital. The RSO stated that emergency personnel were on the scene, but none had radiation detection equipment to perform a survey to ensure that the camera (QSA Global 880 D) in the truck still contained its radioactive source. The RSO stated that the Site Radiation Safety Officer (SRSO) for the licensed site the camera was stored at was en route to the scene but would not arrive for at least two more hours. An investigator for the Agency happened to be performing field work in that area and he was able to be at the site to perform a survey within 45 minutes. The investigator's survey determined that during transportation the camera had been locked in a plywood box located in the dark room of the truck, but due to the force of the impact, the camera was ejected from the plywood box. The camera was within the debris of the dark room, which had been dislodged from the bed of the truck. The investigator determined that the radiography truck had collided head-on with a tractor trailer carrying gravel. The investigator found a maximum dose rate of 2.2 millirems per hour at one foot from the camera. The licensee's Site RSO arrived at the scene to retrieve the camera. On April 8, 2010, the Agency received the source information from the RSO as well as the leak test results performed on October 20, 2009. The RSO also stated that the device had been removed from service and would be sent to the manufacturer for inspection and repairs. On April 13, 2010, the RSO supplied the leak test results, maintenance reports, and inspection reports from the manufacturer. All the leak test results were within regulatory limits. No violations were cited.

File closed.

I - 8729 - Abandoned Well Logging Sources Down Hole - Schlumberger Technology Corporation - Zapata County, Texas

On April 14, 2010, the Agency was notified that the licensee had abandoned a 16 curie americium (Am) - 241/beryllium (Be) and a 1.7 curie cesium (Cs) - 137 source downhole in a well in Zapata County. The sources were abandoned at depths of 5,743 and 5,755 feet respectively. An 880-foot red dye cement plug was placed above the sources and an additional 300 feet of cement was placed above the first cement plug. A 5.5 inch pipe was placed above the second plug to act as a deflection device. A plaque was ordered for placement at the well head and the sources were abandoned in accordance with Railroad Commission regulations. The well will be sidetracked at 4,500 feet. No violations were cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8731 - Badge Overexposures - Non-Destructive Inspection Corporation - Lake Jackson, Texas

On April 8, 2010, the Agency received an email from the licensee's Radiation Safety Officer (RSO) stating that he had just received a call from the company's dosimetry processor informing him that two employee badges had high readings. One was reading 21.4 rem and the other 24.1 rem. One of the badges was from the January 2010 exposure period and the other for February 2010 exposure period. The dosimetry processor stated that the exposure results were inconclusive. An investigation by the licensee could not identify a specific reason for the exposure. Both radiographers stated that they could not think of any reason why their badge readings would be so high. The RSO indicated that the badges may have been exposed to radiation while the workers were not wearing them. Based on self-reading pocket dosimeters for the period, the radiographers were assigned 167 millirem and 81 millirem. The RSO stated that he held safety meetings with all the licensee's radiographers and warned against tampering with exposure badges. He also changed the way badges are issued to workers to prevent anyone from having unauthorized access to them. No violations were issued.

File closed.

I - 8732 - Gauge Shutter Failure - Sherwin Alumina Company - Gregory, Texas

On April 20, 2010, the Agency was notified by the licensee that on April 19, 2010, while conducting calibrations on two continuous density measurement detectors, the associated gauge shutters were found to be stuck in the open position. "Open" is the normal operating position for these gauges. The gauges are Ohmart Vega model SR-A gauges containing 100 millicuries each of cesium (Cs) – 137. The licensee's Radiation Safety Officer (RSO) placed notification tags on the gauges to warn workers of the problem. On August 10, 2010, the manufacturer removed the gauges from the vessels, packaged them for shipment, and shipped them to the manufacturer's facility. The failure was caused by a buildup of chemical residue on the operating mechanism. The licensee stated that they will install a stainless steel plate above the new gauges to prevent a recurrence. No violations were cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8733 - Gauge Shutter Failure - OXEA Corporation - Bay City, Texas

On April 21, 2010, the Agency was notified by the licensee that while performing a scheduled shutter operation check, the shutter on a Ronan Model SA1 nuclear gauge failed in the open position. The gauge contained five millicuries of cesium (Cs) – 137. The gauge was in its normal operating position and a radiation survey conducted by the licensee indicated that radiation levels were normal. The licensee stated that there was no risk of additional exposure to workers in the area. The gauge was repaired by the manufacturer on May 18, 2010. The manufacturer found that the rubber seal on the operating shaft was missing and allowed a build up of dirt and dust causing the shaft to freeze. The gauge was repaired, cleaned, leak tested, and returned to operation. The leak test results were acceptable. During the investigation it was discovered that the licensee was not cycling the shutter to the fully closed position during their maintenance check. The licensee has changed its inspection to include fully closing the shutter to verify proper operation. The licensee was cited for the violation.

File closed.

I - 8734 - Radiation Sticker on Drum - North 10th Street Storage - McAllen, Texas

On April 27, 2010, the Agency received an email notification from the Agency's call center. An Agency investigator contacted the individual reporting the incident who stated that a drum with a radiation label had been found at a storage facility. The individual stated that the fire department was called to the scene and they performed a survey of the drum, opened the drum, and did not find any radiation above background. The individual stated that after the fire department performed their survey, they emptied the contents of the drum into the dumpster. The individual agreed to send the Agency the photographs of the drum taken by the owner of the facility. On April 27, 2010, an Agency investigator contacted the owner of the storage facility who stated that the unit was being cleaned because the tenant was delinquent on his payments. The owner stated that the tenant began renting in 2002 and with the exception of his initial storage of items in the unit, he has never returned to the unit. The owner stated that the drum contained a piece of Styrofoam and two pieces of wood. The owner stated there were no metal pieces or pipe in the container. The fire department then discarded the contents of the drum into the dumpster and advised the owner to remove the labels from the drum and discard it in the dumpster as well. In the photos, a shipping receipt could be seen taped to the drum which revealed that the drum originally contained germanium (Ge) – 68, a material commonly used in positron emission tomography devices. The activity was stated on the receipt as 21 megabecquerels (0.57 millicuries). The Agency calculated that the current activity of the source would be 0.603 microcuries, an exempt quantity. The Agency was unable to contact the individual the storage unit was leased to. No violations were cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8735 - Unauthorized Removal of RAM - Environmental Health Center - Dallas, Texas

On April 27, 2010, the Agency received a facsimile from a licensee (Licensee-A). The letter stated that another licensee (Licensee-B) had removed some radioactive materials from their facility on April 15, 2010, without permission. Licensee-A stated in the letter that Licensee-B was renting equipment from Licensee-A. The letter also stated that Licensee-B's Radiation Safety Officer (RSO) had been asked by Licensee-B's owners to order calibration sources under Licensee-A's license for use in the calibration of newly acquired equipment at one of Licensee-B's licensed locations. The doses were ordered from the nuclear pharmacy by someone that was not employed by Licensee-A and were delivered to Licensee-A's facility. One of Licensee-B's owners came to Licensee-A's facility and took the doses, even though the Licensee-B's RSO protested. The owner transported the doses without proper HAZMAT training as required by rule. One violation was cited.

File closed.

I - 8736 - Source Leak Test <0.005 Microcuries - Ametek Process and Analytical Inst. - Austin, Texas

On April 16, 2010, the Agency was notified by the licensee that a 100 microcurie iron (Fe) - 55 source was leaking as indicated by the leak test results of 0.0258 microcuries. The licensee stated that the source was contained in an Asoma model 8620 x-ray fluorescence analyzer that was being prepared for disposal. The licensee placed the source in storage for later disposal. No other contamination was found on the device by the licensee. No violations were cited.

File closed.

I - 8737 - Gauge Shutter Failure - Chevron Phillip Chemical Company - Borger, Texas

On May 4, 2010, the Agency was notified by the licensee that the shutter on an Ohmart-Vega Model SH-F1 nuclear gauge with a 20 millicurie cesium-137 source failed to function properly. The gauge shutter had failed previously in October 2009, incident I - 8675. That event was caused by a build up of debris in the operating arm shaft bushing area. A protective device had been placed over the gauge to prevent a recurrence of this buildup. A manufacturer representative inspected the gauge on May 28, 2010. Inspection revealed a large buildup of corrosion material in the operating shaft bushing area. The inspection did not identify a cause for the corrosion. The gauge was cleaned and returned to service. No violations were cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8738 - Stolen Radioactive Materials - Apex Geoscience - Dallas, Texas

On April 30, 2010, the Agency received a report from the licensee stating that a Troxler moisture/density gauge (Model 3430) was missing from a construction site in Dallas. The gauge contained an 8 millicurie cesium (Cs) - 137 and a 40 millicurie americium (Am) - 241/beryllium (Be) source. The licensee reported that the gauge user (worker) had used the gauge earlier in the day and had secured and locked it in the licensee's storage trailer at the site around 1:00 p.m. The worker left the site for his lunch break and returned around 4:00 p.m., when he returned to the storage trailer. At that time, he discovered the trailer lock and gauge were missing. The worker informed the Apex personnel on site and a search of the grounds was completed. After the search was completed, it was determined that the gauge had been stolen. On May 3, 2010, the Radiation Safety Officer stated that they would report the theft to the local law enforcement agency for investigation. The licensee's corrective action included reviewing internal policies and retraining personnel by stressing the importance of security of their radioactive materials. On June 10, 2010, the Agency contacted Troxler Labs to report the device and source serial numbers to them in case the gauge is sent back to them for repair. Troxler stated that they would notify the licensee if the gauge was returned to them. The licensee was reminded that they must notify the Agency when/if the gauge is located. No violations were cited.

File closed.

I - 8739 - Lost Laser - Alcon Research LTD - Fort Worth, Texas

On May 5, 2010, the Agency's incident investigations program received an email from the Agency's laser registration program that stated the registrant had reported the loss of a class 4 laser. The laser registration program stated that they received the initial 24-hour telephone notification on April 23, 2010, and the 30-day report from the registrant on April 30, 2010. An Agency investigator contacted the corporate Laser Safety Officer (LSO) on May 7, 2010 who stated that the last record of the laser showed it was in Fort Worth, but that it was a training device and was most likely shipped to numerous locations, including international ones. The LSO stated that he had determined that the laser was missing when he reviewed records kept by the previous LSO. Corrective actions taken by the registrant include a new checkout procedure to be used when transferring the laser devices between facilities. No violations were cited.

File closed.

I - 8742 - Radioactive Material Found - Austin Cancer Center - Austin, Texas

On April 7, 2010, the Agency was notified by a metal scrap dealer in Seguin that two pieces of scrap unloaded from a rail car were radioactive. An Agency investigation revealed that the contents of the rail car came from Austin and the two pieces were identified as parts of a dismantled medical therapy accelerator. Agency staff identified the radionuclide as cobalt (Co) - 60 and the activity was estimated to be one microcurie. The owner of the accelerator was identified and the Radiation Safety Officer was notified. Arrangements were made to properly dispose of the activated parts. One violation was cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8743- Gauge Shutter Failure - Drilling Specialties Company - Conroe, Texas

On May 19, 2010 the Agency received a phone call from the licensee's Radiation Safety Officer (RSO). The RSO stated that the shutter on a fixed gauge failed to operate at approximately 1700 CDT on May 18, 2010. The gauge houses a 50 millicurie cesium (Cs) - 137 source. The RSO stated that the shutter failed in the open position, the normal operating position for the gauge, and that exposure rates in the area were normal. The gauge is located high above the ground, on the side of a water tank. The licensee stated that the manufacturer was contacted and service on the gauge was scheduled within the next 30 days. On May 27, 2010, the licensee sent a facsimile to the Agency stating that the shutter had been repaired on May 26, 2010. It was determined that the gauge had failed because the gauge shutter was corroded and a seal on the shutter was required to be replaced. The gauge had been placed in service in December 1994. No violations were cited.

File closed.

I - 8744 - Medical Event - University of Texas Health Science Center - San Antonio, Texas

On May 20, 2010 the Agency was notified by the registrant's Radiation Safety Officer (RSO) that a misadministration had occurred. The RSO stated that when the patient's name was called, the wrong patient responded. The RSO stated that the treatment the patient received, while it was intended for a different patient, was very similar to the treatment he was prescribed to receive. The RSO stated that the anatomy aligned properly, and the patient was treated with a fraction of 180 centigrays to the treatment sight. An onsite investigation was conducted by the Agency because this event was one of three misadministrations the registrant experienced within the past four months. The investigation found that this area of the hospital had been under staffed and the existing staff had been working long hours. Because the staff were working long hours, they were more prone to make mistakes. The licensee has hired additional staff since the event, conducted an evaluation of staffing needs, and has a program in place to increase staffing to the level they determined would be adequate. One violation was cited.

File closed.

I - 8745 - Misadministration - University of Texas Health Science Center - San Antonio, Texas

On May 20, 2010 the Agency was notified by the registrant's Radiation Safety Officer (RSO) that a therapy event occurred when the wrong patient was treated. The event occurred at their facility on May 5, 2010. The event involved a patient (Patient-A) who was intended to be treated with radiation. The patient was treated with a different patient's (Patient-B) treatment plan. The Radiation Safety Officer stated that this occurred because the Patient-B was to be treated immediately before Patient-A, but Patient-B's treatment was cancelled. Patient-B's treatment plan had already been brought up on the computer and was not removed. An on-site investigation was conducted by the Agency because this event was one of three misadministrations the registrant experienced within the past four months. The investigation found that this area of the hospital had been under staffed and existing staff had been working long hours. Because the staff were working long hours, they were more prone to make mistakes. The licensee hired additional staff since the event, conducted a staffing evaluation, and has a program in place increase staffing to the level they determined would be adequate. One violation was cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8746 - Gauge Shutter Failure - Diamond Shamrock Refining Company LP - Three Rivers, Texas

On May 21, 2010, the Agency was notified by the licensee that while conducting a routine inspection of a Ronan Engineering model SA1-4F6S nuclear gauge serial number M6134 the shutter failed to close. The gauge contains a cesium (Cs) - 137 source with an original activity of 20 millicuries. The open position is the normal operating position of the gauge. A dose rate survey on the gauge indicated that dose rates in the area were normal. The licensee posted the vessel associated with the gauge indicating that the gauge shutter was not functioning. On June 17, 2010, a manufacturer's field engineer (FE) inspected the gauge and found that the rubber seal around the operating shaft had disintegrated and allowed contaminants to enter the shutter cavity. The FE cleaned the cavity, performed a leak test of the source, and replaced the rubber seal. The FE tested the gauge and the gauge functioned normally. The leak test results indicated the source was not leaking. The licensee is instituting additional preventive maintenance to prevent this type of failure in the future. No violations were cited.

File closed.

I - 8747 - Patient Treatment Error - John Peter Smith Hospital - Fort Worth, Texas.

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8748 - Transportation Violation - Specialty Pharmacy Services Inc - Temple, Texas

On May 25, 2010, the Agency received a courtesy e-mail from the Nuclear Regulatory Commission, Region IV State Agreements Officer stating that a licensee from Texas had shipped a package containing 79 millicuries of technetium (Tc) - 99m, to a Veterans Administration (VA) facility in Temple, Texas. A radiological survey was conducted on the package by the VA facility upon its arrival. The survey results indicated that the removable contamination on the outside of the package had exceeded the limit. The licensee stated that they conducted one on one interviews with the individuals involved in the event. Based on its investigation, the licensee determined that the contamination was on the package label, and it was about the size of a finger print. The licensee held a meeting with all employees to review the event, shipping protocols, and required each individual who shipped radioactive material show proficiency in performing a shipment survey for radioactive contamination. The licensee was cited for the violation.

File closed.

Incidents Opened Second Quarter 2010

I - 8749 - Possible Abandoned Radioactive Material - Site Concrete Incorporated - Grand Prairie, Texas

On May 25, 2010, an Agency inspector informed the central office that she had gone to a licensee's facility to perform a routine inspection on May 21, 2010, and found the door locked. The inspector left a note on the door requesting that the licensee contact her to set up a time for the inspection. The inspector returned to the address on May 25, 2010, and found the door was locked, but saw people inside and knocked on the door. She asked for the licensee's Radiation Safety Officer (RSO) and was told that the company she was looking for was no longer at that location. A new company had purchased the facilities in January 2010 and no one could provide any additional contact information for the licensee. A search of the licensee's file revealed a letter from the Agency's licensing program to the licensee, dated June 6, 2009, which outlined the steps necessary to terminate the license. No additional information on the disposition of the gauges was contained in the license file. The licensee had been in possession of two Troxler moisture/density gauges, 3400 model series, each containing 40 millicuries of americium (Am) - 241 and 8 millicuries of cesium (Cs) - 137. Three service providers were contacted to see if they had any records regarding the licensee's gauges. One of the companies had serviced the gauges, but they did not have any information on them after June 2006. Contact information for a previous RSO for the licensee was located and the RSO was contacted by the Agency. The RSO stated that he had left the company in May 2007. He stated that just before he left the company, the new RSO stated that the licensee was going to sell the gauges and terminate their license. The previous RSO could not provide any additional information about the gauges or contact information for any of the individuals he had worked with while serving as the RSO. An e-mail was sent to all Agency radioactive materials inspectors notifying them that the gauges were missing and requesting that they notify the Incident Investigation Program staff if they discovered any of the gauges during inspections. No violations were cited.

File closed.

I - 8750 - Abandoned Radioactive Material - DFW Group Inc. - Arlington, Texas

On May 27, 2010, an Agency inspector attempted to conduct an inspection of a licensee who was licensed for 15 millicuries of cobalt (Co) - 57. When she arrived, the inspector found that the licensee no longer occupied the licensed location. The individuals who did occupy the location were unaware that radioactive material was being stored there. The inspector performed an ambient radiation survey of the facility and did not find any readings above background. On June 1, 2010, the inspector received a voice mail providing a new phone number for the licensee's Radiation Safety Officer (RSO). The RSO was contacted and provided a phone number of a manager for the licensee. The manager was contacted and stated that the device was being stored in a back room of the facility at the licensed location and that they would be able to show it to the inspector. On June 9, 2010, the Agency inspector returned to the licensed location and performed an inspection. The equipment was found to be properly secured and protected. A violation was cited for lack of a documented radiation protection program.

File closed.

Incidents Opened Second Quarter 2010

I - 8751 - Medical Event - Oncology Hematology Consultants, PA - Fort Worth, Texas.

On June 8, 2010, the licensee's Radiation Safety Officer (RSO) notified the Agency that five patients received under-doses between 30-50% over a six month period from September 2009 to March 2010. The device was a high dose rate afterloader brachytherapy unit which contained up to a 15 curie source of iridium (Ir) -192. An authorized user (AU) evaluated the treatments delivered and determined that doses delivered would have no adverse effects on the patients. The errors were discovered when a new group of medical physicists were hired and the licensed medical physicist (LMP) from the new group chose to compare his treatment plan of a cylinder case to one that had been done by an LMP in the previous group. It was then discovered that the treatment planning system had been set up to calculate the time in seconds for a single fraction instead of three fractions which constituted the prescribed dose. Four of the cases had a prescribed dose of 1400 centigray (cGy) and one was 2100 cGy. In each case, the patient received only one third of the prescribed dose. No additional doses to these patients were scheduled because, an AU determined that there was no medical benefit to be derived. To prevent recurrence, the licensee has included a second check by another physicist for each plan and increased training and oversight of new staff. The licensee was cited for failure to provide a written directive for one of the treatments.

File closed.

I - 8752 - Retrieval of Radioactive Material - Acuren Inspection Inc - Beaumont, Texas

On June 9, 2010, the Agency was notified by the Nuclear Regulatory Commission that the licensee had experienced a failure to retract a radiography source. The event occurred on March 11, 2010, in Beaumont, Texas. A radiography crew from Sulphur, Louisiana was working under reciprocity with a radiography camera containing a 96 curie, iridium (Ir) – 192 source. During the crew's sixth exposure, the source became stuck out of the camera in the unshielded position. The two-person radiography crew then extended their barricade to about 350 feet from the source. The crew notified their site representative, as well as the Site Radiation Safety Officer (SRSO) of the Sulphur, Louisiana office. While one of the radiographers verified the 2 millirem per hour (mrem/hr) boundary with a survey meter, the other stood behind a large pump at the plant and repeatedly tried to crank the source back into the camera. After approximately seven minutes, the radiographer was able to return the source to the camera. The radiography crew conducted a survey and verified that the source had been returned to the shielded position. According to the report submitted by the Louisiana SRSO, no members of the public or workers were overexposed. Later that same day, the SRSO met with the radiographers. The SRSO subsequently sent the radiographers' TLD badges to be read on Friday March 12, 2010. The results were returned on Monday, March 15, 2010. According to the badge reports, it was determined that one of the radiographers received 55 mrem and the other 210 mrem since the beginning of the monitoring period (March 1, 2010). On June 15, 2010, Agency staff reviewed the event. From a health and safety perspective, the licensee responded appropriately. No violations were cited.

File closed

Incidents Opened Second Quarter 2010

I - 8753 - Gauge Shutter Failure - NRG Texas Power LLC - Jewett, TX

On June 11, 2010, the Agency was notified by the licensee that the shutters on six gauges failed in the open position. Three of the gauges were manufactured by Berthold and each contained 30 millicuries (decay corrected to approximately 17 millicuries) of cesium (Cs) – 137. The other three gauges were manufactured by Ohmart/VEGA and each contained 150 millicuries (decay corrected to approximately 86 millicuries) of Cs – 137. The licensee stated that dose rates taken in the area were normal, since the shutters failed in their normal operating positions. The licensee believes the Ohmart gauges failed because they were located in an area that was exposed to an unspecified amount of limestone powder. The licensee reported that the limestone powder concentrated near the shutter mechanism, and combined with moisture to form cementitious material that subsequently caused the gauge to fail. The licensee stated that it appeared that the Berthold shutters stuck because a “corrosive liquid seeped into the source shield along the metal shaft that operates the on/off mechanism.” No violations were cited.

File closed.

I - 8754 - Lost Equipment Containing Radioactive Material - The Shaw Group Inc. - Hewitt, Texas

On June 15, 2010, the Agency received a letter from a general licensee stating that, while conducting an inventory of tritium (H-3) exit signs, they found that two signs containing 10 curies each of H-3 were missing from a facility in Hewitt, Texas. A search of the facility was conducted, but the signs were not found. Interviews with individuals working at the facility were held, but did not provide any information on the location or disposition of the signs. The company is removing all exit signs containing tritium and returning them to the manufacturer to prevent a recurrence of the event. No violations were cited.

File closed.

I - 8755 - Transportation Event - Petrochem Inspection Services Inc. - Corpus Christi, Texas

On June 14, 2010, the Agency was notified by the licensee that one of its trucks carrying a radiography camera containing 13.7 curies of iridium (Ir) - 192 was involved in a traffic accident. The radiography truck struck a large item lying in the road, catapulted into the air, and burst into flames when it landed back on the highway. The two radiographers were able to evacuate from the truck without injury. The radiographers set up a barrier to limit access to the area until the integrity of the camera could be determined. The Texas Department of Public Safety and the local fire department responded to the event. When the fire was extinguished, the camera was found still locked inside its transportation container. A survey of the camera indicated that dose rates from the camera were normal. The radiography camera was returned to the licensee's office and sent to the manufacturer for inspection. The manufacturer's inspection confirmed that the camera was not damaged in the fire and the camera was returned to service. No violations were cited.

File closed.

Incidents Opened Second Quarter 2010

I - 8756 - Sources Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On June 23, 2010, the licensee notified the Agency that a 1.5 curie cesium (Cs)-137 and a 15 curie americium (Am) – 241/beryllium source had been abandoned downhole at a depth of 13,200 feet. The tool containing the sources became stuck on June 7, 2010, and attempts to retrieve the sources were unsuccessful. The licensee reported there was 920 feet of drill pipe above the abandoned sources with 772 feet of red-dyed cement on top of the drill pipe. The sources were abandoned in accordance with Railroad Commission regulations. A plaque has been mounted 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 - 8757 - Possible Abandoned Radioactive Material - Concept Phoenix Diagnostics LP - Katy, Texas

On June 25, 2010, an Agency inspector reported that a licensee had apparently closed its facility without informing the Agency as required. The licensee was licensed to possess any radioactive material with a half-life less than 120 days, except positron emitters and any level of activity as needed for its studies. The inspector tried calling the Radiation Safety Officer (RSO) several times but was forwarded to a voicemail each time. The inspector went to the licensee's site and found it closed and everything inside appeared to have been removed. A review of Agency records revealed the RSO's name associated with a second licensee. The inspector contacted the RSO and determined that the original licensee no longer possessed radioactive material. The inspector informed the RSO that the license should be terminated and gave him the appropriate contact information. No violations were cited.

File closed.

I - 8758 - Abandoned Radioactive Material - Valley Diagnostic Clinic - Harlingen, Texas

On June 30, 2010 the Agency's central office was notified by an Agency inspector that, while performing an inspection at a facility, she was informed that the licensee had gone out of business. The licensee had possessed a cesium (Cs) - 137 check source. The Agency was able to obtain documents showing that the source had been properly transferred to a current license holder. The licensee was advised to terminate their license with the Agency. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8652 - Abandoned Source - Healthmont of Texas LLC - San Benito, Texas

On July 30, 2009, an Agency inspector went to the licensee's address and found it closed. The licensee had listed a 110 microcurie cesium (Cs) -137 source on its last source inventory sheet. The inspector was unable to gain access to the facility. An investigation by the Agency's incident investigation program revealed that the hospital had closed in October 2008 and had been sold by the United States Internal Revenue Service to a group of investors in May 2009. The City of San Benito provided the Agency with contact information for the new owners. Attempts to contact the new owners were unsuccessful until May 2010. A representative of the owners met with an Agency inspector at the hospital on May 24, 2010. The source was impounded by the inspector and taken to the Agency office in Corpus Christi, Texas. No violations were cited.

File closed.

I - 8668 - Damaged Device Containing Radioactive Material - BetaBatt - Alvin, Texas

On September 1, 2009, the Agency was notified by the State of Florida reporting that during a routine inspection of a facility in Florida, tritium (Hydrogen-3) contamination was found on and outside of a container, which contained prototypes of tritium batteries. The battery was sent to Florida from a facility licensed in the State of Texas. The batteries are prototypes and each contained 40 curies of tritium in a beta carotene oil. The Texas licensee went to Florida and personally transported the batteries back to his facility. The licensee believes that the contamination may have occurred in Florida when a container holding one of the batteries was opened to investigate an internal failure. An Agency inspector went to the facility in Alvin, Texas, to perform a radiation survey at the facility. Tritium contamination was found throughout the facility exceeding the removable contamination limit for H-3. The licensee conducted decontamination operations at the facility. On November 17, 2009, the licensee reported that the initial decontamination was completed. The licensee continued to decontaminate the area, but could not achieve unconditional release limits. The licensee has decided to leave the area as a controlled access area. The licensee believes the leaks in the battery occurred due to a failure of the seal where the electrical leads penetrate it. The licensee is working on a new design for the battery to prevent any additional problems with H-3 leakage. The licensee was cited for two related violations.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8696 - Lost Source of Radioactive Material - Lantheus - North Billerica, Massachusetts

On January 5, 2010, the Agency received a phone call from the United States Department of Transportation (USDOT) informing them that on December 27, 2009, 38 molybdenum generators containing various activities of molybdenum (Mo) – 99 were shipped from a company in Massachusetts to the Dallas/Fort Worth Airport. Some of the generators were to be delivered to various surrounding states and 24 were intended for delivery to licensees in the State of Texas. One of the devices containing four curies of Mo-99 for a licensee in Abilene, Texas, was missing. USDOT and the manufacturer contacted all companies who had received generators contained in this shipment, but none of them indicated that they had received the missing generator. The air cargo and the ground carrier stated that a search of all transportation vehicles used to transport the devices was conducted, but the device was not located. The shipping company in Massachusetts and the transportation company in Texas conducted additional searches for the device, but the device was not located. Discrepancies in various documents provided by all parties made it impossible to determine where or when the device was lost. The manufacturer stated that they are screening all returned device serial numbers and will notify this agency if the device is returned to them. No violations were cited.

File closed.

I - 8706 - Source Disconnect - Desert Industrial X-Ray - Abilene, Texas

On January 26, 2010, the Agency was notified by the licensee that a source disconnect had occurred on January 22, 2010. A radiographer was cranking a 26 curie iridium (Ir) -192 source out of a Spec 150 radiography camera when he began having difficulty driving the source. He decided to retract the source into the camera when the source pig tail disconnected from the drive cable. The source was then driven into the collimator at the end of the guide tube. The radiographer contacted the licensee's Radiation Safety Officer and informed him of the event. An individual authorized to perform source retrieval was sent to the location. The source was retracted into the camera, and the camera was returned to the licensee's facility. The licensee determined that the drive cable had broken at the connector attached to the end of the cable. The entire source crank mechanism was returned to the manufacturer for inspection. The manufacturer found that the drive cable was rusted and brittle near the end where the source connects. The manufacturer stated the probable cause was inadequate maintenance of the cable. The licensee provided additional training to their radiographers on proper inspection procedures for the device. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8709 - Radiography Source Disconnect - Southern Services Inc. - Lake Jackson, Texas

On February 9, 2010, the Agency was notified by the licensee that while performing radiography a 22 curie iridium (Ir) - 192 source could not be retracted into the camera. The radiographer noted that when he returned the source to the camera, the auto-locking mechanism failed to activate. The radiographer then cranked the source back out and tried again to lock the source in the camera. The locking mechanism failed to lock the source in place. The source drive cable was left in the position where the source should be shielded by the collimator. The radiographer performed a dose rate survey on the guide tube. He found the dose rates near the end of the guide tube were elevated and he contacted the licensee's Radiation Safety Officer. An individual authorized to perform source retrieval went to the location and retrieved the source. No overexposures were reported. An inspection of the source pig tail and drive cable found that the ball on the drive cable side of the connection had broken off from the drive cable. The cable was returned to the manufacturer for inspection. The manufacturer stated that the connector showed signs of wear and some bending. No violations were cited.

File closed.

I - 8714 - Overexposure - Blazer Inspection - Texas City, Texas

On February 25, 2010, the Agency received a report from the licensee stating one of their radiographers had received 5,563 millirem for the year 2009 exceeding the annual limit for deep dose equivalent. The licensee's Radiation Safety Officer (RSO) stated that he was aware of how much dose the individual had prior to the last exposure period and cautioned him to closely watch his exposure to prevent the overexposure. The licensee's investigation into the event determined that the radiographer had been performing radiography on small diameter pipes with a high activity source, and was not able to reduce his time near the crank out cables due to the short exposure times. The dose recorded on the individual's daily radiation reports indicated that the individual's exposure was 4,192 millirem for the year. No explanation for the discrepancy between the two dose records could be identified. The licensee stated that they reviewed the event with all of their workers in a safety meeting, and provided training on the company's policy for controlling personnel dosimetry. The licensee was cited for the overexposure.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8715 - Source Abandonment - Warrington Inc. - Pflugerville, Texas

On February 25, 2010, the Agency received a phone call from a local realtor stating that one of their commercial tenants who used radioactive material in their business had abandoned the rented facility. After coordinating with the licensing unit, it was determined that the licensee properly disposed of a cesium (Cs) - 137 source, however, they were also licensed for cobalt (Co) - 57 sources. On February 25, 2010 two Agency inspectors performed an investigation at the licensed facility. Two button sources were found, one was a carbon (C) - 14 source and the other was a Cs - 137 source. The quantities of the sources were exempt from licensing requirements. The sources were taken back to the Agency. There were no Co-57 sources found. Several contamination swipes were taken throughout the facility. The wipes were counted on March 4, 2010 by the Agency and all samples were within applicable limits. The three swipes with the highest counts were sent to the laboratory on March 5, 2010. The laboratory results were indicated that no regulatory limits were exceeded. No violations were cited.

File closed.

I - 8716 - Source Leak Test Exceeds Limit - Methodist Willowbrook Hospital - Houston, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8719 - Wrong Patient Examined - St. Paul University Hospital - Dallas, Texas

On March 11, 2010, the Agency was notified by the registrant that on March 10, 2010, the wrong patient received computerized tomography (CT) scan without contrast. The incorrect patient was scanned because they had the same last name as the patient intended to be examined. The wrong patient responded when the last name was called. The patient received approximately 1,720 millirem from the CT scan and was notified of the error. To prevent recurrence of this event, the Imaging Department of the registrant conducted a review of department policy for patient identification and provided remedial training for their personnel. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8720 - Overexposure - Valley Positron, LLC - McAllen, Texas

On March 12, 2010, the Agency's incident investigations program received a phone call from an Agency inspector who stated that during a recent inspection she found one of the licensee's employee badges had received a dose to 59,130 millirem (mrem) to his left hand during the one month period from July 15 - August 14, 2009. This brought the employee's annual dose to 62,800 mrem, exceeding the limit of 50,000 mrem. The inspector stated that when she asked the licensee's Radiation Safety Officer (RSO) why the licensee did not report it, the RSO stated that the licensee was unaware of the reporting requirement. The Agency contacted the individual involved who stated that when they make the PET doses, they usually have a mechanism that handles the doses, but it was broken during the period of the overexposure. The individual stated that they had repeatedly asked the manufacturer to send the part to repair the mechanism, but it was on back-order and so he handled the doses himself. The individual stated that when he learned his dose was high, he immediately quit working with radiation for the remainder of the year. The Agency received the badge reports for the entire year of 2009 for the individual. After reviewing the reports, it was determined that the individual continued to receive dose after he was made aware of his overexposure. The licensee submitted a written report to the Agency which verified the overexposed individual continued to receive dose even though the regulatory limit had been exceeded. The licensee was cited for the violation.

File closed.

I - 8721 - Gauge Shutter Failure - Totak Petrochemicals USA - Deer Park, Texas

On March 12, 2010, the Agency received a request to perform work in the State of Texas under reciprocity from a nuclear gauge manufacturer. The request was to repair two nuclear gauges with stuck shutters. The gauges are Ronan Engineering model SA1-C10 each containing 200 millicuries each of cesium (Cs) -137. The Agency contacted the Radiation Safety Officer (RSO) for the licensee for more information. The RSO stated that the two gauges had been removed from storage and installed on a piece of equipment for use. A service company was testing the equipment prior to placing it in service and found that the gauge shutters would not function. The licensee then contacted the gauge manufacturer to repair the gauges. The RSO stated that he was not aware of the reporting requirement and would submit a written report to the Agency. On March 17, 2010, the gauge shutter was repaired. It was determined that the shutter seal lubricant had dried up while the gauge was in storage. The licensee stated that they will notify the Agency within the required time period in the future. The licensee was cited for failure to report the event within the required time period.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8723 - Sources Abandoned Down Hole - Schlumberger Inc. - Zapata County, Texas

On March 15, 2010, the Agency was notified by the licensee that they had abandoned a 16 curie americium (Am) - 241/beryllium (Be) source at 14,547 feet, and a 1.7 curie cesium (Cs) – 137 at 14,574 feet. A 100 foot red dye cement plug was placed above the source tool and a whip stock placed above the cement plug as a deflection device. The radioactive sources were abandoned according to Railroad Commission regulations. A plaque will be mounted 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 - 8725 - Gauge Shutter Failure - Structural Metals, Inc. - Seguin, Texas

On March 19, 2010, the Agency was contacted by the licensee's Radiation Safety Officer (RSO). The RSO stated that the licensee had experienced a gauge shutter failure. The Agency contacted the RSO for the licensee who stated that the source had failed in the open position, which is the normal operating position. The source is a 2.51 millicurie cobalt (Co) – 60 source, and the RSO stated that the licensee would not be using the device until it was fixed. Dose rates taken in the area were normal. The licensee stated that molten steel had spilled onto the gauge preventing the shutter from operating properly. The licensee stated that it was going to have the source removed and put into a functioning device by a licensed vendor. It was requested that the licensee update the Agency when the transfer had been complete. No violations were cited.

File closed.

I - 8726 - Well Logging Tool Ejected from Well - Weatherford - Howard County, Texas

On March 19, 2010, the Agency was notified by the licensee that a blow-out had occurred in a well in Howard County, Texas. The well was being logged using a tool containing a 1.5 curie cesium (Cs) - 137 source and a 5 curie americium (Am) – 241/beryllium (Be) source. The well operator noted that the flow from the well was returning to the surface and ordered the well logging tool removed from the well. As the tool reached 3,500 feet, the withdrawal of the tool was stopped because the flow out of the well had increased to a point where it was forcing the tool and wire line out of the well. The crew was ordered to evacuate the drilling rig due to the hazards associated with the high down-hole pressure. A short time later, the tool and wire line were ejected from the well bore. The flow preventers were then operated and flow from the well was controlled. A logging company manager conducted radiation surveys and found the tool with the sources still in place near the logging truck. The sources were removed from the tool and placed in their shipping casks. Neither source appeared to be damaged. The sources were returned to the licensee's facility and leak tested. The leak test results for both sources were satisfactory. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8727 - Radioactive Material Found at a Scrap Yard - Texas Port Recycling - Conroe, Texas

On March 30, 2010, the Agency was contacted by a scrap yard who reported that a container of scrap metal alarmed their radiation monitors. The scrap yard inspected the material and found the alarm was caused by a gauge panel containing several gauges. The Agency went to the scrap yard on April 5, 2010. The gauges were found to contain radium (Ra) - 226. The gauge panel was impounded by the Agency and returned to Austin for storage until disposal. The Agency contacted the United States Army Rad Waste Operations Division for assistance in disposing of the gauges. They agreed to receive and dispose of the gauges. No violations were cited.

File closed.

I - 8730 - Theft of Radioactive Material - ProTechnics - Alice, Texas

On March 19, 2010, at 2350 hours, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that 120 millicuries of iridium (Ir) – 192 was stolen from one of their trucks parked at a store parking lot in Alice, Texas at about 2320 hours. The iridium was packed in six, 20 milliliter vials each containing 20 millicuries (15 grams) of Ir-192 in the form of sand. Each vial was placed into a labeled lead pig and each pig was then shrink-wrapped. The six pigs were then placed into a zip lock bag. The zip lock bag was placed into an unlocked tool box in the back of the pick up truck. On March 24, 2010 it was determined that two individuals were responsible for the theft of the materials, and the radioactive materials were recovered at the private residence of one of the suspects. Dose estimates for the members of the public were below applicable limits. An unannounced investigation was performed at the licensee's Alice, Texas location on March 25, 2010, and an unannounced routine inspection was performed on March 26, 2010. Agency investigations cite seven violations for the incident and four were cited for the routine inspection.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2010

I - 8740 - Use of Veterinary X-Ray Equipment for Humans - Texas A & M University - College Station, Texas

On January 25, 2010, the Agency was contacted by the licensee's Radiation Safety Officer (RSO) and notified that the RSO was investigating an event that involved a student who x-rayed herself after being stepped on by a horse. On May 5, 2010, the RSO provided a written report of the event. The document stated that two, fourth year veterinary students were working with a horse when the horse stepped on one of the students. The student was in great pain and decided to x-ray herself. The student went to the small animal x-ray device and x-rayed herself. When asked about the event, the student stated that she was not aware this was a violation the registrant's permit. On February 16, 2010, in response to the event, a professor in the radiology department sent a letter to all fourth year students informing them that this activity is not allowed and that it could result in disciplinary actions against the student and/or the university. The student was counseled by her supervisor and received additional training. The registrant was cited for the violation.

File closed.

I - 8741 - Use of Veterinary X-Ray Equipment for Humans - Texas A & M University - College Station, Texas

On May 5, 2010, the Agency received a letter from the registrant stating that on February 24, 2010, a faculty member's wife had injured herself at home. The faculty member took an x-ray of her using an x-ray device registered for veterinary practice. The faculty member was interviewed by the Hospital Administrator. A letter was sent out by the Dean of Veterinary Medicine to every individual in the College of Veterinary Medicine stating that "there can be absolutely no human use of their x-ray equipment," and that to do so was a violation of both university policy and Agency regulations. The registrant was cited for the violation.

File closed.

Complaints Opened Second Quarter 2010

C - 2250 - Inadequate Credentialing - Texas Regional Asthma & Allergy - Southlake, Texas

On March 11, 2010, the Agency received a complaint alleging that a registrant was using non-credentialed technicians to perform computed tomography scans. An Agency inspector performed an onsite inspection on May 20, 2010. The inspection did not find any instances where scans were performed by individuals not holding current credentials. The complaint could not be substantiated. An unrelated violation was cited.

File closed.

C - 2251 - Uncredentialed Technicians - Medical Edge Healthcare Group - Dallas, Texas

On April 15, 2010, the Agency received a complaint alleging that the registrant was using uncredentialed individuals to perform x-rays. An Agency inspector performed an onsite inspection on April 22, 2010. The inspector found four individuals working at the facility who held appropriate credentials to perform x-rays. The inspector also found that only credentialed individuals had initialed patient logs as performing the x-rays. The complaint was not substantiated. No violations were cited.

File closed.

C - 2252 - Unregistered Dental Equipment - Fife, Russell, DDS - El Paso, Texas

On April 26, 2010, the Agency's incident investigation program received information for investigation from the Agency's registration program. On October 19, 2009, the registration program had asked the registrant to amend his certificate of registration to reflect the addition of a new location to his license. The registration program had received a notice from a service provider of dental equipment installation under the registrant's name at a facility in El Paso. The equipment had been installed under the registrant's name on September 23, 2009. The Agency received a letter from the registrant stating that the equipment was ordered without his authorization and he did not have a facility in El Paso. The Agency's investigation confirmed the registrant's claims. On June 30, 2010, the complaint was referred to the Texas Dental Board as well as the Agency's drugs and medical devices group. No violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2253 - Burns from Laser - Laser Solutions - Plano, Texas

On April 28, 2010, the Agency received a complaint from an individual claiming that she received burns as a result of laser hair removal treatment she had received at a facility in Plano, Texas in February 2010. The complainant alleged to have made multiple attempts to see the doctor of the facility, but the facility representative would not respond to her requests. The complainant stated that she didn't know who the physician on staff was, but she was told that a doctor rented space in the facility. An Agency investigator asked the complainant if she ever went to another doctor to have her burns diagnosed and she stated that she had not. On May 19, 2010, an Agency inspector performed an unannounced investigation. The inspector was unable to substantiate the allegation. One unrelated violation was cited.

File closed.

C - 2254 - Providing X-Ray Services Without Registration - Calvary Services Inc. - Fort Worth, Texas

On May 5, 2010, the Agency received a complaint from an anonymous caller stating that a company providing x-ray equipment services was not registered to do so. The complainant stated that the unregistered company had provided services to a hospital in Amarillo, Texas. An inspection conducted by the Agency at that facility determined that the company the allegation was made against had not performed any services on any radiation generating devices at that location. An Agency inspector met with the owner of the service company on August 16, 2010. The owner provided service invoices for the previous three months. The inspector obtained the names of five facilities where he had provided services. The facilities using x-ray equipment were contacted by phone. In addition to the phone calls, the registration files for these registrants were reviewed. The results of both inquiries and file reviews indicated that services provided to the registrants was completed by an entity registered to do so by this Agency. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2255 - Potential Exposure to Individual - DSHS Central Campus - Austin, Texas

On May 5, 2010, the Agency received a complaint from an individual stating that he was concerned that he was being exposed to radiation from radioactive material stored in his work area. The Agency conducted an investigation. The room had historically been the Agency's source storage location, but it was closed out over 10 years earlier. A review of the close-out documentation confirmed that all of the radioactive material had been properly removed and surveys showed no residual contamination. On August 5, 2010, the Agency placed two dose measuring devices at the facility to monitor the dose in the area for a one month period. The report from this monitoring was that the levels were indistinguishable from background. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2256 - Unregistered Laser - Ink Pit Tattoo - Fort Worth, Texas

On May 10, 2010, the Agency received a complaint alleging that a facility was performing tattoo removal with the use of a laser without being registered with the Agency. Registration with the Agency for use of the laser on humans could not be confirmed. On June 6, 2010, two Agency investigators performed an unannounced investigation at the facility. The complaint was substantiated. Several violations were cited.

File Closed.

C - 2257 - Tattoo Removal without Physician Supervision - Fade Fast Laser - Dallas, Texas

On May 10, 2010, the Agency's incident investigation program received a complaint that was forwarded from the Agency's drugs and medical devices group. The complaint alleged that the registrant was performing tattoo removal without the supervision of a physician. On June 2, 2010, the Agency conducted an unannounced investigation. During the investigation, the registrant showed sufficient proof that a physician was supervising the use of the registrant's Class IV laser on humans. The complaint was not substantiated. No violations were cited.

File closed.

C - 2258 - Unregistered Laser - Cat Tattoo Studio - Addison, Texas

On May 10, 2010, the Agency's incident investigation program received a complaint, forwarded from the Agency's drugs and medical devices group, alleging that a facility was performing tattoo removal with the use of a laser without being registered with the Agency. On June 2, 2010, an investigation was performed at the facility. The investigation determined that the facility had used a Class IV laser on humans for approximately two years without submitting an application to the Agency for the registration. The complaint was substantiated. Two violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2259 Various Regulation Violations - Advanced Pain Care - Austin, Texas

On May 10, 2010, the Agency received a written complaint stating that the registrant was operating unsafe equipment, had no radiation monitoring equipment for workers or the public, and personnel operating the C-Arm device were not qualified to do so. An onsite inspection was conducted by the Agency on May 18, 2010. The inspector found that the C-Arm device had been transferred to a location in Round Rock, Texas, on May 15, 2010. A review of the registrant's records indicated that the individual operating the C-Arm device was the individual indicated in the complaint. Prior to performing the inspection, the inspector had confirmed with the Medical Radiologic Technician Board that this individual's certificate had expired in April of 2009. The operator had been transferred to the Round Rock location to operate the device and was not available for an interview. The Round Rock office was contacted for a copy of the individual's credentials. The office faxed a copy of his certificate to the inspection site. The certificate indicated that it expired in April of 2011. The registrant could not explain the discrepancy in dates. A tour of the facility found additional x-ray devices not listed on the registration certificate. The registrant stated that when they moved into the facility, the devices were inspected and were not operational. The registrant could not provide documentation showing all the devices were not operational. A review of dosimetry records found that one individual was not properly monitored for exposure in the year 2009. On July 20, 2010, an Agency inspector went to the Round Rock location to complete the investigation. The inspector found that the device had not been operated at that location. The registrant was cited for eight violations.

File closed.

C - 2260 - Inadequate Shielding - Medical Specialist Group PA - Corpus Christi, Texas

On May 20, 2010, the Agency received a phone call from an individual stating that the registrant had moved its x-ray device from another building to the office next to his. The complainant was concerned that the walls did not have any lead in them and that he may be exposed to radiation that could harm him. An agency inspector performed an unannounced investigation on June 11, 2010. The inspection revealed the registrant had used uncredentialed individuals to operate x-ray devices, failed to perform radiation surveys in unrestricted areas, failed to monitor an employee for exposure to radiation, failed to notify the Agency of the new address, and several other violations. The complaint was substantiated. Seven violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2261 - Laser Registration - Haven Spa - Weatherford, Texas

On May 18, 2010, the Agency's incident investigations program received information from the the Agency's drugs and medical devices group that indicated there was an unregistered laser at a facility in Weatherford, Texas. On June 3, 2010, the Agency conducted an unannounced onsite investigation. It was determined that the facility was unaware of the requirement to be registered with the Agency. The facility immediately initiated the registration process after the investigation was completed. The complaint was substantiated. Two violations were cited.

File closed.

C - 2262 - Regulatory Violations - 1-800-Go-Dentist - Corpus Christ, Texas

On June 1, 2010, the Agency received a complaint forwarded from the United States Department of Labor. The complaint alleged that a Texas registrant did not provide any protection for exposure to workers while taking x-rays, folded and stored patient vests improperly, and required workers to hold an x-ray head in place during operation because it would not stay positions as designed. A review of the certificate of registration indicated that the dentist listed on the permit is not the same person currently listed at the address. The Agency called the facility and found that the dentist listed on the registration had died about two years earlier. An Agency inspector performed an onsite inspection on June 9, 2010. The inspector found that an x-ray device exceeded the entrance exposure limit, a technique chart was not available for the operators, the tube housing on an x-ray device was not stable, and a tube housing assembly support was being hand-held in place by employees during exposures. The complaint was substantiated. The registrant was cited for six violations.

File closed.

C - 2263 -Regulatory Violations - Benco Dental - Houston, Texas

On June 7, 2010, the Agency received a complaint alleging that technicians working for the registrant intentionally exposed themselves to x-rays while servicing dental equipment in San Antonio, Texas. The complainant was contacted by the Agency on June 19, 2010, to obtain additional information. The complainant provided the name of the registered facility at which the alleged incident occurred and it was also contacted on June 19, 2010. Personnel at the facility stated that they had observed the same behavior as the complainant. On July 7, 2010, the Agency conducted an unannounced onsite investigation at the facility where the complainant alleged the incident occurred. The personnel at the facility could not produce any evidence to support that the incident occurred. The registrant's technician was contacted on July 30, 2010, and denied the allegation. The Agency was unable to find any evidence to support the allegation. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2264 - Regulatory Violation - Austin Radiological Association - Austin, Texas

On June 7, 2010, the Agency was contacted by an individual concerned that a registrant could not provide her with an estimate of the radiation exposure she would receive from a computed tomography scan of her ankle. She was informed that our regulations do not require a registrant to provide information to the patient regarding how much radiation they will receive from these studies; therefore, it does not constitute a violation of our rules. A website was provided to her that could provide an estimate of exposure from various types of medical studies. The complaint was not substantiated. No violations were noted.

File closed.

C - 2266 - Non Certified Technologists - Arbor Green Family Medicine Clinic - Dallas, Texas

On June 17, 2010, the Agency received an anonymous complaint alleging that the registrant is allowing people without proper credentials to operate the radiographic equipment. On July 8, 2010, an Agency inspector performed an unannounced investigation. The inspector found that only one technologist was operating the device and the technologist was properly credentialed with the Agency. The registrant's Radiation Safety Officer stated that there were two new employees that were training to become technologists, but they merely practiced positioning and did not operate the x-ray machine. The inspector performed a routine inspection along with the complaint investigation, and subsequently noted four areas of non-compliance. The complaint was not substantiated. Four violations were cited.

File closed.

C - 2267 - Laser used without Physician Supervision - Radiance Medspa - Sugarland, Texas

On June 17, 2010, the Agency received an anonymous complaint. The complainant stated that the registrant was operating a Fraxel laser without physician supervision. On July 14, 2010, an Agency inspector performed an unannounced investigation. The inspector found that there were no Class IIIb and/or Class IV lasers on the property. The facility manager stated that the laser safety officer had initiated discussions of renting a Fraxel laser, but nothing had come of the discussions. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2010

C - 2268 - Uncredentialed Technologists - Ulupi A. Choksi, MD - Kingwood, Texas

On July 5, 2010, the Agency received a complaint that a technologist was performing bone density exams without the proper credentials. On September 30, 2010, an Agency inspector performed an announced investigation. The inspector asked the registrant about the technologist allegedly performing bone densitometry exams. The registrant stated that the technologist had performed exams from February 2007 to July 2010. The registrant stated that they discovered the technologist was not credentialed and the technologist's employment was terminated on July 7, 2010. The complaint was substantiated. One violation was cited.

File closed.

C - 2273 - Inadequate Credentialing - Triumph Hospital of North Houston - Houston, Texas.

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2010

C - 2203 - Failure To Provide Records - 12 Oaks Medical - Houston, Texas

On July 24, 2009, the Agency receive a complaint alleging that the registrant had ceased business and that a patient who had requested a copy of her mammography records was unable to obtain them. During the investigation, the Agency contacted seven individuals who were given as possible sources of information for the location of the records. None of the individuals could provide any information as to the location of the records. The complainant did not respond to an Agency request for additional information. Since no further information on the location of the file could be obtained, the investigation was terminated. No violations were cited.

File closed.

C - 2222 - Allegation of Inadequate Training - University of Texas Health Science Center (UTHSCH), Houston, Texas

On October 23, 2009, the Agency received a complaint concerning inadequate training for post graduate physicians. The letter stated that the duration of the training course was insufficient to meet regulatory requirements for licensure of Authorized Physician Users (APU). Specifically, the complainant indicated that the training was only 24 hours instead of the required 80 hours. The Agency's investigation determined that the training provided did equal 80 hours of instruction. The complainant also alleged the Agency performed an inadequate review of physician training. The Agency reviewed documents from the licensee and confirmed adequate physician training. The complaint was not substantiated. No violations were cited.

File closed.

C - 2243 - Groundwater Contamination - Various Companies - Sonora, Texas

On February 24, 2010, the Agency received a complaint referred to them by the Nuclear Regulatory Commission from an individual who was concerned about exposure to radioactive contamination during his work at oil and gas wells. He expressed a concern over contamination of his well water by fracturing operations of gas wells on his property. On March 31, 2010, an Agency inspector performed an on-site investigation. The inspector took samples from three different water sources on the complainant's property. A contamination survey was conducted at the company where he had worked cleaning frac valves. The water samples did not contain any activity other than trace amounts of Naturally Occurring Radioactive Materials. The contamination survey indicated that contamination levels were at or just above background. The complainant was informed of the results. No violations were cited. The complaint was not substantiated.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2010

C - 2247 - Radiographer Rule Violations - Marco Inspection Services, LLC - Marshall, Texas

On March 11, 2010 the Agency received an allegation that a radiographer was performing radiography by himself, without a survey meter, and without properly operating dosimetry. The complaint also stated that on one occasion the radiographer did not secure the camera during transit and on another occasion did not determine the proper boundaries. The complaint stated that the radiographer worked mainly out of the Louisiana office but that on at least one occasion was observed working in Marshall, Texas. On April 2, 2010 the licensee's Radiation Safety Officer (RSO) was contacted. The RSO also stated that neither the radiographer nor the complainant was still employed by the licensee. The RSO stated that the complaint had been investigated by them as well as by the State of Louisiana regulatory program. The complaint was forwarded to the State of Louisiana. The complaint was not substantiated. No violations were cited.

File closed.

C - 2248 - Naturally Occurring Radioactive Material - Fairfield, Texas.

On March 11, 2010 the Agency was notified by Texas Commission on Environmental Quality that an individual was fired from his job at a Freestone County area construction firm for allegedly expressing concern for him and co-workers from possible exposure to contamination from de-scaled oil field pipe. The complainant also stated that the workers had been salvaging the pipe for scrap and some loads were rejected from scrap yards due to radiation being detected. As the pipe was returned to the originating construction company, the complainant stated that the owner of the construction company ordered his workers to rinse out the pipe to remove the scale. The NORM decontamination was said to have occurred on several sites throughout the 80 acres of property. On June 3, 2010, two Agency inspectors performed an on-site inspection. The inspectors surveyed the property and focused on racks of pipe and cleared patches of dirt which gave the appearance of work or prep areas. Most all areas (including stacks of pipe) were at background levels ranging from 7-15 $\mu\text{R/hr}$ with one "patch" elevated to 44 $\mu\text{R/hr}$. The property owner denied any participation in de-scaling pipe and stated that others are given permission to store pipe on his property. The complaint was not substantiated and no violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2010

C - 2249 - Burns from a Laser - Novopelle - Addison, Texas

On March 17, 2010 the Agency received a complaint from an individual alleging that she had undergone a laser hair removal procedure on several body areas. She stated that a particular technician performed her last scheduled treatment on February 16, 2010. As a result of this treatment, the complainant suffered extensive burns on the areas treated. The complaint stated that she contacted the registrant and that they asked her to return the next day, and when she did the lead technician examined her and then gave her topical treatments for the burns. On March 17, 2010 the Agency contacted the complainant for more information. The complainant stated that she went to her primary physician who agreed that she was indeed burned by the laser, and her physician prescribed lotion to treat the burns. The complainant stated that technician who performed the final treatment no longer works at the facility, and that she did not know if the burns were reported to the State of Texas, as required by rule. The complaint was forwarded to the Agency's Drugs and Medical Devices Group and the Texas Medical Board. On May 13, 2010 the Agency contacted the registrant and asked if they were aware of the incident. The Laser Safety Officer (LSO) stated that he was aware of the incident, but he did not report the event to the Agency because he was unaware of reporting requirements. The Agency instructed the LSO that he was to submit a report to the Agency. The LSO agreed to submit a report to the Agency. The complaint was substantiated. One violation was cited for failure to report the burns.

File closed.