



**INCIDENT AND COMPLAINT SUMMARIES
FOR THE
SECOND QUARTER 2011***

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Regulatory Services Division
Inspections Unit
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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 2011

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Incidents Opened Second Quarter 2011

I - 8830 - Not Licensed For Radioactive Material - Port Assets LLC - Bay City, Texas

On April 1, 2011, the Agency was notified by an individual that two Ronan density gauges, one containing a 20 millicurie cesium (Cs)-137 source and the other a 30 millicurie Cs-137 source, were installed at a facility that no longer had a valid General License Acknowledgement (GLA). The individual stated that the gauges were mounted on pipes--one 10 feet above the ground and the other 20 feet above the ground. He stated that since his company had not used the system, the shutter operation had not been verified, but that both gauges were in the locked closed positions. The caller stated that he had visually verified that the gauges were still located at the facility in January 2011. The new owner was reported to be a company in Pittsburgh, Pennsylvania. The company's web site stated it bought the facility in 2007. The Agency contacted the President of Operations of the company. He stated that they no longer owned the property, but stated he was acting for the group who had purchased the property. He stated that the facility was in bankruptcy and that he was representing the liquidation group who is trying to sell the property. He stated that the head of that group was going to contact the Agency's licensing group and begin the licensing process. On May 13, 2011, the Agency contacted the Radiation Safety Officer for the new owners and he stated that they were waiting on funding to send the license application and fee to the Agency. On May 24, 2011, the Agency received copies of the application and check for their General License Acknowledgement. On June 13, 2011, the GLA for the licensee was issued. No violations were cited.

File closed.

I - 8832 - Gauge Shutter Failure - Ticona Polymers Inc. - Bishop, Texas

On April 6, 2011, the licensee reported to the Agency that during its six month inventory and inspection it found the shutter on an Ohmart Model SH-F1 nuclear gauge, containing 60 millicuries of cesium (Cs)-137, stuck in the open position. Open is the normal operating position so the failure did not create an increased exposure risk. The gauge was repaired on April 27, 2011. The apparent cause for the failure was a buildup of bird feces on the operating device. The licensee has instituted a bird abatement program to reduce this type of failure in the future. No violations were cited.

File closed.

I - 8835 - * _____ - Northwest Texas Healthcare System - Amarillo, Texas

* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8836 - Equipment Malfunction, Fixed Gauge - BP Products North America, Inc. - Texas City, Texas

On April 19, 2011, the Agency received notification that on April 18, 2011, during reinstallation of a nuclear gauge on a process vessel, the chain attached to one of the two 2-curie cesium (Cs)-137 sources broke allowing the source to fall to the bottom of the insertion tube. The bottom of the insertion tube is the normal operating position. The process vessel had been out of service for repairs and the device was being reinstalled to return it to service. No additional radiation exposure to the general public or individual resulted. The service company reported that the source had been successfully lowered but it was being cranked back up into the shielded position because the device was to be removed due to issues with the mechanism controlling the other source. When the source was being raised, it jammed and the chain broke during the attempt to force it free while cranking the mechanism. The chain and source were "fished" out of its insertion tube. The device was repaired and reinstalled, at which time a second malfunction occurred (I-8837). The service company determined that the ultimate cause of the malfunctions with the device was an alignment issue involving the alignment pins and forced fitting which had created a kink in the tubing. Future preventative action will be for the service company to ensure proper alignment on all future installations and never force any fitting between the device and the vessel. No violations were cited.

File closed.

I - 8837 - Equipment Malfunction, Fixed Gauge - BP North America, Inc. - Texas City, Texas

On April 22, 2011, the Agency was notified that on April 21, 2011, a malfunction occurred when a repaired gauge was being re-installed on a process vessel at the licensee's facility. The device has two, 2-curie cesium (Cs)-137 sources, each attached to a separate chain, that are lowered into place in the insertion tube using a hand crank. The service company reported the first source was lowered with no problem. When the second source was being lowered into the tube, it jammed just below the bottom housing. It was not permanently stuck and the chains did not break. The sources were pulled back into the shielded position and the device was removed from the vessel and returned to the service company's business location for repairs. During reinstallation, it was noted that one of the alignment pins had been removed at some time during the past and a bolt had been being used instead. Because of this, it did not align properly and it was realized that forcing the alignment would cause the insertion tubing to kink. The service company believed this is how the tubes were originally damaged and that damage was determined to be the root cause of the malfunctions. The hole on the centering tube of this device was enlarged on-site and the device and sources were installed with no further problem. No additional radiation exposure to any member of the public or radiation worker resulted from this incident. To prevent recurrence, the service company will ensure proper alignment on all future installations and never force any fitting between the device and the vessel. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8838 - Inability to Retract Source - Stork Testing & Metallurgical Consulting - Houston, Texas

On April 20, 2011, the Agency was notified that a 58 curie iridium (Ir)-192 radiography source had failed to retract to the shielded position in a QSA Global model 880-D camera because the material being radiographed had fallen on the guide tube and crimped it. The licensee's Radiation Safety Officer was notified and the area was restricted to avoid public or excessive employee exposures. Several entries were made to shield the source and several more entries were required for the authorized individual to straighten the crimped portion of the tube and then retract the source into the shielded position. The source retriever and his assistant received radiation exposures of 170 millirem and 20 millirem, respectively, during the procedure and no public exposures reportedly occurred. No violations were cited.

File closed.

I - 8839 - Damaged Device Containing Radioactive Material - IRISNDT, Inc. - Corpus Christi,

On April 26, 2011, the Agency was informed by a licensee that on April 25, 2011, a QSA Global model 880-D radiography camera, containing 92 curies of iridium (Ir) - 192, fell off a 16 inch pipe it was sitting on and onto the guide tube. The guide tube was crimped and when the radiographer attempted to retract the source it became stuck in the crimp. During source retrieval activities directed by an authorized individual, the guide tube was hammered and the source became dislodged, but it could only move out. The source was cranked out into the collimator. The guide tube's outer casing was cut and channel locks were used to work the tube back into shape. The source was retracted into the camera. A leak test was performed with negative results. No member of the public received any exposure from this event and none of the radiographers received dose that exceeded regulatory limits. The licensee instructed the radiographers responsible for the incident on the proper placement of devices to ensure their stability. Safety meetings and training sessions were held and all of the licensee's staff in the United States have received the same instruction. No violations were cited.

File closed.

I - 8840 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On May 2, 2011, the Agency was notified by the licensee that during the routine check on an Ohmart/Vega nuclear gauge, model SHD containing 250 millicuries of cesium (Cs)-137 (original activity), the shutter was found stuck in the open position. The gauge is mounted on a tank and is located 100 feet above ground and did not create an exposure risk. The licensee lubricated the operating mechanism to get the shutter to operate. On May 3, 2011, the licensee was able to close and freely cycle the shutter open and closed. The licensee implemented a new lubrication program for nuclear gauges as part of its routine inspection program. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8841 - Stolen Radioactive Material - Aviles Engineering Corporation - Houston, Texas

On May 3, 2011, the Agency was notified by the licensee that a Troxler Model 3430 moisture/density gauge, containing an 8 millicurie cesium (Cs)-137 source and a 40 millicurie americium (Am)-241 source, had been stolen from the back of one of its pickup trucks in Houston, Texas. On May 7, 2011, the local police department, who had been notified of the gauge theft, responded to a residence due to a domestic dispute and saw the radiation symbol on the case containing the gauge. The police confiscated the gauge and contacted the licensee. The licensee inspected the gauge and returned it to service. No violations were cited.

File closed.

I -8842 - Gauge Shutter Failure - Shell Chemical LLP - Houston, Texas

On May 6, 2011, the Agency was notified by the licensee that the shutter on a Berthold Model 440 nuclear gauge containing an original activity of 50 millicuries failed to shut during an inspection in June 2009. The licensee was reviewing documents when it found a letter sent out by this Agency regarding the reporting of gauge shutter failures and reported the event. The licensee stated that the shutter did not close for the first few attempts, but they were able to close the shutter. The gauge was taken out of service when the shutter failed to close properly. No violations were cited.

File closed.

I - 8843 - Radiography Source Disconnect - METCO - Houston, Texas

On April 19, 2011, while performing radiographic operations with a QSA Global model 880-D camera, a radiographer found that the 58.6 curie iridium (Ir)-192 source could not be retracted into the safe storage position. The radiographers established barriers at the 2mR/hr line and ensured that others were alerted to stay clear of the area. The device was positioned 40 feet in the air on the side of a tank. The camera was lowered to the ground using a lift. The guide tube was covered with bags of lead shot. The company source recovery team (SRT) responded to the location. The SRT disconnected the guide tube from the camera and noticed the source had disconnected from the drive cable and was sticking out of the front of the camera. Using remote handling tools, the SRT removed the source from the camera and reinserted the source into the camera backwards so that the source capsule was positioned in the center of the camera shielding. No individual involved in this event exceeded any limit. The cause for the disconnect was determined to be that the coupling on the drive cable had separated from the drive cable due to excessive force. The licensee's investigation into the event revealed that the camera, with the crank-out device attached, had fallen 40 feet just prior to the disconnect. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8844 - Damaged Device Containing Radioactive Material - Team Industrial Service, Inc. - Alvin, Texas

On May 10, 2011, the Agency was notified by the licensee that a pipe had fallen on the guide tube of a QSA Global model 880-D camera during radiography operations at a temporary job site. The pipe damaged the guide tube preventing the radiographer from retracting the 34.1 curie iridium (Ir) -192 source into the camera. The licensee's source recovery team was able to repair the guide tube enough to retract the source. The camera was returned to the licensee's facility for inspection. The camera was inspected, leak tested, and returned to service. The damaged guide tube was removed from service. There was no exposure to a member of the general public and the highest exposure to a member of the recovery team was 28 millirem for the event. Corrective actions taken by the licensee include additional training for the radiographic crew concerning setups and configuration stability and the event details will be shared throughout the company to be used to improve safety in radiographic operations. No violations were cited.

File closed.

I - 8845 - * - Northwest Texas Hospital - Amarillo, Texas

* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

I - 8846 - Equipment Malfunction - Ineos USA LLC - Alvin, Texas

On May 12, 2011, the Agency was notified that the operating mechanism on an Ohmart Model SHLM-BR-2 nuclear gauge containing 1,000 millicuries of cesium (Cs)-137 had failed. The gauge's operating mechanism consists of two rods. The source is mounted on one rod and the other rod is used to move the source into and out of the source holder. The roll pin used to connect the two rods together sheared so the source could not be manipulated. The gauge was repaired on June 27, 2011. The technician who repaired the gauge recommended more frequent inspections of the roll pin for major wear. The licensee is training all of its gauge inspectors to increase the frequency of inspections and to look for wear on the pins. No violations were cited.

File closed.

I - 8847 - Gauge Shutter Failure - Solo Cup Operating Corporation - Dallas, Texas

On May 12, 2011, the Agency was notified by the licensee that the shutter on an Ohmart/Vega Model BAL nuclear gauge containing 100 millicuries of strontium (Sr) - 90 was stuck in the closed position. The gauge had an electronic shutter and it was not functioning. The licensee contacted its service provider for assistance in repairing the gauge. The service provider stated that it did not have any personnel who could repair the gauge. The manufacturer was contacted and it stated it did not have parts nor the expertise to make repairs to the device. The licensee decided to dispose of the device. No violation was cited.

File closed

Incidents Opened Second Quarter 2011

I - 8848 - Gauge Shutter Failure - Solo Cup Company - Dallas, Texas

On May 12, 2011, the Agency was notified by the licensee that while conducting a routine inspection of a NDC nuclear gauge containing 80 millicuries of americium (Am)-241, it found that the shutter for the device was missing. The licensee conducted a search of the area around the gauge but the shutter was not found. The licensee contacted the manufacturer for assistance in repairing the gauge. In the interim, the licensee placed a lead plate over the shutter opening to prevent exposure to personnel. The gauge was repaired by the manufacturer on April 29, 2011. The manufacturer stated that the shutter screw loosened and fell out due to vibration created by the equipment. The licensee added thread-locking adhesive to the screw threads when the new shutter was installed to prevent the shutter screws from loosening. The licensee was cited for a violation.

File closed.

I - 8849 - Gauge Shutter Failure - Union Carbide Corporation - Port Lavaca, Texas

On May 12, 2011, the Agency was notified by the licensee that while performing a routine inspection of a Ohmart/Vega model SH-F2 nuclear gauge containing 200 millicuries of cesium (Cs)-137 it found the shutter for the device stuck in the open position. The gauge is used for level detection on a vent stack in an area of the plant not routinely occupied. The licensee believed the probable cause for the event is a buildup of debris in the operating mechanism of the gauge. The licensee repeatedly applied lubrication to the operating mechanism followed by attempts to open the shutter. On May 13, 2011, the gauge shutter was worked free and the gauge was returned to normal service. The facility has implemented a policy of lubricating the shutter operating mechanisms every time the shutter is operated. There was no increased exposure to any personnel due to this event. No violations were cited.

File closed.

I - 8850 - * _____ - El Paso County Hospital District - El Paso, Texas

* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8851 - Device Leaking Radioactive Material - Texas A & M University - College Station, Texas

On May 18, 2011, the Agency was notified by the licensee that the university was demolishing a student dorm that had 16 tritium exit signs (TES) that were to be removed. When one of the TES was being removed, it was noted that the short tube making up the "X" was broken. A contamination survey of the sign and the floor below it indicated readings above the limit for tritium. The licensee stated that they could not determine how much influence the luminescent material in the sign had on the readings. The area was decontaminated and the area released. The individuals involved in the event received bioassay analysis. The results indicated that they had not received any internal deposition of tritium. The sign was packaged and returned to the manufacturer for disposal. The licensee is proposing the removal of most tritium exit signs and increased inventory frequency for those remaining. No violations were cited.

File closed.

I - 8852 - Gauge Shutter Failure - ExxonMobil Oil Corporation - Beaumont, Texas

On May 19, 2011, the Agency was notified by the licensee that the shutter on an Ohmart/Vega model SH-F2 containing 1.6 curies of cesium (Cs)-137 would not close. The licensee stated the failure occurred when they were attempting to close the shutter in preparation to enter a vessel to perform maintenance. No access to the tank was made. Open is the normal operating position for the shutter, therefore the gauge did not present any additional exposure hazard outside the tank. Access into the tank was secured to prevent entry until the gauge was repaired on June 15, 2011. The service company determined that the cause for the failure was rust deposits preventing the operating arm from turning. A shield box has been placed over the gauge. No violations were cited.

File closed.

I - 8853 - Lost Equipment Containing Radioactive Material - Texas A & M University - College Station, Texas

On May 19, 2011, the Agency was informed by the licensee's Radiation Safety Officer (RSO) that while making preparations to demolish a student dormitory it was discovered that a tritium exit sign (TES) was missing. The RSO stated that they had verified the sign was still there on April 14, 2011, but when they went to remove it on the May 19th it was missing. The RSO questioned maintenance personnel about removing the sign but they stated that they had not. The RSO sent a request to dormitory residents requesting any information on the location of the sign but received no responses. The licensee stated that it has proposed the replacement of a majority of the tritium exit signs and it will increase the inspection frequency for the signs. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8854 - Lost Source of Radioactive Material - FedEx - Houston, Texas

On May 19, 2011, the Agency was notified by a consultant for a shipping company that on May 18, 2011, at 0900 hours a package containing an 8 curie iridium (Ir)-192 source was lost in Houston, Texas. The shipper stated that the door on the back of the truck popped open and the container with the source fell onto the road. A member of the general public (MGP) driving the same direction a few minutes later stopped to pick up envelopes that had fallen out of the truck and saw the package on the other side of the road. He stated that there was too much traffic for him to retrieve it so he went on his way. About an hour later he passed by the area again and noted that the package was gone. The driver of the shipping company's truck discovered that the package was missing when he made his next stop. The driver retraced his path, but only found a bin that had fallen from his truck. The MGP took the envelopes he had found to one of the shipping company's facilities and told them what he had seen. The shipping company made a total of three searches for the package, but did not find it. On May 19, 2011, after being notified, the Agency contacted Houston HAZMAT and informed them of the event. Houston Haz Mat began calling fire stations and located the package at the Aldine Fire Department. The Agency attempted to perform an on-site investigation at the shipping company's facility on May 20, 2011. The shipping company initially agreed to the inspection, but later informed the Agency that it did not believe that the Agency had any jurisdiction and denied access to the facility. On August 10, 2011, the shipping company was informed of the Agency's intentions and sent a copy of the Health Warrant to the shipping company's legal counsel. The shipping company responded and stated that while it did not agree with the Agency's opinion it would allow an inspection. It further stated that it did not recognize this Agency as having any regulatory authority. On August 31, 2011, the shipping company agreed to the inspections under the conditions presented by the Agency. On September 7, 2011, the Agency conducted an on-site investigation at the shipping company's facility. The investigation found that the driver failed to recognize that he had loaded a package containing radioactive material into his truck and failed to properly brace and block the package to prevent movement during normal transport. The locking mechanism for the roll up door in the back of the truck was loose and allowed the door to open while the truck was being driven and the package to roll out. The driver was reprimanded and the shipping company's policies were changed at the facility to prevent a recurrence of the event. Three violations were cited.

File closed.

I-8855 - Damaged Source of Radioactive Material - Harrington Cancer Center - Amarillo, Texas

On May 24, 2011, the Agency was notified that in an effort to remove a stuck iodine-125 seed from an applicator, the authorized user damaged the source. The patient's treatment continued without event as a second applicator was readily available in the operating suite. No contamination of the patient, personnel, or facility was reported. The 0.3 millicurie seed had apparently become lodged in the barrel of the applicator and was damaged while being removed. Some activity was discharged into the sanitary sewer and the seed with two towels used in the clean-up were retained and placed in storage for decay and subsequent disposal. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8856 - Equipment Malfunction - IRISNDT Inc - Deer Park, Texas

On May 24, 2011, the Agency was notified by a licensee that they were unable to retract a 27.7 curie iridium (Ir) - 192 radiography source into a QSA Global model 880-D camera at a field site. The licensee's source recovery team was able to return the source to the fully shielded position. The licensee stated that a 6 inch portion of the drive cable was melted on non-insulated hot piping in a low-lighted area on a previous shot the same night. The licensee reported that this prevented the radiographer from retracting the source to the fully shielded position during a subsequent shot. The camera was taken to the licensee's facility for inspection and the drive cable was removed from service. There was no exposure to the general public and the highest exposure to a member of the source recovery team was 406 millirem. The licensee's corrective action included training for its radiographers on conducting more thorough inspections of work spaces and a pre- and post-inspection of equipment with each use. No violations were cited.

File closed.

I - 8857 - Unlicensed Possession of Radioactive Material - Cav-Tech, Inc. - Houston, Texas

On May 4, 2011, the Agency was informed by a licensee that handles source disposals that it had received an inquiry into the disposal costs of well logging sources by a non-licensed individual. It appeared that an individual was interested in purchasing property, which was owned by a licensee with well logging sources stored in down-hole storage, that presumably had been seized by Harris County Appraisal District (HCAD). The Agency's attempts to contact the Radiation Safety Officer (RSO) for the well logging licensee were unproductive so an on-site inspection was attempted May 5, 2011, but the inspector could not gain access to the property. On May 18, 2011, the Agency contacted the HCAD office and was informed that the county had not taken possession of the property as it was still in litigation with the owner. Later that same day, the Agency received documents showing that the property had been sold on April 15, 2011, to an entity that did not possess a license for radioactive material. On May 25, 2011, the Agency performed an on-site inspection with the assistance of the new owner. The investigator was not able to verify the location of the sources, but the area previously identified as the source storage area was locked by the Agency investigator and impoundment tags were placed on the fence surrounding the storage location. On May 28, 2011, the RSO for the original license was contacted. He stated that the sources were being stored at a different location and agreed to meet an Agency investigator at the licensed location to place the sources in the approved storage area. On May 31st, the licensee and a representative for the new owner met the Agency investigator at the licensed location. The sources were placed into the below ground storage location and the access covers were locked using Agency locks. The new owner of the property agreed to rent the storage area to the licensee and allow the sources to be stored there until other arrangements could be made. The sources were impounded in place. Later that day, the Agency was contacted and informed that the two parties could not come to an agreement for renting the storage location. The Agency investigator went back to the storage area with the licensee, removed the sources, and took them to the Agency's storage location in Austin. On June 20, 2011, the licensee received the renewal of its license including an amendment for a new storage location. On June 24, 2011, the licensee picked up the sources once the impoundment had been lifted. The licensee was cited for one violation.

File closed.

Incidents Opened Second Quarter 2011

I - 8858 - Stolen Tritium Exit Signs - AMC American Multi-Cinema, Inc. - Houston, Texas

On May 26, 2011, the Agency was notified that during the performance of routine inspections for the facility's site safety systems, it was discovered that two tritium exit signs that had been affixed above exits were missing. These signs were affixed using security mountings, but they had been essentially pulled off the walls leaving evidence that they were removed without the knowledge of site personnel. Each sign contained 9.5 curies of tritium. The facility filed a report with local law enforcement. The company has ordered wire cages from the sign manufacturing company to affix over the exit signs of this and other facilities in Texas as a deterrent of future thefts. No violations were cited.

File closed.

I - 8859 - Abandoned Well Logging Sources Down Hole - Thrubit, LLC - Freestone County, Texas

On June 2, 2011, the Agency was notified by the licensee that they were abandoning a 1.6 curie cesium (Cs)-137 source and an 18.9 millicurie californium (Cf)-252 source down hole in a well located in Freestone County. The sources are at depths of 7,459 and 7,446 feet respectively. Two 100 nanocurie Cs-137 sources inside the detector in the tool were also abandoned at 7,446 feet. The sources were abandoned in accordance with Railroad Commission and Agency regulations. A red-dyed cement plug was set with the top at 6,938 feet with a whipstock installed on top to act as a deflection device. The owner of the well opted to then plug the well back to the surface. A plaque has been ordered to mount at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well with the radiation control program contact information. No violations were cited.

File closed.

I - 8860 - Gauge Shutter Failure - City Public Service - San Antonio, Texas

On June 3, 2011, the licensee's Radiation Safety Officer (RSO) notified the Agency of a shutter failure on a Kay-Ray Model 7062BP nuclear gauge. He stated that on May 31, 2011, the licensee's employees had closed the gauge shutter while calibrating the detector. When one of the employees attempted to re-open the shutter, the employee said he felt something "sort of give". The shutter would not open and the shutter handle was loose. The RSO verified, using radiation detection equipment, that the shutter was completely closed. On June 3, 2011, a service company came on-site and repaired the handle. The RSO stated that the service company found that the shutter keeper shim and spring were completely corroded, though no liquid or wet spots were observed around the mechanism. The gauge is located in an area of high humidity. As immediate corrective action, the licensee inspected the shutter handle gaskets on the other Kay-Ray Model 7062BP gauges in the sludge conveyor system and were to replace any found to be in poor condition. The licensee stated they would provide training for staff that conduct gauge inspections to ensure they visually inspect the gaskets during future inspections. The licensee failed to report the event to the Agency within 24 hours as required. During the Agency's investigation, it was also discovered that the licensee had failed in 2010 to conduct visual inspections within the time interval required by its license conditions. Two violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8861 - Nuclear Pharmacy Error - Cardinal Health Nuclear Pharmacy Services - Orange, Texas

On May 27, 2011, the Agency was notified by the licensee that one of their drivers had delivered a package of radiopharmaceuticals to the wrong recipient licensee. The licensee was contacted by the recipient of the material and informed of the error. The licensee retrieved the material and delivered it to the correct facility. An investigation by the licensee determined that the driver did not verify that the address on the package label was for the location where the package was delivered. The driver was counseled and received additional training. No violations were issued.

File closed.

I - 8862 - * - Las Colinas PET Oncology MSO LP - Irving, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8863 - No Radiation Safety Officer - Richmond Foundry - Richmond, Texas

On June 17, 2011, the Agency received a reciprocity request indicating that a service company was going to remove three sources from a company in Richmond, Texas. The Agency contacted the facility manager. He stated that the company had not filed for bankruptcy, but had changed this location to a distribution center and no longer needed the sources. He stated that the company had terminated the Radiation Safety Officer position and it was in the process of terminating its license. He stated that the sources were still locked in an area which met the increased control requirements and a security force was in place at the facility. He stated that the company was in the process of disposing of the sources using a service provider who was making arrangements to ship the sources for disposal within the next few days. The Agency contacted the service provider and it stated that it intended to ship the sources June 22, 2011. On June 24, 2011, the service provider confirmed that all sources had been shipped from the facility in Texas. On June 29, 2011, the service provider provided documents indicating that the sources were in its possession at the disposal location. No violations were cited.

File closed.

Incidents Opened Second Quarter 2011

I - 8864 - Abandoned Well Logging Source(s) Down Hole - Schlumberger - San Jacinto County, Texas

On June 20, 2011, the licensee reported that a 16 curie americium (Am)-241/ beryllium (Be) source and a 1.7 curie cesium (Cs)-137 source were abandoned down hole in a San Jacinto County well. The sources were abandoned at depths of 8,197 and 8,210 feet respectively. The hole also contained almost 5,500 feet of cable above the tool containing the sources. A 1,623 foot red dye cement plug was placed above the cable from 7,623 feet to 6,000 feet. The well also has production casing above the tool to prevent intrusion on the tool. Under current plans, the well will be side tracked and produced. A plaque for placement at the well head has been ordered. The sources were abandoned in accordance with Texas Railroad Commission and Agency regulations. No violations were cited.

File closed.

I - 8865 - Radiography Source Disconnect - Team Industrial Services Inc. - Alvin, Texas

On June 23, 2011, the Agency was notified by the licensee that a 67.5 curie iridium (Ir) -192 source disconnected from its drive cable on a QSA Global model 880-D camera during the first radiographic operation at a field site. The disconnect occurred because the connector on the drive cable separated from the drive cable. The licensee's source recovery team was able to return the source to the fully shielded position in the camera. No exposure exceeding a regulatory limit was received during the source retrieval. The drive cable, connector, and the camera were returned to the manufacturer for inspection. The manufacturer's report stated that the drive cable had been exposed to a force great enough to cause the plastic coating on the cable to stretch and become thinner, allowing the connector to slip off of the cable. When, and the manner in which, this force was applied was not identified. The cable was repaired and returned to the licensee. The manufacturer retained the connector and a section of the drive cable for additional testing. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2011

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

On February 15, 2011, the Agency was notified by the licensee that during an internal investigation it was discovered that two patients were administered 88% (565 gray) and 153% (506 gray) over the prescribed dose of phosphorus (P)-32 chromic phosphate colloid to treat cysts. These procedures were performed in July and September of 2010, with an ordered activity of 0.2 and 2.5 millicuries for a prescribed dose of 200 gray and 300 gray, respectively. The incidents were discovered when the authorized user (AU) noticed an area of inflammation surrounding the cyst and along the track where the drug was administered. According to the AU, both patients have managed the treatment successfully without any other adverse reactions. The referring physicians and patients were notified of the event. To prevent recurrence, the licensee will perform a verification assay at its facility as well as assess the dose volume for calculating the specific activity. One violation was cited.

File closed.

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

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

File closed

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

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

File closed.

Incidents Opened in a Previous Quarter and Closed in Second Quarter 2011

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

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

File closed.

Complaints Opened Second Quarter 2011

C - 2328 - Laser Injury - Aspasia Medical Solutions - Bee Caves, Texas

On March 31, 2011, the Agency was notified that an individual was injured while being treated with an intense pulsed light (IPL) device for a photofacial treatment and without physician supervision. On April 11, 2011, investigators from the Agency's Drugs and Medical Devices Group and Radiation Incident Investigations conducted a site visit. A laser and intense pulsed light devices were impounded because the facility could not present a medical director's agreement. The facility presented the agreement the next day after retrieving a copy from its lawyer. A physician's examination of the person who complained of an injury documented the alleged injury as a skin eruption that had nothing to do with the IPL treatment. The complaint was not substantiated and no violations were cited.

File closed.

C - 2329 - Regulation Violations - Arends Inspection LLC - Houston, Texas

On April 5, 2011, the Agency received an anonymous complaint. The complainant stated the licensee was violating several regulations including failure to properly use collimators and barricades during industrial radiography, using survey meters that were not in calibration, and allowing individuals to perform radiography who are not authorized by the Agency. An on-site investigation was conducted as well as review of work being performed at a temporary job site. The allegations could not be substantiated. No violations were cited.

File closed.

C - 2330 - Radiation Exposure To Member Of General Public - Ludlum Measurements Inc. - Sweetwater, Texas

On April 6, 2010, the Agency received a complaint alleging that the licensee was using a 5 curie cobalt (Co) - 60 source with inadequate shielding and allowing workers to receive radiation exposure greater than the annual limit. The Agency conducted an on-site investigation on May 11, 2011. The inspection revealed that the sources were properly posted. Access was not restricted to the sources, but posted thermoluminescent dosimeters in the area of the sources of concern indicated that the dose to people in the area would not exceed any regulatory limits. The complaint could not be substantiated. One unrelated violation was cited.

File closed.

Complaints Opened Second Quarter 2011

C - 2331 - Regulation Violations - Mandes Inspection & Testing Services, Inc. - Houston, Texas

On April 12, 2011, the Agency received a complaint alleging that radiographers were napping and not providing source security during long shots at a temporary job site. Additionally, the complainant stated there were no alarms on the truck. On May 31, 2011, an on-site investigation was conducted at the radiography company. The company had recently terminated the employment of the Radiation Safety Officer (RSO). The new RSO, who started work in early May, had refurbished all of the radiography trucks and had new alarms installed on each vehicle. On June 1, 2011, during a phone interview with the complainant, who was the assistant to the radiographer, he admitted that the radiographer was sleeping during a 5 hour shot but that he, the assistant, was monitoring the source the whole time. The complaint was not substantiated. No violations were cited.

File closed.

C - 2332 - Inadequate Credentialing - Southwest X-ray LP - El Paso, Texas

On April 13, 2011, the Agency received a complaint alleging that a registrant was allowing technologists to perform fluoroscopy studies who did not hold the adequate credentials to do so. An on-site investigation conducted by the Agency on April 21, 2011, determined that individuals who had performed fluoroscopy at the registrant's location did hold the required credentials. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2333 - Laser Registration - Laser Beauty Medical Spa - Dallas, Texas.

On April 23, 2011, the Agency received an allegation that the facility was using a laser for hair removal and was not registered with the Agency. The allegation also stated that the facility did not provide patients with appropriate eye protection. The facility was contacted and an inspection was performed which verified that the facility was not registered with the Agency but eye protection was provided. One violation was cited.

File closed.

Complaints Opened Second Quarter 2011

C 2334 - Laser Injury - Status Body Studio - McKinney, Texas

On May 3, 2011, the Agency received an anonymous complaint alleging that a spa was performing laser hair removal and other laser procedures without being registered with the Agency, without physician supervision, without adequate training, and had burned clients. The Agency conducted an onsite investigation. The investigation revealed that the facility was not properly registered with the Agency. The facility did have a contract with a physician, the owner/technician had received training which fulfilled the current training requirements, but there was no evidence to support that any individual had been burned. The complainant called the Agency to follow up on their complaint. When asked for more detail concerning the allegation of burns, the complainant could only report that they had seen someone leave the facility wearing a gauze bandage. The facility was not properly registered with the Agency, but the other allegations could not be substantiated. One violation was cited.

File closed.

C - 2335 - Not Registered For Radiation Generating Device - South Texas Diagnostics - San Antonio, Texas

On May 7, 2011, the Agency received a complaint alleging that a clinic was operating an accuDEXA x-ray device and was not registered. The complaint also alleged that the individuals operating the device had not been properly trained. An on-site investigation was conducted by the Agency. The investigation found that the device was located in the office, was plugged in, and connected to a printer. A manager stated that the device had been used a few times by a doctor who worked at a different location and came to their office to operate the device for them. He could not provide a valid registration for the device. The complaint was substantiated. One violation was cited.

File closed.

C - 2336 - Exposure to the Public - Apple Dentist - Houston, Texas

On June 13, 2011, the Agency received an anonymous complaint alleging that the registrant was exposing its workers and members of the general public to radiation every time they operated their x-ray machine. On July 7, 2011, the Agency conducted an onsite visit. Upon investigation, the Panoramic unit was found to be in compliance and the staff conducted visual checks for personnel in the area and announced "clear" before operating the unit. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2011

C - 2337 - Damaged Device Containing Radioactive Material - LML Engineering - Arlington, Texas

On May 17, 2011, the Agency was informed by a licensee that a partnership had been dissolved. Part of the agreement involved the transfer of a Troxler 3440 nuclear gauge from Party-A to Party-B. Party-B arranged a time and place to pickup the gauge. When Party-B arrived at the agreed to location, Party-A brought the gauge, inside its locked case, out to Party-B. Party-B stated that he wanted to inspect the gauge prior to signing the transfer paperwork. Party-A refused to unlock the case and said that inspection of the gauge prior to transfer was not part of the buyout agreement. Party-B signed the transfer form, took possession of the device, and left. After cutting the lock off of the case, Party-B found the lock for the operating rod had been inserted into the lock to prevent its operation. Also, the lock bail had been filled with washers to prevent cutting it. Party-B was able to remove the lock on the operating rod and found that it had been bent and glue was placed on the rod to prevent operation of it. Party-B took the gauge to a service company where the gauge was repaired and returned to service. Party-A stated that they had refused to open the case when asked and had placed washers on the lock bail, but denied using glue to make the gauge difficult to operate. The service company reported that the sources were not damaged. No rule violation could be supported by the investigation. No violations were cited.

File closed.

C - 2338 - Radiation Injury - Spine Team Texas - Southlake, Texas

On May 13, 2011, the Agency received a complaint that an individual claimed to have received burns during x-ray procedures. It was suspected by the complainant that the markers used as positioning indicators may have caused an electrical discharge during the exposure. An investigation and inspection was performed and the machine was found to be in normal working order. The review of the x-ray machine documentation revealed that there was a current physicist survey with no deficiencies noted and previous Agency inspection reports showed no violations on the last three inspections. The facility's staff reported that they had not received any other complaints of thermal or radiation burns. During records review, it was noted that the complainant had had previous surgeries and/or invasive procedures. Also, the physician assistant that examined the lesion(s) that the complainant suspected had resulted from the x-rays noted that they were possibly a specific illness (not related to radiation or thermal burn). The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2011

C - 2339 - Regulation Violations - Affordable Laser Centers, LLC - Pasadena, Texas

On June 3, 2011, the Agency received an anonymous complaint alleging that the registrant had committed regulation violations of inappropriate advertising in declaring permanent laser hair removal, that the required Notice to Workers had not been provided, keys were left in the machines at all times, protective eyewear is old and inadequate, required warning posters are not available at all treatment areas, and client records are not adequately maintained. During the Agency's investigation, the registrant submitted copies of documents and photographs in response to the Agency's inquiries concerning the allegations. The registrant admitted they had used the flyer with the verbiage "permanent hair removal", which is prohibited by U.S. Food and Drug Administration as well as by Agency rules as false or misleading advertising, at the end of 2010 but stated they would make sure to not use it again. The rest of the complaint could not be substantiated. No violations were cited.

File closed.

C - 2340 - Regulation Violations -Aids Outreach Center Inc. - Fort Worth, Texas

On June 3, 2011, the Agency received an anonymous complaint stating that a dental assistant was required to manually hold the x-ray head and/or arm in place while performing x-ray procedures. The Agency conducted an on-site investigation. The investigation found that two of the x-ray devices owned by the registrant did require the head and/or arm of the device to be held on occasion by a technician. The units were repaired on June 7, 2011. The investigation also found that an x-ray device was being used by the registrant that was not on their Certificate of Registration. The complaint was substantiated. Two violations were cited.

File closed.

C - 2341 - Not Licensed For Radioactive Material - Hicks Industries - Garland, Texas

On April 27, 2011, the Agency received an allegation that an individual was performing well-logging services utilizing radioactive materials in the State of Texas without possessing a license. On June 26, 2011, the Agency received a response to a letter sent to the company's owner stating that they were not in possession of any radioactive material. On June 28, 2011, the owner was contacted on the phone and he stated that he does not perform any activities in the State of Texas that would require a license from this Agency. He further explained that, as a consultant, he had received the documents associated with the allegation (source leak test results) from the company that had performed the tests for a facility in Arizona for which he provides consulting services and that he did not perform source leak tests. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Second Quarter 2011

C - 2342 - Regulatory Violations - National Laser Institute LLC - Dallas, Texas

On June 21, 2011, the Agency received a complaint concerning the way a laser training provider, approved by the Agency, was conducting business. The complainant alleged the training facility was telling the students they were "certified" when they weren't yet; telling students they will be able to buy a laser when they won't be able to; and, misleading the students and "ripping them off." The complainant was upset that the training school was performing free hair removal and this threatened the complainant's and others' business and the complainant felt the state should protect them from these schools giving away their services. The Agency determined that allegations were not regulatory issues under its authority but were consumer-type complaints. The Agency did contact the training facility and made it aware of the complaint and asked it to evaluate and address the issues if applicable. The complainant was informed they could pursue the complaint through other consumer advocacy/complaint systems. No violations were cited.

File closed.

C - 2343 - Uncredentialed Technologists - Texas Managed Inc dba Texas Urgent Care - Houston, Texas

On June 21, 2011, the Agency received an anonymous allegation stating that the registrant was using unlicensed technologists to perform x-rays and that the registrant was not monitoring occupational dose to their workers. The investigation into this event is on going.

File open.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2011

C - 2292 - Regulatory Violation - Berry Fabricators - Corpus Christi, Texas

On December 8, 2010, the Agency received a phone call from an individual who stated that he had a friend who worked for the licensee and that the friend had not been issued any personnel monitoring devices, did not have any radiation survey instruments, and that the guide cables were in such bad shape that they were often unable to retract sources into the camera. He stated that when sources did stick, the workers were required to perform source retrievals. An on-site investigation was attempted by the Agency on December 16, 2010. The licensee's Radiation Safety Officer (RSO) was contacted, but he stated he had worked the night shift and would not come in to the plant. There were no individuals at the facility that could provide access to records needed to conduct the investigation. A routine inspection was conducted on February 10, 2011. The RSO stated to the inspector that their records had been boxed up when he moved from one office to another and were inadvertently thrown into the trash. The RSO stated that they would not be doing any radiography work in the near future. The inspection report included 17 violations. On April 2, 2011, the Agency was contacted by an individual who stated that the licensee was conducting radiography operations in an unsafe manner. An on-site investigation was conducted on April 9, 2011, but the allegations could not be substantiated. No additional violations were cited.

File closed.

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

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

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2011

C - 2309 - Naturally Occurring Radioactive Material - Justin Palmer Welding - Wichita Falls, Texas

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

File closed.

C - 2312 - Laser injury - Medi-Bella, LLC - Buda, Texas

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

File closed.

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

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

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2011

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

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

File closed.

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

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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

* Health and Safety Code Chapter 241.051(d)

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

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2011

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

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

File closed.

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

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

File closed.

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

On March 22, 2011, the Agency received a phone call from an individual stating that he/she had received burns to the face during laser vein treatments at a facility in Dallas. On April 13, 2011, the Agency conducted an on-site investigation of the facility. The investigation revealed the facility was not registered with the Agency to possess and use Class 4 lasers for laser hair removal and vein treatments, nor did it report the injury to the Agency. Supporting documentation from a physician confirmed that burns were present. The complaint was substantiated. Four violations were cited.

File closed.

Complaints Opened in a Previous Quarter and Closed in Second Quarter 2011

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

On March 22, 2011, the Agency received a complaint referral from U.S. Department of Labor-Occupational Safety and Health Administration (OSHA) involving an oil and gas well pipe inspection company operating in Cleburne, Texas. The original complainants were concerned about radiation levels from stacks of pipe that they believed contained Naturally Occurring Radioactive Material (NORM) and lack of personal protective equipment for employees working on scale removal. The Agency conducted an on-site inspection, in conjunction with OSHA, on March 25, 2011. The investigator was able to determine that the facility was not descaling pipe at this location and that the facility did not routinely survey pipe prior to working on it until March 9, 2011. On January 26, 2011, the facility conducted a survey of all pipe located on the site and found 19 pipe sections reading greater than 50 microrem/hour. The facility's operations manager stated that none of this pipe had been worked on and that it was removed from the site by a contractor. The investigation found that appropriate protective clothing was available for the workers. Dust masks were also available for the workers' use. The facility's safety coordinator stated that after they received their training the first week of March 2011 all individuals who had worked on the pipe were sent for bioassay samples. The doctor who screened all of the individuals' medical reports indicated that he did not find "any ill effects" from the exposure to the individuals involved. However, the samples were not analyzed for radioactivity. The complaint could not be substantiated. No violations were cited.

File closed.