



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

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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 & Health and Safety Code Chapter 241.051(d). These summaries will not appear in this report.

Incidents Opened Third Quarter 2009

I - 8643 - Source Abandonment - Halliburton Energy Services Inc. - Penwell, Texas

On July 2, 2009, the Agency was notified by the licensee that a 1.78 curie cesium (Cs) - 137 source and a 15 curie americium -241/beryllium (Am/Be) source were stuck downhole at a well site south of Penwell, Texas. Later that day, the sources were considered irretrievable and were abandoned downhole. A red dye cement plug was placed above the sources from 5,873 to 5,673 feet. A whipstock deflection device was placed above the cement plug. A plaque has been ordered for placement at the well head. No violations were cited.

File closed.

I - 8645 - Radiation Alarm at Landfill - Allied Waste Management - Fort Worth, Texas

On July 15, 2009, the Agency received a call from a waste management company stating that radioactivity had been detected at the landfill. A truck carrying waste was determined to contain a small quantity of iodine (I)-131. The material was most likely from an individual treated with radioactive iodine. Human excreta contaminated with short lived radioactive material is exempt under radiation control rules. The landfill operator was instructed that the material was exempt and could be buried. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8646 - Overexposure - Radiographic Specialists Inc. - Houston, Texas

On July 17, 2009, the Agency was informed by the licensee that its dosimetry processor informed it that a radiographer's film badge was reading 9,000 millirem for the exposure period of June 10, 2009, through July 9, 2009. The licensee's Radiation Safety Officer (RSO) stated that, based on the information obtained in his investigation, he believed the dose to be to the badge only. On July 21, 2009, the licensee reported that the same individual's badge for the exposure period of May 10, 2009 through June 9, 2009, was reading 17,840 millirem. The RSO stated that he was arranging for a medical examination for the individual. The Radiation Emergency Assistance Center/Training Site (REAC/TS) was contacted and a blood sample was taken and sent to them. The RSO provided a document from the REAC/TS which stated that "there was no evidence based on the dicentric assay of a recent exposure to ionizing radiation. In this case, the dose estimate is not significantly different from background." Immediately after the licensee learned that the individual's badge dose was high, the individual's current badge was processed with only ten days of wear. The reading for this badge was within the normal range for that individual. The Agency performed an announced investigation on August 18, 2009. The investigators reviewed dosimetry records and daily utilization logs for the radiographer. The investigators were unable to determine how the badge received the high dose. The individual stated that he had not remembered dropping his badge near an exposed source, allowing his badge to be tampered with by another employee, or any other activity that would account for the high reading. The individual also stated that his self reading dosimeters never read extraordinarily high while on a job. However, because of lack of physical manifestations associated with a whole body dose of this magnitude, the Agency agreed with the licensee that the dose was indeed to the badge only. The individual was assigned 417 millirem for each of the exposure periods, which brought his total exposure to less than the annual limit. The licensee stated that it has changed its policy for issuing and receiving dosimetry to its workers. The licensee was cited for a related violation.

File closed.

I - 8647 - Therapy Event - The University of Texas MD Anderson Cancer Center - Houston, Texas

On July 1, 2009, the Agency was notified by the registrant that a therapy event occurred when a patient was treated with 6 MeV electrons instead of the prescribed 9 MeV electrons for one fraction of a treatment. An investigation performed by the registrant determined that the error occurred due to confusing treatment instructions. Changes to the current procedures were made to provide clearer instructions for this type of procedure and additional reviews by the oncologist and therapist. The event was reviewed with the patient. The radiation oncologist does not believe that there will be any adverse effects to the patient as a result of the error. The remaining fractions will be altered to provide the prescribed total dose for the patient. The event will be reviewed by the registrant's Radiation Oncology Quality and Safety Council, which may recommend additional corrective actions. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8648 - HDR Machine Malfunction - Joe Arrington Cancer Research and Treatment Center - Lubbock, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8649 - Naturally Occurring Radioactive Material - Private Residence - Fort Worth, Texas

On July 21, 2009, the Agency was informed by the city of Fort Worth's Hazmat team that two individuals had dismantled a boat dock on Lake Granbury that contained what appeared to be drilling pipe. The pipe was cut into four foot sections and taken to a scrap yard where it alarmed a radiation portal monitor. The individuals took the pipe to two additional scrap yards. It was surveyed for radiation and refused at both scrap yards. The individuals took the pipe to their home and off-loaded the pipe in their yard. Some undetermined time later, the individuals began to feel sick and decided to go to the hospital. The Fort Worth Hazmat team was called to the hospital to assist in performing radiological surveys on the individuals and their vehicle. The Hazmat team surveyed the individuals and found no reading significantly above background. They also surveyed their truck at the hospital and found readings of approximately 310 counts per minute and 110 microrem per hour in the bed of the truck. The piping was surveyed at the home and readings were reported as high as 8.2 millirem/hr on contact. The Hazmat Incident Commander stated that the radionuclide was identified with high confidence (>80%) as radium. He stated that the contamination in the truck bed was identified as radium, but with a low confidence. The truck was returned to the individual's home. Two Agency investigators went to the residence the next day and surveyed the material. They confirmed the radionuclide was radium - 226, a naturally occurring radioactive material (NORM). They instructed the owners on how to properly dispose of the material.

On July 26, 2009, the Agency took sediment, vegetation and surface water samples at three locations along Lake Granbury. All sample results were normal. On July 31, 2009, sediment samples were taken at the location where the dock had been removed from and a second dock in the same general location. All sample results were normal. On August 3, 2009, the Agency performed radiological surveys on 33 boat docks located in Lake Granbury which appeared to be built using drilling pipe. None of the surveys indicated radiation readings above background.

File closed.

Incidents Opened Third Quarter 2009

I - 8650 - Unintentional Exposure - South Texas Cancer Center - Harlingen, Texas

On July 22, 2009 the Agency was contacted by the registrant's medical physicist. The physicist described an incident involving an unintentional exposure to an engineer performing maintenance on a linear accelerator. After the physicist had assisted the engineer with repairs to the accelerator, the physicist left and later returned to the linear accelerator to perform his checks on the machine. He made several attempts to determine if the engineer was present in the accelerator room without any response from the engineer. He then assumed that the engineer had left. The physicist then began to initiate his checks on the machine, and within a second the emergency shut off switch was triggered. The engineer made the physicist aware that he was in the accelerator room, behind the Klystrom cabinet. The physicist determined from the machine monitors that 86 monitor units were delivered by the machine in 0.22 seconds. The physicist then recreated the event and, using an overly conservative methodology, he calculated the maximum exposure to the engineer to be 47.4 mR, including the neutron dose. The engineer is badged through his company, but was not wearing the badge at the time. The physicist ordered more badges, recreated the scenario, and exposed the badges. The physicist contacted the Agency on August 13, 2009 and stated that he had telephoned the dosimetry processor and the maximum reading on the exposed badges was 3 millirem, without including the neutron dose, which was still being processed. On August 26, 2009 the physicist contacted the Agency and stated that his manager had cancelled the processing of the badges from the dosimetry processor. It was determined that the physicist's report contained sufficient information for the dose assessment of 47.4 mR. No violations were cited.

File closed.

I - 8651 - Possession of Radioactive Material with an Expired License - AEP Texas Central Company - Corpus Christi, Texas

On July 28, 2009, the Agency's incident investigation group received a request from the Agency's licensing group to locate a licensee whose license had expired and had not provided any information on the location of the licensed material. The company's contact information was located and an Agency investigator contacted the licensee's Radiation Safety Officer (RSO.) The RSO stated that she was unaware that the company's license had expired. She stated that all licensed material had been moved to the location listed on the license as location 001. The RSO contacted the licensing group and stated that the material they possess should be classified as generally licensed material, so they will terminate their current license. No violations were cited.

Incidents Opened Third Quarter 2009

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 - 8653 - Abandoned Sources - Highland Medical Center - Lubbock, Texas

On July 22, 2009, an Agency inspector contacted a licensee to arrange for an inspection when she was informed that the facility had closed. She was told that the two sources had been abandoned in the facility when the facility closed. The inspector performed a radiological survey of the facility and found no readings above background. An individual who was at the facility informed the inspector that the sources had been returned to the manufacturer. The inspector contacted an Agency investigator in Austin, Texas, and informed him of her findings. The investigator searched the license file for the licensee and found termination documents and documents showing that the sources had been returned to the manufacturer prior to closing the facility. No violations were cited.

File closed.

I - 8654 - Stolen Troxler Gauge - PaveTex Engineering and Testing Inc - Dripping Springs, Texas

On August 11, 2009, the Agency was notified by the licensee that a Troxler Model 4640-B density gauge containing a 8 millicurie cesium (Cs) - 137 source was stolen from one of their vehicles while it was parked at an auto parts store in Big Spring, Texas. The operator had secured the gauge in the back of his truck using a chain and lock. He then checked the status of his work to determine if he could begin his survey. When he returned to the truck, he found the truck's tailgate down, the chain cut, and the gauge and its container missing. The operator notified local law enforcement and his Radiation Safety Officer of the theft. The operator searched for the gauge in the local area, but did not locate it. The licensee was contacted the next morning by an individual who stated that they had found the gauge in a road about six blocks from where it was stolen. The licensee picked the gauge up later that day. An inspection of the gauge indicated that there was no damage to it. The licensee has performed additional training with all of its operators and added a second locking mechanism to all of its trucks. The licensee was cited for failure to use two locking mechanisms to secure the device while not under direct surveillance.

File closed.

Incidents Opened Third Quarter 2009

I - 8655 - Transportation Violations - Baker Hughes Oilfield Operations Inc - Houston, Texas

On August 13, 2009, the Agency received a call from the licensee's Radiation Safety Officer (RSO) stating that on July 13, 2009, one of two containers they shipped via common carrier to Tyler, Texas, from Van Buren, Arkansas contained a 2.5 curie cesium (Cs) - 137 source. On August 12, 2009, the licensee discovered that the source had been shipped in a container designed to carry americium sources. The licensee recreated the event and measured the dose rate in the cab of the transport truck at 25 millirem per hour. The trip was estimated to have taken six hours to complete, so the dose to the driver was calculated to be 150 millirem for the trip. The Agency performed an on-site investigation in Tyler, Texas on August 21, 2009. The inspector was able to confirm the calculated dose to the truck driver using time stamped pictures provided by the licensee. The RSO stated that, to the best of his knowledge, the individual who had sent the shipment from Arkansas had never shipped radioactive material before and had never received any training to ship radioactive materials. The inspector found that the shipping container was improperly labeled and that the containers were not properly monitored for dose rates. The licensee ordered a cancellation of all work involving radioactive material in the two locations involved until all employees there received further training in: the company's policies, performance of radiation survey, types of sources and containers, and Department of Transportation rules for shipping radioactive material. The licensee intends to retrain all company employees in the United States on these topics by the end of 2009. The licensee was cited for six violations.

File closed.

I - 8656 - Source Found in International Mail - U.S. Customs And Border Protection - Dallas,

On August 14, 2009, the Agency was notified by U.S. Customs and Border Protection (CBP) that a package shipped to the United States from Thailand had been searched and found to contain a small container with an unknown quantity of material identified as strontium (Sr) - 90. The package was addressed to a house located in Fort Worth, Texas. On August 26, 2009, the Agency along with members of CBP; the International Mail Branch; U.S. Immigration and Customs Enforcement; and a member of the Tarrant County Sheriff's office, performed an on-site inspection at the home. The resident of the home stated that he had ordered the materials from Thailand, but was unaware that it contained radioactive material. A radiological survey of the residence found contamination on several sets of dice, two small bowls, and a piece of aluminum foil that were located in a backpack in a closet. While questioning the home owner, it was discovered that there was an additional container in the individual's truck, which was identical to the one discovered at the airport. The individual stated that he had ordered it a few months prior to this and had not ordered or received any additional containers. A survey of the truck found the source and a set of contaminated dice. No other contamination was discovered during the radiological surveys. The radioactive material was placed in a container and removed from the premises to storage at the Agency. The resident was asked if he was aware of anyone else who may have one of these sources. He stated that he did not. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8657 - Badge Overexposure - Solara Hospital Brownsville - Brownsville, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File Closed.

I - 8658 - Source Disconnect - Fugro Consultants, Inc. - Pasadena, Texas

On August 17, 2009 a 79.1 curie iridium (Ir) -192 radiography source in a Sentinel Model 880 exposure device could not be retracted into the fully shielded position. After several attempts to return the source to the shielded position, it was determined that the source remained at the end of the source tube. The licensee's Radiation Safety Officer (RSO) was notified, and a two millirem per hour line was established by the radiographers. The licensee's report stated that visual surveillance of the radioactive material was maintained at all times by the radiographers. The RSO then utilized additional shielding and remote handling tools to retrieve the source and place it into another camera. It was later determined that the ball shank broke from the drive cable leaving the source pigtail in the guide tube. The RSO reported that all personnel were monitored with direct reading devices and no exposures exceeded regulatory limits. No violations were cited.

File closed.

I - 8659 - Lost Static Eliminators - Toppan Photomasks, Inc. - Round Rock, Texas.

On August 17, 2009, the licensee had determined that four static eliminators containing less than 0.10 millicuries each of polonium (Po) - 210 could not be located and were presumed lost, most likely discarded in the trash. The sources had been removed from the machines they were mounted on while the area was undergoing some renovation and relocation of equipment. The licensee made several attempts to locate the sources but could not find them. To prevent recurrence, the inventory of these devices will be maintained by the licensee's environmental health and safety department who oversees the acquisition and disposition of all hazardous materials at the facility. There was no threat of exposure to any member of the public. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8660 - Damaged Moisture Density Gauge - Team Consultants Inc. - Dallas, Texas

On August 20, 2009, the Agency was informed 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/beryllium source was damaged at a work site. The operator had exited the trench he was working in and had set the gauge at the edge of the trench. He left the area to report his findings to the job supervisor working nearby. While he was talking to the supervisor, the backhoe operator swung the bucket around striking the gauge, bending the source operating rod and index rod, and cracking the display face. The Cs-137 source was locked in the shielded position when the gauge was struck. The operator performed surveys of the backhoe bucket, ground in the area, and the moisture/density gauge. All readings were normal. The gauge was transferred back to the storage location. The licensee's service contractor was contacted and performed a leak test of the gauge. The results were below the applicable limit. The gauge will be returned to Troxler Electronics Laboratory. The operator was given additional training in the proper controls required for use of this device. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8661 - Access Restricted for Greater Than 24 Hours - Nuclear Source and Services Inc. - Houston, Texas

On August 28, 2009, the Agency was notified by the licensee that while performing radiological surveys in response to a shipping event, removable contamination levels which exceeded the limits in TAC 289.202 (ggg) were found. As a result, access to an area of their facility not normally controlled due to radioactive contamination levels was isolated due to the presence of radioactive contamination for greater than 24 hours. The source of contamination was a curium (Cm) - 244 source shipped for disposal from Loma Linda University (LLU) in California. The source had been leak tested by the licensee and the counting equipment indicated that the contamination level was zero counts per minute. The licensee later shipped a shipping container and a pallet to a university in Pennsylvania. The university in Pennsylvania surveyed the pallet and container and found contamination on some external surfaces and notified the Texas licensee. The truck used for the shipment was surveyed for radioactive contamination, and no contamination was detected. The licensee performed contamination surveys at its facilities and found the area where the drum had been stored was contaminated. The licensee determined that the pallet and drum had been stored in the area where the leak test survey of the source from LLU was performed. A review of the counting results for the source leak test found that the count rate of the sample had exceeded the capabilities of the counter and it defaulted to a value of zero counts per minute. The licensee also determined that the source was not a sealed source as first believed, but an electroplated source and had been shipped inside a small plastic case. The source had been removed from the case when the leak test was performed causing the contamination of the licensee's facility. The licensee stopped all work in the area and the facility was isolated. The licensee conducted surveys in all areas where contamination may have spread and all areas that exceeded the limits in TAC 289.202 (ggg) were decontaminated. The decontamination of the facility was completed in mid-March 2010. A survey performed by this Agency after the decontamination by the licensee did not detect any contamination. The area has been released for unrestricted access. The licensee is making arrangements for disposal of the waste resulting from the clean up of the facility. The licensee stated that leak test swipes for alpha sources will be counted using a portable instrument prior to using the scintillation counter to prevent this type of counting error. No violations were cited.

File closed.

I - 8662 - Nuclear Gauge Involved in Fire - Liberty Pressure Pumping, LP - Springtown, Texas

On September 2, 2009, the Agency was notified by the licensee that a mobile slurry unit using a Thermo Fischer Scientific Model 5190 density gauge containing a 200 millicurie cesium (Cs) - 137 had caught fire. This occurred at an oil field temporary job site south of Fort Worth, Texas. The licensee's Radiation Safety Officer (RSO) stated that the fire had melted the lead at the top of the shield exposing the source. The RSO stated that he had measured elevated dose rate readings on the gauge. The RSO stated that the source is still in the holder and that no release of radioactive material had occurred. On September 3, 2009, workers for the gauge manufacturer properly packaged the gauge and transported it to their licensed facility. There were no public exposures due to this incident and no violations were issued.

File closed.

Incidents Opened Third Quarter 2009

I - 8663 - Dispensing Error - Cardinal Health - Corpus Christi, Texas

On September 2, 2009, the Agency received a letter from the licensee stating that, on August 11, 2009, the licensee intended to inject the patient with technetium - 99 metastable (Tc - 99m) mebrofenin for imaging of a specific organ (Organ-A). When the patient was imaged, only uptake to a different organ (Organ-B) was evident. The licensee determined that the dispenser used to obtain the mebrofenin also housed Tc-99m mertiatide. The two drugs have the same assay of 15 millicuries (mCi) per milliliter. Five mCi of Tc-99m mebrofenin was ordered for the patient. However, 5 mCi of Tc-99m mertiatide was given to the patient by mistake. This resulted in a dose to the kidney of 72 millirem and a total body dose of 33 millirem. The licensee's corrective actions include more training for staff using the dispensers. No violations were cited.

File closed.

I - 8664 - Patient Initiated Therapy Event - MD Anderson Cancer Center - Houston, Texas

On July 6, 2009, the Agency was notified by the licensee that a patient initiated therapy event had occurred. The event occurred when a patient was being treated with the 36 pulse of treatment when she tried to call the nurse using a call button. The patient inadvertently pushed a button which raised the height of the bed causing it to damage the source transfer tube. The automatic return device was not able to return the source to the safe storage location. The source was manually cranked back to the safe position by the physicist. A radiation survey of the area indicated radiation levels were normal. The attending physician and manufacturer were contacted along with the Radiation Safety Chief and the Division Chair of Radiation Oncology. A dose estimate of 339 millirad was assigned to the patient. The manufacturer examined the source and determined that the source had not been damaged. The source will be exchanged and repairs completed before the machine will be used again. The hospital employees involved with the event had their dosimetry processed and the highest recorded exposure was 36 millirem. The nurse was provided additional training on the procedure. No violations were cited.

File closed.

I - 8665 - Overexposure - Aloki Enterprise Inc - Stafford, Texas

On September 2, 2009, the Agency received a letter from the licensee's Radiation Safety Officer (RSO) stating that one individual received 5,185 millirem for 2007 and another received 5,195 millirem for the year 2007. The RSO sent the letter after the over exposure was found during an inspection by a DSHS inspector. The RSO stated that he believed the exposures were to the badges, but did not provide any evidence to support his statement. The dosimetry processor's report indicated that the control badge had been damaged, but that both of the individuals' badges were not damaged. The exposure records provided for one of the individuals showed that the individuals received similar exposures in each quarter of 2007. The exposure records for the other individual were incomplete. The licensee changed the company operating procedures. A violation for the over exposures was cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8666 - Potential Inadvertent Exposure - Texas A&M University - College Station, Texas

On September 11, 2009, the Agency received a phone call from the registrant's Radiation Safety Officer (RSO). The RSO informed the Agency that an employee may have received a potential exposure at the food irradiator facility on August 25, 2009. The employee stated that he was able to gain access to the electron beam cell while the device was energized and generating radiation. The RSO stated that a blood sample was sent to Radiation Emergency Assistance Center/Training Site (REAC/TS) for analysis. An on-site investigation by this Agency was conducted on October 7, 2009. Interviews were conducted with the three university individuals involved in the event. The system interlocks were tested and equipment status log generated by the computer were reviewed. The system interlocks shut the device down as designed. The computer log confirmed that the device was shutdown at nearly the same time as entry was made into the room. A document from REAC/TS was provided stating that no exposure above background had occurred. The actual time for each of the actions of the individuals involved are not well documented. There was no way to compare the times on the computer log directly to any activity of the individuals involved in the alleged exposure. Based on the information provided by REAC/TS, the test results on the interlocks, and the statement by the individual involved, the Agency concluded that the individual was not exposed to radiation from this event. A complaint was filed for this event and this investigation will be completed under Complaint number C - 2220. A violation was cited against the registrant.

File closed.

I - 8667 - Radioactive Material Found at Scrap Yard - ELG Metals Southern Inc. - Houston, Texas

On September 14, 2009, the Agency was notified that while performing a final radiation survey of a container of scrap stainless steel, the facility's radiation monitor alarmed. The container was unloaded and a GammaMat radiography camera was identified. An Agency inspector picked the camera up on September 15, 2009, and took it to the Agency's main office. A radiation survey of the camera found the maximum dose rate on contact with the camera was 1.66 millirem/hour. The radionuclide was identified as uranium (U) - 238 using a SAMS 935. Literature from the manufacturer found on the internet stated that depleted uranium was used in the camera for shielding. The manufacturer was contacted. The manufacturer traced the sale of the device to a company in Germany, but could not track it any further. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

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 (H-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.

I - 8669 - Overexposure - National Inspection Services - Crowley, Texas

On September 18, 2009, the Agency was notified by the licensee that its dosimetry processor had notified them that an employee had received 4,973 millirem for that exposure period. The worker's total deep dose equivalent for the year 2009 was 5,573 millirem, exceeding the annual limit. The dosimetry processor reviewed the results of the dosimeter reading and recommended that the original reported dose remain. The worker was removed from any work that would result in additional exposure to radiation for the remainder of the year. The licensee was cited for the overexposure.

File closed.

I - 8670 - Source Abandoned in Well - Pathfinder Energy Services - Webb County, Texas

On September 16, 2009, the licensee reported that a 1.7 curie cesium (Cs) - 137 and a 2.8 millicurie californium (Cf) - 252 source were abandoned downhole. The sources became stuck during logging operations and could not be recovered. The Cs-137 source was abandoned at 12,994 feet and the Cf-252 source at 13,000 feet. A 106 foot red dye cement plug was placed above the two sources and 119 feet of drill pipe above the sources will act as a diversion 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.

Incidents Opened Third Quarter 2009

I - 8671 - Radioactive Material Found at Scrap Yard - Latimore Material Corp. - McKinney, Texas

On September 18, 2009, the Agency was notified by the Alabama Office of Radiation Control that a gauge containing a 0.9 millicurie cesium (Cs) -137 source was found in a scrap yard in Axis, Alabama. The gauge had been shipped to the scrap yard from a company located in Texas. The Texas company had acquired the gauge as part of a dredge included in the purchase of another company in August of 2009. The company was not informed that they had purchased a device containing radioactive material. They dismantled the barge and shipped it to the scrap yard as part of a large load of scrap. The labeling on the gauge had been painted and the device appeared to be just another part of the piping system. The scrap yard gate radiation monitor alarmed on the load of scrap and the gauge was located by the scrap yard. The scrap yard stated they recognized the gauge contained radioactive material and took precautions to minimize exposure to their workers. The gauge was picked up by the manufacturer and has been properly disposed of. The company stated that they have no intentions of owning radioactive material in the future. An investigation by the Agency determined that no individual was exposed to more than 20 millirems during this event. No violations were cited.

File closed.

I - 8672 - Badge Overexposure - Christus Santa Rosa Health Care - San Antonio, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8673 - Failure to Retract Source - University of Texas SW Medical Center - Dallas, Texas

On September 22, 2009, the Agency was notified of an incident that occurred on September 21, 2009 involving a patient undergoing brachytherapy. The patient did not receive the proper dose due to the 9.6 curie iridium (Ir) - 192 source failing to retract back into the high dose rate after-loader unit. The administering physician retrieved the source from the patient and placed it in a shielded container. After an investigation by the Agency was performed on September 29, 2009, it was determined that no overexposure occurred because the dose to the patient differed by less than fifty percent for the fraction of that treatment, and by less than four percent for the entire treatment. No violations were cited.

File closed.

Incidents Opened Third Quarter 2009

I - 8674 - Injury from Laser Use - University of Texas Medical Branch - Galveston, Texas

On August 20, 2009, the Agency was notified that four of the registrant's employees claimed to have received injuries to due to using a laser which did not have a required filter installed. The registrant sent the laser to the manufacturer for inspection. The manufacturer reported that the device did have a filter in it, but it was the wrong size. However, the manufacturer stated that the use of the wrong filter would not have caused injury to the users. The four individuals received medical examinations at the facility. No injury was detected in any of the individuals. The laser was upgraded by the manufacturer and returned to service. No violations were cited.

File closed.

Complaints Opened Third Quarter 2010

C - 2200 - Regulatory Violations - Mandes Inspections & Testing Services Inc. - Houston Texas

On July 2, 2009, the Agency received a complaint alleging that the licensee was allowing radiographers to violate various regulations while performing radiographic operations. The complainant alleged the radiographers did not properly use collimators, did not perform surveys, did not wear TLDs, and did not establish and/or verify the two millirem boundary. The complainant also alleged that one of the cameras was broken and it allowed the radiographers to crank the source in and out without automatically locking in the S-tube. On August 19, 2009 the Agency conducted an investigation into the complaint. No violations were found during this inspection. The Agency was unable to observe the radiographers in the field and the licensee was told that the complaint would remain open until field observation could be completed. On November 15, 2009, the Agency was able to observe a pair of radiographers from the licensee in the field. They found that one of the radiographers did not zero his self-reading dosimeter before beginning work. The complaint was not substantiated. One violation was cited.

File closed.

C - 2201 - Trainee Operating as Radiographer - Eagle NDT - Abilene, Texas

On July 7, 2009, the Agency received a complaint alleging that the licensee was allowing a radiographer trainee to operate as a radiographer, was storing the radiography source at his home at night, and the individual had not met all the requirements for unescorted access to the source. After an Agency investigation was performed on July 9, 2009, it was determined that the individual was qualified as a radiographer in the State of Oklahoma, the radiographer was not allowed unescorted access to the source, and that he had not stored the source at his home. The complaint could not be substantiated. The licensee was cited for two unrelated violations found during the investigation.

File closed.

Complaints Opened Third Quarter 2010

C - 2202 - Regulation Violations - Stephen L. Wilson, MD - Fort Worth, Texas

On July 22, 2009, a letter was received from a complainant alleging the registrant had repaired a dial on a radiographic unit by gluing it on incorrectly, and proceeded to use exposures to a patient to adjust the dial. The complaint also alleged that the physician had not reapplied for a certificate of registration when the other certificate had expired on March 31, 2009. An initial search of the Agency's database revealed that a review of their application is pending. The complaint also alleged that the physician is knowingly using non-radioactive pharmaceuticals that have expired. The Agency's Drugs and Medical Devices Group was contacted in regards to this complaint on July 28, 2009. The Drugs and Medical Devices Group forwarded the information to the Texas Medical Board for further review. On August 13, 2009 an Agency inspector performed an investigation of the facility. The inspector was able to substantiate that for a period of time the radiographic machine was operated without a current Certificate of Registration from the Agency. The inspector was not able to substantiate that the physician incorrectly repaired the radiographic machine. The complaint was substantiated. The registration violation was cited, along with several other violations.

File closed.

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 - 2204 - Resident was being Irradiated - Cedar Park, Texas

On July 28, 2009, the Agency received a complaint forwarded by the U.S. Environmental Protection Agency in Dallas. The complainant stated that some teenagers living in the apartment above her had stolen some radioactive material and were pointing it through the floor and it caused her teeth to crack and her hair to fall out. An on-site investigation was conducted by an Agency inspector and a survey was conducted with a scintillation counter. No readings above background were observed. The complainant was informed of the results of the radiation survey. The complaint could not be substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2010

C - 2205 - Radiography Violations - H & H X-ray Services - Teague, Texas

On August 4, 2009, the Agency received a complaint alleging that a radiographer trainer working for the licensee was allowing his trainee to operate a radiography camera containing a radioactive source unsupervised. The complainant also alleged that the trainer routinely parked his company truck outside his place of residence. On September 16, 2009, two Agency inspectors performed a field investigation where the radiographer was working. The inspectors observed the radiographer operate the camera and his trainee change the film. The inspectors questioned both the radiographer and his trainee and could not substantiate the accusations. The inspectors identified four violations while observing the radiographers. Both the radiographer and the licensee were cited for the violations.

File closed.

C - 2206 - Regulatory Violations - QC Laboratories Inc. - Houston, Texas

On August 13, 2009, the Agency received a complaint alleging that the licensee was allowing radiographers with expired certificates to continue doing radiography, was allowing individuals to conduct radiography operations even though they had not passed the radiographers exam, and allowing an individual to conduct radiography prior to completing the 40 hour required training. An on-site investigation was conducted on November 12, 2009. The investigators found that the facility had not performed any radiography work from October 22, 2009 to November 12, 2009. They reviewed various documents and found that only qualified individuals had checked out radiography cameras and that the trainees listed on the daily radiation report were always accompanied by a qualified trainer. An individual hired in January 2009, did not receive a trainee's card until July 2009. The Radiation Safety Officer stated that this individual was used to deliver goods until he received his trainee card. The inspectors did not find the individual's name listed on any daily radiation logs prior to July of 2009. The complaint could not be substantiated. The licensee was cited for two violations.

File closed.

Complaints Opened Third Quarter 2010

C - 2207 - NORM Remediation Work without Proper Notification - Frisbie & Edwards - Fredericksburg, Texas

On August 14, 2009, the agency received an email from a complainant that stated that Frisbie & Edwards had been awarded three contracts from the Texas Railroad Commission (RRC) for NORM remediation work. The complainant provided a copy of the notice of award which provided the lease number for the impacted property. The complainant alleged that the work was performed without due notification of "Intent to Provide Services" or Notice of Reciprocity. On August 24, 2009 the RRC was contacted and stated that Frisbie & Edwards had contracted out the remediation work to company properly license by the Agency to perform NORM remediation work. The company named by the RRC is properly registered with the Agency, and they have complied with license conditions requiring them to notify the Agency prior to beginning and after finishing work with NORM. A "Written Notification of NORM License Activity" letter found in their license file dated July 7, 2009 and a "Completion Letter for NORM licensed Activity" letter dated July 20, 2009 served as proper notification of the work performed at the site listed on the bidding award provided by the complainant. The complaint was not substantiated. No violations were cited.

File closed.

C - 2208 - Uncredentialed Technologist - Jeffrey Cantrell - Lewisville, Texas

On August 17, 2009 an anonymous written complaint was received that alleged a technologist employed by the registrant was performing radiographic exposures without being properly credentialed. The complaint also alleged that the technologist had been working for over a year without credentials. On September 4, 2009, a Department of State Health Services inspector performed an inspection. The inspector documented that the technologist was uncredentialed from May 2, 2008 through June 11, 2009. The complaint was substantiated. The registrant was cited one violation.

File closed.

C - 2209 - Regulatory Violations - Ballinger Memorial Hospital - Ballinger, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were issued.

File closed.

Complaints Opened Third Quarter 2010

C - 2210 - Unlicensed Storage Location - Midwest Inspection Services - Burleson, Texas

On August 18, 2009 an anonymous telephone complaint was received by the Agency. The complainant alleged that the licensee was storing radioactive material in a residential area, not listed on the license. The location given by the complainant is more that 300 miles from the closest of the two licensed storage locations. Two Agency investigators surveyed the entire street given by the complainant several times, and could not detect anything above background and did not see a radiography truck parked at any of the residences. No violations were cited.

File closed.

C - 2211 - NORM Decontamination Without a Permit, International Oilfield Services - Alvarado, Texas

On August 26, 2009 the Agency received an allegation from another Agency which alleged that a company was decontaminating NORM from oil field pipe without a proper permit. The Agency assessed the site using survey instruments and no significant readings exceeding background were measured. Individuals at the site were questioned and they had no knowledge of NORM decontamination activity at this site. The complaint was not substantiated.

File closed.

C - 2212 - Radioactive Industrial Brick Oven - All American Rigging - Houston, Texas

On August 27, 2009, the Agency received a telephone complaint alleging that approximately six years ago, the complainant's employer, All American Rigging, acquired an industrial sized brick oven to sell as scrap. It was refused at several scrap yards over the years because it was found to be radioactive. The complainant stated that he did not attend work on August 27, 2009, but he has learned that the company was dismantling the oven and was throwing the steel and the bricks into the dumpster. The complainant said that he believed high levels of radiation were contained in the brick. On September 2, 2009, two Agency inspectors went to the facility to perform an announced investigation. The inspectors surveyed the brick and detected radiation levels slightly higher than background. The inspectors also determined that the radioactive material was naturally occurring, and identified it as thorium (Th) - 232. The inspectors told the facility manager that he could dispose of it at any industrial solid waste landfill. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2010

C - 2213 - Radioactive Drainage Pipe - Private Residence - Trinity, Texas

On September 1, 2009, the Agency received a phone call from an individual who stated that he had removed some drainage pipe and later found it was radioactive. Since removing the pipe, the individual has felt "nauseous, blah, with no appetite." He stated that pipe had been removed, but some of the radioactive residue might still be in the ditch. On September 4, 2009, an Agency inspector traveled to the site and met with the complainant to discuss his concerns. The complainant pointed out a location where a culvert pipe had been removed from the road and stored next to a ditch for a short time. The complainant explained that he attempted to take the pipe to a metal recycler where radioactivity was detected on the pipe. The inspector asked him where the pipe was located and he stated that he found a recycler who would take it. The inspector conducted a radiation survey over the location where the new culvert pipe was installed and along the location where the pipe had been stored before it was recycled. There was some scale residue at the storage location where the pipe had been stored. Radiation measurements taken at these locations were not different than other readings taken around the area. The inspector explained that the readings in the general area were a little higher than expected, but that the readings were not unusual for background radiation. He also told the complainant that there was no radiation hazard from the measured radiation levels. The complainant was also advised that the detected radiation at the metal recycling facility was most likely NORM and that, since background levels along the road appeared high, that could have explained the detection at the recycling facility. No violations were cited.

File closed.

C - 2214 - Radiography Regulation Violations - Texas Gamma Ray LLC - Houston, Texas

On September 1, 2009, the agency received a complaint alleging that the licensee was allowing radiographers to perform radiography without the use of collimators or adequate shielding. Two agency inspectors performed an on-site investigation on September 23, 2009. No radiography was being conducted at that time. The Radiation Safety Officer stated that work was normally conducted at this location in the evening. On November 12, 2009, the agency again went to the location to investigate after hours. On two consecutive occasions, the inspectors observed the radiographers crank the source out and leave the area unmonitored. They found that no barriers or postings were in place and that no radiation surveys were conducted after returning the source to its fully retracted position. One radiographer had failed to recharge his self reading dosimeter and the Utilization Log was not always completed. The licensee and radiographer were cited for the violations.

File closed.

Complaints Opened Third Quarter 2010

C - 2215 - Non-Credentialed Technicians - Med Cure PA - Houston, Texas

On September 1, 2009, the Agency received a complaint alleging that the registrant was using non credentialed technologist (students) to perform x-rays in one of their clinics. On September 22, 2009, the Agency conducted investigations at two of the sites. The inspector found that two individuals at one site, and three individuals at the other had performed x-rays and were not credentialed to do so. The registrant was cited for the violations.

File closed.

C - 2216 - Uncredentialed Technicians - Valley Day and Night Clinic - Brownsville, Texas

On July 27, 2009, the Agency received an anonymous complaint stating that the registrant was using "non-licensed" personnel to perform x-rays. On October 9, 2009, an Agency inspector performed an unannounced inspection at two of the registrant's facilities. The inspector determined that uncredentialed technicians were being used at both sites to perform x-rays. The registrant was allowing the individuals to perform the x-rays because they were preparing to enter Non-Certified Radiologic Technician training in the near future. The registrant has stopped using the uncredentialed technologist at their facilities. The complaint was substantiated. The registrant was cited for the violations.

File closed.

C - 2217 - Uncredentialed Technologists - Mobile Medical Services - Lubbock, Texas

On September 8, 2009, the Agency received an anonymous email stating that the registrant routinely hires non-certified technologists and requires that they perform work beyond the scope of their certification. On September 16, 2009, an Agency inspector performed an unannounced investigation. The inspector checked the registrant's records and found that all technologists that were performing x-rays at the registrant's facility between September 2007 and August 2009 were properly credentialed. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Third Quarter 2010

C - 2218 - Radiation Exposure to General Public - Private Residence - Houston, Texas

On September 25, 2009, the Agency received a phone call from an individual who stated that she was being exposed to radiation and excessive heat directed at her house by two individuals in her neighborhood. The individual was provided a thermoluminescent dosimeter for a period of 48 days. The dosimeter reading was 8.4 millirem. The individual was informed that the level of exposure recorded on the badge did not pose any radiological risk and was within normal background levels. She asked if she could be provided with a radon test kit. The kit was ordered for her. No violations were cited.

File closed.

C - 2219 - Broken Laser - American Laser Center - The Woodlands, Texas

On September 22, 2009, the Agency received a complaint alleging that the registrant used a machine that was broken, and consequently, a patient was burned. The complaint stated that the glass tip of the laser wand was cracked and this allowed the laser to operate at a "higher level." The complainant stated that management knew the laser was broken and continued to use it. She stated that some of the technicians that operate the laser had not gone through proper training with a nurse. On November 13, 2009, the Agency performed an on-site investigation at the facility. The investigation found that the glass prism at the end of the wand did not appear to be damaged on either machine used by the registrant. The training allegation could not be substantiated. A notice of violation was cited for not having a licensed practitioner of the healing arts supervising the administration of a laser to humans.

File closed.

Complaints Opened Third Quarter 2010

C - 2220 - Potential Inadvertent Exposure - Texas A&M University - College Station, Texas

On September 22, 2009, the Agency received a phone call from an employee of the registrant who stated that he was able to gain access to the electron beam cell while the device was energized and generating radiation. The individual stated that a short time after this event, he experienced his eyes dropping, spots that appearing and disappearing a short time later, reddening of his skin, swelling of his left ear, watering of his eyes, and itching of the skin. The registrant's Radiation Safety Officer (RSO) had contacted the Agency before the complaint was received. The RSO stated that they had sent a sample of the individual's blood to REAC/TS for analysis. An on-site investigation by this Agency was conducted on October 7, 2009. Interviews were conducted with the three university individuals involved in the event. The system interlocks were tested and equipment status log generated by the computer integrated with the device were reviewed. During the test, the noise made by the operation of the device was evident from outside the room with the door shut. When tested, the system interlocks shut the device down as designed. The review of the computer log confirmed that the device was shutdown at nearly the same time entry was made into the room. The actual time for each of the actions of the individuals involved is not well documented therefore, there was no way to compare the times on the computer log directly to any activity of the individuals involved in the alleged exposure. A document from REAC/TS was provided to the Agency stating that their study indicated that no exposure above background had occurred to the complainant. Two complete blood counts were conducted on the complainant and the results of both indicated normal readings. Based on the information provided by REAC/TS, the results of two CBC studies, the test results on the interlocks, and the statement by the individual involved that he did not hear the increased noise level created by the e-beam tube and air knife when he entered the room, it was determined that the individual was not exposed to radiation from this event. An incident investigation of this event was also conducted under incident file number I-8666. The complaint could not be substantiated. A notice of violation was issued for a related violation.

File closed.

C - 2224 - Regulation Violations - Medical Edge Healthcare Group P.A. - Dallas, Texas

On September 29, 2009, the Agency received a complaint alleging that the mammography registrant deleted some of its required records; did not perform required quality control testing on various components; failed to provide records within 30 days; and failed to provide the equipment necessary to perform compression tests. The Agency performed unannounced inspections at two of the registrant's locations on November 3, 2009. The inspectors found that required records for personnel and equipment were missing. They also found that required quality control tests had not been performed and/or analyzed and that not all required notifications to the Agency had been made. They found that the equipment for performing compression test was available. The complaint was substantiated. Seven violations were cited against the registrant.

File closed.

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

I - 8580 - Breached Source - Ludlum Measurements Inc - Sweetwater, Texas

On November 13, 2008, the Agency was notified by the licensee that while performing modifications to a calibration device, a 50 millicurie cesium (Cs) - 137 source was breached. The source was breached when a technician used a grinder to shorten the source thinking it was a spacer. The four individuals directly involved with the source breach received in vivo and in vitro bioassay analysis. The exposures assigned to each of the four individuals was less than 10 millirem. Exposures to the hands of individuals who handled the source were calculated and all were below regulatory limits. Service contractors were hired to perform area decontamination and radiological surveys of the facility. The contamination was restricted to the facility and most of the contamination was found near the location where the source had been breached. All machines and areas of the facility were decontaminated and released by May 1, 2009. The Agency performed confirmation surveys on May 6, 2009. No additional problems were identified. The licensee has amended their procedures to prevent a reoccurrence of this type of event. The licensee received a violation for failure to implement sound as low as reasonably achievable (ALARA) principles for the event.

File closed.

I - 8596 - Lost Sources - Wal-Mart - Various Locations in Texas

On January 13, 2009, the Agency was notified by the licensee that 1,558 tritium exit signs (TES) were lost from stores located throughout the State of Texas. This information was gathered during a review of records of TES sent to Wal-Mart stores located in the State of Texas, and was being conducted as part of a nation wide inventory done by Wal-Mart. The Nuclear Regulatory Commission coordinated with Wal-Mart and agreement states to collect and track the results of inventories by Wal-Mart of these signs. Wal-Mart provided specific reports to each agreement state as required. The report included specific information for each TES reported as lost. Wal-Mart remediated contamination from damaged signs at several stores, and subsequently removed all tritium exit signs in Wal-Mart facilities in Texas replacing them with exit signs that do not contain radioactive material. Wal-Mart updated the Agency with information as they continued their investigation, and it was finally determined that a total of 1,557 signs were lost in the State of Texas. A total of 15,863 exit signs were unaccounted for nation wide. Due to Wal-Mart's prompt, comprehensive, and extraordinary corrective and preventive actions, no violations were cited.

File closed.

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

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

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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

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

File closed.

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

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8640 - Radiation Alarm at a Landfill - Baptist Health System - San Antonio, Texas

* Health and Safety Code Chapter 241.051(d)

The licensee was cited for the violation.

File closed.

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

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

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

File closed.

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

* Health and Safety Code Chapter 241.051(d)

Two violations were cited.

File closed.

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

C - 2165 - Substandard Mammograms being Performed - Victory Breast Diagnostics & Women's Imaging - Dickinson, Texas

On October 13, 2008, the Agency received an anonymous complaint stating that substandard mammograms were being performed by technologists at this facility. An inspection was performed at the facility and mammograms as well as the mammography techniques were found to be in compliance with the Agency rules. No violations were cited.

File closed.

C - 2172 - Unlicensed Source - Cummings Wireline - Kyote, Texas

On January 21, 2009, the Agency received a complaint alleging that an individual is using a well logging source without a license. The company's license was revoked in August of 2000. The Agency could not locate a current address for the individual alleged to be using the source. An Agency inspector attempted to locate the individual to perform an inspection and was unable to find him. On June 6, 2009, the inspector found a phone number listed on a sign located at a different property owned by the licensee. The individual was contacted, and he stated that the source was being stored under reciprocity in the State of Arkansas. He stated that the source had been transferred to Arkansas prior to his license in Texas expiring. The individual was informed that the Agency would notify the State of Arkansas that his license in the State of Texas had expired. The individual decided to return the source to the State of Texas where it was impounded at the storage location by the Agency. The individual filed for a license with the State of Texas and received it on September 9, 2009. The sources were released on September 28, 2009. No violations were cited.

File closed.

C - 2177 - Wind Turbine Causing Adverse Health Effects - IBERDROLA Renewables - Jacksboro, Texas

On February 13, 2009, the Agency received a complaint from an individual alleging that he was suffering adverse health effects caused by a wind turbine farm located next to his property. An Agency inspector performed a field inspection on March 5, 2009. He performed decibel readings in various locations at the wind turbine farm and near local residents homes. The maximum reading taken at the wind turbine was about 80 decibels. Readings taken in front of the complainant's home were about 40 decibels. The complaint was not substantiated. No violations were cited.

File closed.

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

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

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

File closed.

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

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

File closed.

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

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

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

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

File closed.