



**INCIDENT AND COMPLAINT SUMMARIES  
FOR THE  
THIRD QUARTER 2010\***

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

**Incident and Complaint Summaries  
3rd Quarter 2010**

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## Incidents Opened Third Quarter 2010

### I - 8759 - Retrieval of Radioactive Material - Texas Department of Transportation - Hebbbronville, Texas

On July 2, 2010, the Agency received a report from the licensee that a tornado had touched down in the town of Hebbbronville, Texas, and destroyed the storage building where two moisture density gauges were stored. The licensee located the gauges on their property and determined that the transport cases were still closed. A radiation survey conducted on the cases indicated that the shielding was still intact. The gauges were taken to the licensee's facility in Pharr, Texas, where they were inspected and found to be undamaged. No violations were cited.

File closed.

### I - 8760 - Radioactive Material Found - Esco Marine - Brownsville, Texas

On July 7, 2010, the Agency received a report from the general licensee stating that an industrial radiography camera was found at its scrap yard. The licensee stated that the camera was found within a car that was brought to the yard for scrap. The dose rate was reported to the Agency to be about 200 microrem per hour (urem/hr) at the surface of the camera. The Agency was able to track the serial number of the device to a Texas licensee that had gone out of business in 2008. According to the device manufacturer, the last source that was issued by them to the licensee was returned to the manufacturer in December of 2008. On July 14, 2010, an Agency inspector went to the scrap yard and performed a visual assessment of the device and determined that there was no radioactive source within it. The manufacturer of the device was willing to accept the device and made arrangements with the scrap yard for its return. No violations were cited.

File closed.

### I - 8761 - Stolen Radioactive Material - Alliance Engineering & Testing Svcs Inc - Fort Worth, Texas

On July 9, 2010, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that one moisture/density gauge had been stolen from an employee's truck. The gauge contained a 40 millicurie Americium - 241/Berilium (AmBe) source and a 10 millicurie Cesium (Cs) – 137 source. The technician had completed testing on concrete rebar and had returned to his truck when he found the tailgate down and two sections of the locked chain used to secure the gauge in the truck bed had been cut. The gauge and additional equipment were missing. The technician searched the area for the gauge and when he could not find it, he contacted the company RSO. The RSO stated that the truck was parked in a position where the technician could not see it while he was performing his testing. The RSO contacted local law enforcement and informed them of the event. A reward was offered for the return of the gauge. The licensee has changed the way the gauge is locked on the vehicle so that it now provides two tangible barriers. They also now require the vehicle to be in view of the gauge operator anytime a gauge is stored on it. The licensee was cited a violation for failure to provide two tangible barriers for the gauge.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8762 - Overexposure - IBA Molecular North America - Dallas, Texas

On July 16, 2010, the Agency was notified by the licensee that an employee's personal dosimeter had received 4,153 millirem, resulting in a total of 5,809 millirem deep dose equivalent for the year, exceeding the annual dose limit. The licensee stated that the work load for the month of June 2010 was not significantly greater than the previous months, but that they had problems with their cyclotron and had been purchasing bulk units of fluorine (F) - 18 from two providers. During their investigation, the licensee (Licensee-A) discovered that on June 9, 2010, a package of F-18 from another licensee (Licensee-B) had been damaged during shipment. Licensee-A stated that the package was transferred from Licensee-B's transport vehicle to Licensee-A's transport vehicle in Centerville, Texas. No surveys were performed and no shipping papers were obtained by Licensee-A during the transfer. When the package arrived at Licensee-A's facility, the site manager performed an arrival survey. The dose rate at 1 meter from the package was 47 millirem and the contact reading over-ranged his survey meter. The swipe survey indicated that there was no removable contamination on the package. Licensee-A's site manager stated that when he opened the package to remove the vial of F-18, he found the vial had come out of the shielding and was lying on top of the packaging material. Licensee-A did not report the event to the Agency as required by regulation. The Agency performed on-site investigations at both Licensee-A's and Licensee-B's facilities. During the investigations, both licensees provided conflicting information on the layout of shielding for the vial. It was determined that the package was damaged sometime during the event, but neither licensee could offer an explanation on how the vial separated from the shielding materials. No pictures were taken by the Licensee-A. Through Licensee B's investigation, it was determined that the vial could not separate from the shielding unless the package was opened. Due to the conflicting information from both licensees, the Agency could not determine how the vial separated from the shielding. Licensee-A determined that the overexposure was caused by deficiencies in their procedures for handling bulk vials of F-18, a lack of adequate equipment to handle this type of material, errors in judgment by people handling the bulk vials, and a lack of communication within their company. Corrective actions by Licensee-A included removing the individual receiving the overexposure from any duties involving exposure to additional radiation, no longer receiving bulk F-18 units until new procedures have been put in place, replacing broken vial handling equipment, ordering backup parts, and providing additional training for their personnel. Licensee-A was cited violations for the overexposure, failure to report the transportation event, and failure to obtain shipping papers for the transportation of radioactive materials.

File closed.

### I - 8763 - Gauge Shutter Failure - Meadwestvaco Texas LLP - Silsbee, Texas

On July 20, 2010, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that the shutter on a nuclear gauge failed in the open position. The gauge contains 10 millicuries (original activity) of Cesium (Cs) – 137. The RSO stated that while trying to close the shutter, too much pressure was applied to the operating arm breaking the operating pin which attaches the arm to the shutter. The gauge normally operates with the shutter open. The RSO stated that the radiation level at one foot from the gauge is 0.015 millirem per hour, and presented no additional risk of radiation exposure to any individual. On August 12, 2010, a technician from the manufacturer repaired the broken handle and shutter. The cause for the shutter failure was a build up of rust in the shutter cavity caused by the intrusion of water due to a failed seal. The seal was replaced and the gauge returned to normal service. The licensee was cited for not reporting the event by phone within 24 hours as required.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8764 - Lost Radiation Generating Device - Ashtead Technology, Inc / All Tech Inspection - Corpus Christi, Texas

On July 21, 2010, the Agency received a report from the registrant's Radiation Safety Officer who stated that a radiation producing machine (a portable alloy analyzer) had been lost. The device was believed to have been lost during transport, when the registrant (Registrant-A) was shipping the device to another registrant (Registrant-B). The device was shipped using a common carrier. According to the carrier's online tracking system, the package had been delivered to Registrant-B on July 2, 2010. Registrant-A had contacted Registrant-B, and Registrant-B stated that they had searched for the device and did not have it. Registrant-B stated that several packages had been received that same day. The Agency contacted the carrier to determine where the package was, and they were only able to verify that the package had been received by Registrant-B and signed for at Registrant-B's site in Corpus Christi. The Agency required both registrants to submit a 30-day report. The reports were received on August 10, 2010 (Registrant-A) and August 26, 2010 (Registrant-B). Registrant-B reported that the device had been found at one of their locations, but not the warehouse in Corpus Christi. No violations were cited.

File closed.

### I - 8765 - Possible Abandoned Radioactive Material - Duncanville Medical Center - Duncanville, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations cited.

File closed.

### I-8766 - Lost Source of Radioactive Material - Southwest Research Institute- San Antonio, TX

On July 23, 2010, the Agency was notified by the licensee that a device containing a 4.4 millicurie Nickel (Ni) - 63 source had inadvertently been placed in a waste dumpster during a site clean up operation on or about July 7, 2010. The contents of the dumpster were later buried in a local landfill. The source does not present a hazard to members of the general public. The licensee has changed its procedures regarding controlling these sources and have increased the number of employees who must be trained on the procedures. The licensee was cited for improper disposal of a radioactive source.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8767 - Inadequate Credentialing - South Texas Imaging Center - Harlingen, Texas

On July 14, 2010, the Agency received a call from one of its inspectors reporting the possibility that a non-certified tech was administering PET doses. The inspector believed that the administrative assistant was administering the doses because the handwriting on the dose log matched that of the secretary and not of the credentialed technologists on staff. On September 9, 2010 the Agency performed an onsite investigation at the facility. The administrative assistant was the only person present at the time of the investigation. The Agency found that there were two technologists employed by the licensee (Licensee-A) at the facility and both were licensed to administer radioactive pharmaceuticals for PET imaging. The two technologists were also employed at another licensee's (Licensee-B) location. The Agency investigators collected documentation at both licensee's locations. The documentation from Licensee-A's facility was not in accordance with Agency rule, and a violation had been previously cited by the inspector for failure to comply with the regulations regarding the documentation of the dose logs. The documentation did not prove that there was a time when doses were administered at Licensee-A's facility and a credentialed technologist was not present. Furthermore, the administrative assistant repeatedly stated that she did not administer doses. No violations were cited.

File closed.

### I - 8768 - Potential Exposure to Individual - Team Industrial Services Inc. - Houston, Texas

On July 26, 2010, the Agency received a report from one of its inspectors stating that while conducting an inspection at a licensee's facility, he/she was informed of a possible exposure event that occurred while another radiography company was conducting radiography operations at the facility. The Radiation Safety Officer (RSO) for the facility was contacted and stated that one of their workers had walked up on a radiography crew from the previous radiography company while they were performing radiography, and found that there were no radiation boundaries in place. The radiography device in use contained a 38 curie Iridium (Ir)-192 source. The individual's dose was calculated to be less than 1 millirem. An Agency inspector went to the radiography company involved in the event to discuss it with the RSO. The RSO was out of the office, so the inspector talked with the Operations Manager. The manager stated that he was aware of the allegation, but stated that he did not believe that it happened. The RSO later contacted the Agency and he stated that while he did not believe their radiographers had broken any rules, he stated they reviewed the event with their radiographers and reviewed the posting and access control requirements when conducting radiography. No violations were cited.

File closed

## Incidents Opened Third Quarter 2010

### I - 8769 - Damaged Device Containing Radioactive Material - Chevron Phillips Chemical Company - Borger, Texas

On August 5, 2010, the Agency received a report from the licensee's Radiation Safety Officer (RSO) stating that a nuclear gauge had been separated from its anchor. The RSO stated that maintenance activities were being performed in the area. During the maintenance, the concrete floor holding the gauge mounting bracket was removed for repair thereby removing the gauge from its original mounted location. The RSO responded to the location and locked the shutter in the closed position. The gauge was placed in a storage location. Radiation surveys taken around the gauge indicated dose rates were normal. While conducting an investigation of the incident, the RSO determined that two of the workers had been exposed to the direct beam of the source during this event. Interviews with the workers indicated that the workers had been within two feet of the unshielded source for less than thirty seconds. The deep dose equivalent to the two workers were calculated to be 10 and 31 millirem for the event. The licensee was cited for allowing the dose rate to exceed 2 millirem in any one hour in an unrestricted area.

File closed.

### I - 8770 - Possible Abandoned Radioactive Material - Valley Cardiac Care Center - Brownsville, Texas

On August 12, 2010, the Agency was contacted by one of its inspectors that while attempting to conduct an inspection of a licensee, they discovered it was no longer located at the address listed on the license. The inspector stated that a new company was operating at the address and could not provide any contact information for the old company. The inspector contacted the nuclear pharmacy who provided materials to the licensee and asked if they knew where the radioactive sources could be located. On August 13, 2010, the pharmacy provided information to the inspector accounting for all the radioactive material that had been held by the licensee. The licensee had properly transferred ownership of the material to a licensed entity, but failed to request termination of the license. One violation was cited for failure to terminate their license.

File closed.

### I - 8771 - Gauge Shutter Failure - Albemarle Catalysts LP - Pasadena, Texas

On August 13, 2010, the Agency was notified by the licensee that on July 16, 2010, the shutter on a nuclear gauge containing 100 millicuries (original activity) of Cesium (Cs) - 137 was inoperable. The gauge shutter was stuck in the open position, which is the normal operating position. There was no additional exposure risk to any individual due to the failure. The licensee discontinued the use of the gauge and contacted the manufacturer to schedule the gauge shutter repair. On July 29, 2010, the manufacturer's technician arrived at the plant to repair the gauge. The technician found a build up of corrosion which prevented the gauge shutter from operating properly. The technician advised the licensee that the gauge and source should be replaced due to the corrosion. The gauge was removed from the vessel on July 29, 2010. Shielding was secured over the source and it was placed in storage. No exposures above regulatory limits were received during the source/gauge removal. A leak test of the source was conducted and the results were below regulatory limits. The gauge was returned to the manufacturer for disposal on July 29, 2010. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8772 - Radioactive Material Found - Newell Recycling - San Antonio, Texas

On August 13, 2010, the Agency was notified by the safety officer at a scrap yard in San Antonio, Texas, that a radiation monitor detected radiation on a load of scrap metal. The safety officer stated that the radioactive material had been isolated and a radiological consultant was contacted to determine the radionuclide involved. The consultant identified the radionuclides as plutonium (Pu) - 239, americium (Am) -241, and uranium (U) - 238. An Agency inspector went to the location and identified the radionuclides as being depleted uranium and a metal-thorium alloy. These identifications were supported by spectroscopy from the DSHS Laboratory using a high purity germanium detector. The metal was traced to a scrap yard in El Paso, Texas, where a 1960-era passenger airliner, in which depleted uranium was used as a counterweight, was being dismantled. An Agency inspector conducted surveys of the area, but found no additional radioactive material. The scrap yard in San Antonio arranged for the disposal of the material. No violations were cited.

File closed.

### I - 8773 - Badge Overexposure - Turner Industries Group - Paris, Texas

On August 17, 2010, the Agency was notified by the licensee that a radiographer's badge read 37,064 millirem for the month of July, 2010. The radiographer was sent to a local medical facility to have his blood tested. The test did not indicate any abnormal exposure to radiation. Samples of the individual's blood were sent to Radiation Emergency Assistance Center/Training Site (REAC/TS.) REAC/TS' evaluation indicated no exposure above background had occurred. The licensee has adjusted the radiographer's exposure to 30 millirem for the exposure period based on his pocket dosimeter readings. The licensee believes the badge may have been exposed by another employee, but could not prove it. The licensee has changed its procedures to require the shift supervisor to issue the badges at the start of each shift. No violations were cited.

File closed

### I - 8774 - Therapy Event - Texas Oncology PA - Paris, Texas

On August 19, 2010, the Agency was notified by the registrant that a therapy event had occurred when a technician inadvertently selected the wrong patient's electronic chart and used it to deliver a dose fraction to another patient. A review of the two plans found that the treatment area of the selected plan included the treatment area for the patient treated. The review also found that the patient received 25 centigrays more exposure than was prescribed by the treatment plan. The dose was corrected in the next fraction delivered to the patient. The medical physicist stated there were no critical structures intercepted by the beam used during the treatment in error. The patient and the referring physician were notified of the event. The registrant is adding face photos to the treatment verification system to prevent a recurrence. The technicians involved were counseled on their need for attention to details. No violations were cited.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8775 - Badge Overexposure - Texas Gamma Ray - Pasadena, Texas

On August 23, 2010, the Agency was notified by the licensee that two of its radiographers had exceeded an annual exposure limit. An on-site investigation was conducted by the Agency on September 14, 2010. The licensee's Radiation Safety Officer (RSO) stated that the two individuals terminated their employment with the company on July 20, 2010, and had left their badges in the glove compartment of the company truck that had been assigned to them. The truck was used as a work bench for other radiographers next to the location where test weld samples were examined. The RSO stated that the radiographer trainer had been injured early in the month of June, 2010, and had not worked since. The radiography trainee had been reassigned to a different trainer until he left their employment. The RSO calculated the dose the badges would have received in the truck based on the daily use logs for that location. The licensee determined that the most conservative dose the badges could have received was 3,123 millirem. The Agency calculated the dose to be between 2,762 millirem for a fully shielded source and 44,202 millirem for an unshielded source. The licensee assigned a dose of 832 millirem to both individuals for the two exposure periods using one twelfth of the annual limit per period. A violation for failure to process individual monitoring devices within 14 days after the exchange date was cited.

File closed.

### I - 8776 - Source Leak Test Exceeds Limit - Southwest Research Institute - San Antonio, Texas

On August 24, 2010, the Agency was notified by the licensee that the leak test results for a 12.36 millicurie Nickel (Ni) - 63 source had exceeded the regulatory limit. The source was stored separate from the device it was used in at the time of the survey. Contamination surveys of the source storage drawer were conducted and no contamination was detected. The source was packaged and removed from service. The source will be returned to the manufacturer for disposal. No violations were cited.

File closed.

### I - 8777 - Badge Overexposure - Texas Health Harris Methodist Hospitals - Stephenville, Texas 76401

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## Incidents Opened Third Quarter 2010

### I - 8778 - Gauge Shutter Failure - Cryovac Inc. - Iowa Park, Texas.

On September 3, 2010, the Agency was notified by the licensee that on September 2, 2010, the shutter on a nuclear gauge failed to fully open during a routine maintenance check. The gauge contains a 150 millicurie americium (Am) - 241 source. The gauge shutter was locked closed. The gauge was removed from the vessel and placed in storage. The dose rate measured at three feet from the gauge was 0.4 millirem/hour and the dose rate at 6 inches from the gauge was measured at 11.8 millirem/hour. The manufacturer was contacted and on September 3, 2010, repaired the gauge. The manufacturer's technician found the failure was caused by the shutter roller assembly. The technician replaced the shutter roller assembly with an assembly of a different design and the gauge operated properly. No radiation exposure exceeding regulatory limits was received by any individual during this event. No violations were cited.

File closed.

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

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

File closed.

### I - 8780 - Therapy Event - The Methodist Hospital - Houston, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

## Incidents Opened Third Quarter 2010

### I-8781 - Sources Abandoned Downhole - Schlumberger Technology Corporation - Hockley County, Texas

On September 7, 2010, the Agency was notified by the licensee that it had abandoned a 16 curie Americium - 241 / Beryllium (AmBe) source and a 1.7 curie Cesium (Cs) - 137 source at depths of 10,629 feet and 10,642 feet, respectively. Sources were abandoned September 4, 2010 in the Levelland Unit 108 WD well in Hockley County, Texas in accordance with Railroad Commission's requirements. A 217-foot red dye cement plug was placed above the source. A 7- 7/8 inch tri-cone drill bit was permanently attached to the top of the cement plug to act as a deflection device. A plaque has been ordered for placement at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well the radiation control program contact information. No violations were cited.

File Closed.

### I - 8782 - Source Leak Test Exceeds Limit - Southwest Research Institute - San Antonio, Texas

On September 7, 2010, the Agency was notified by the licensee that a source leak test had exceeded the limit. The source had been previously checked on July 7, 2010, and found to be leaking, but below the level requiring a report to this Agency. The licensee's Radiation Safety Officer (RSO) requested that it be retested and the results of the second test showed an activity of 0.0106 microcuries. The source was sealed in a plastic bag and the storage area was sealed and properly posted. The licensee stated that they plan to decontaminate the drawer where the source had been stored after providing additional training to the individuals who will perform the decontamination. The RSO stated that the source will be shipped to a licensed service provider for repair or disposal. No violations were cited.

File closed.

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

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

File closed.

## Incidents Opened Third Quarter 2010

### I - 8784 - Impersonating a State Employee - Ronald James LeBlanc, Sr. - Orange, Texas

On September 20, 2010, the Agency was notified by a licensee that one of its radiography crews was approached by an individual who identified himself first as an Agency inspector and then as the Radiation Safety Officer for Orange County. The licensee stated that the radiography crew had set up their barricades and was making preparations, but had not yet begun radiographic operations. The individual made statements that the barricades were wrong, told the radiographers that the calibration on the survey meters should be every three months instead of six, and became hostile and began yelling. The individual reached across the barricade and slapped the survey meter off the truck onto the ground. One radiographer notified their main office of the incident. The individual continued to portray himself as a person of authority by asking for the radiographer's state certification card. After the individual left the site, he called the licensee's office. The office manager stated the individual identified himself as the "Orange County RSO" and said there was an x-ray crew that did not have the proper equipment and the licensee needed to do something about it. The licensee stated they did not call local law enforcement because they did not feel the security of the source was compromised. The radiographers identified the individual by a photograph from Agency files. At the time of the incident, the individual held a current radiography certification from the Agency. The individual admitted to an Agency investigator that he had made statements that he was a state inspector and the Orange County Radiation Safety Officer, stating he did so because he observed actions by the radiography crew that he felt posed a serious hazard and he made the claims about his identity to get their attention. The individual's claims concerning the actions of the radiography crew could not be substantiated. No violations were cited against the licensee. One violation was cited against the individual and his industrial radiography certification was revoked.

File closed.

### I - 8785 - Transportation Event - Cardinal Health - Dallas, Texas

On September 21, 2010, the Agency was notified by the licensee that a shipment of eight doses of Fluorine (F) - 18 radiopharmaceuticals had not reached its destination in a reasonable time frame. Several attempts to contact the driver of the truck were unsuccessful. The licensee contacted the highway patrol in an effort to determine if the vehicle had been reported in an accident and found it had not. The licensee retraced the route the driver would have taken to make the delivery. After several hours, the driver contacted the licensee and first stated that he had locked himself out of his van and then stated that he had been struck over the head at a gas station. The radiopharmaceutical was delivered to the customer that afternoon. During the investigation by the licensee, the driver gave conflicting information for the delay in delivery of the F- 18. His employment was terminated. No violations were cited.

File closed.

### I-8786 - Lost Source of Radioactive Material - The Methodist Hospital - Houston, Texas

\* Health and Safety Code Chapter 241.051(d)

One violation was cited.

File Closed.

## Incidents Opened Third Quarter 2010

### I - 8787 - Transportation Violations - Texas Health Harris Methodist Hospital - Fort Worth, Texas

\* Health and Safety Code Chapter 241.051(d)

Two violations were cited against the licensee.

File closed.

### I - 8789 - Lost Source of Radioactive Material - Texas Department of State Health Services - Austin, Texas

On September 17, 2010, a routine, semi-annual leak test and inventory of all licensed sealed sources was performed by the licensee. During the course of the inventory, one 17.5 microcurie sealed cobalt (Co) - 60 source was discovered to be missing. The licensee's Radiation Safety Officer rechecked storage/transportation packages, the room where their radioactive material is stored, the vehicle used to transport the package, and the last location where the source had been used. The source was not found. The procedure for inventorying sources after each use has been modified to prevent a recurrence. No violations were cited.

File closed

### I - 8792 - Radiation Exposure to Member of General Public - Desert Industrial X-Ray LP - Denton, Texas

On September 23, 2010, the Agency was notified by the licensee of an incident involving a member of the public. The licensee reported that while conducting radiography operations at a temporary job site, a non-radiation worker from another contractor received an exposure to radiation when he entered the area where radiography using a 38 curie iridium (Ir) – 192 source was being performed. The licensee stated that two of the licensee's radiographers were performing radiography on a water tower. Access to the work area was limited to the use of a man-lift. The radiographers were not trained to use the man-lift, so one of the contractor's employees used the lift and became responsible for changing out the films. A miscommunication occurred while the source was cranked out causing the non-radiation worker to think that the radiographers had instructed him to retrieve the film. The licensee performed dose calculations for the non-radiation worker, and it was determined that he received a whole body dose of 18 millirem for the exposure. The licensee did not exceed the regulatory exposure limit for a member of the public. However, a member of the general public was exposed to a radiation area that was greater than 2 millirems in any one hour. The licensee was cited for the violation.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010

### 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 - 8695 - Possible Abandoned Radioactive Material - Cav-Tec Inc. - Houston, Texas

On December 17, 2009, an Agency inspector attempted to perform an inspection at the licensee's facility. The inspector found the facility locked and no one responded to the inspector's knocking. Several attempts to contact the licensee via phone messages and a letter failed to get a response from the licensee. On July 27, 2010, an Agency investigator found the cell phone number for the licensee's Radiation Safety Officer and provided it to the regional inspector. The inspector was able to contact the licensee and arranged to perform an inspection of the radioactive material. The inspector found that the radioactive material was adequately stored and protected. Five violations were cited.

File closed.

## Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010

### I - 8703 - Equipment Malfunction - Valero Three Rivers Refinery - Three Rivers, Texas

On January 20, 2010, the Agency was notified by the licensee that while conducting routine operational tests of a Thermo Nuclear Model 5192 level gauge containing a 100 millicurie (original activity) cesium (Cs) – 137 source, dose rates were measured to be greater than 200 millirem per hour (mrem/hr) on the top of the gauge. The initial survey for this device was done in November 1981 and indicated a reading of 40 mrem/hr at the same location on the gauge. The licensee measured the highest dose rate in any area that could be occupied by company personnel at 0.3 mrem/hr. On the ground below the gauge, the dose rate was measured at 0.02 mrem/hr. On January 21, 2010, an Agency inspector performed an onsite investigation of the event. A dose rate survey using a Eberline RO 20 dose rate instrument confirmed the high readings with a dose rate measurement of 120 mrem/hr. Dose rates were less than 0.020 mrem/hr in areas where access was not restricted. The gauge was removed by the manufacturer on April 14, 2010, and replaced with another gauge. The manufacturer performed an inspection of the gauge shielding and found a void in the lead. The manufacturer believes that the void was created during a fire in July of 2001. The manufacturer has seen this type of voiding previously in other gauges, but could not provide any documents to support this statement. The licensee does not believe that the fire caused the void because all surveys conducted by a service company and the licensee after the fire did not show elevated dose rates. A review of the licensee's surveys found that they recorded the highest reading found on the gauge, but did not indicate where on the gauge the reading was taken. The licensee stated that no other event had occurred near the gauge, which could explain the voiding in the gauge shielding. The fire appears to be the only plausible cause for the void in the lead shielding which caused the elevated dose rates. No violations were cited.

File closed.

### I - 8713 - Gauge Shutter Failure - Alcoa World Alumina Atlantic - Point Comfort, Texas

On February 23, 2010, the Agency was notified by the licensee that the operating mechanism for the shutter failed on a Thermo Fisher model 5201 nuclear gauge. The gauge contains a cesium (Cs) – 137 source with an original activity of 100 millicuries. The gauge is normally operated with the shutter in the open position. The licensee stated that the current condition of the gauge poses no additional health risk to any individuals. The gauge is located 10 feet off of the ground, and is accessed using a ladder to a platform. The area has been posted to prevent anyone from performing maintenance in the area. On March 11, 2010, the manufacturer replaced the failed piece and returned the gauge to service. The manufacturer inspected the failed parts and determined that the weld between the shutter operating arm and the shutter block failed due to harsh environmental conditions and age of the gauge. The manufacturer concluded that no design change is warranted. No violations were cited.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

### I - 8717 - Badge Only Exposure - Sealed Air Corp. - Iowa Park, Texas.

On February 24, 2010, the registrant was contacted by a dosimetry processor who informed the registrant of a high (>7 rem) but static exposure--which indicates the badge was stationary at the time of exposure--on a individual's badge. The badge was assigned to an employee that had worked on the process line which utilized a 500 KV industrial radiography device. It was discovered that the employee had dropped his badge underneath the device and, according to the operator log, it was exposed with a voltage of 500 KV and an estimated "dark current" of 200-300 uA. Not knowing of this phenomenon, the technician found his badge and placed it on the badge storage area without reporting the situation to the Radiation Safety Officer (RSO). The RSO changed the company policy to have all lost badge incidents reported and provided employee training on being aware of the presence of radiation when the high voltage is activated on the device even if the beam is set at zero current. No violations were cited.

File closed.

### I - 8722 – Radioactive Material Abandoned – Austin Positron Emission Tomography, LP – Austin, Texas.

On February 22, 2010, the Agency attempted to conduct a routine inspection at a medical imaging center that had apparently closed on December 31, 2009, presumably as a result of filing for bankruptcy. The Agency inspector had arranged to meet the licensee's former technologist at the licensee's only authorized site to perform the inspection. When they arrived, it was determined that a different medical practice, one that does not use radioactive material, occupied the building and that the licensed practice was no longer present. Following this discovery, the property owner requested the Agency return to the facility. A different Agency inspector visited the facility and found that all equipment and furniture had been removed and the entire facility was empty. The area was then surveyed for radiation and no readings above background were detected. Using information provided by the property owner, the Agency was able to determine that the equipment and sources were sold and subsequently moved to a facility in Pennsylvania. The Pennsylvania Bureau of Radiation Protection was notified. They were able to determine that two sources were still in the scanner and the remaining sources were in the possession of an unlicensed imaging equipment provider in their state. Leak tests of all sources verified that none of the sources were leaking. The Texas radioactive material license was terminated. No violations were cited as the legal entity no longer exists.

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

### I - 8724 - Individual Impersonating an Agency Inspector - Goolsby Testing Laboratories Inc. - Humble, Texas

On March 17, 2010, the Agency received a report from a licensee informing them that one of their radiographers working at a temporary job site was approached by an individual impersonating an Agency inspector. The impersonator opened and closed the radiographers truck doors, went into the dark room and looked at various items, and then observed the radiographers perform operations for about one hour from beyond the two millirem barrier ropes and. The impersonator was wearing a jacket with TDH on the back of it. The impersonator did not try to gain access to the source. Based on questions asked and statements made by the impersonator, it appeared that this individual had a working knowledge of radiography. Two informational letters were sent to all radiography licensees reminding them that Agency inspectors carry credentials while performing inspections. The letters reminded radiographers that they are within their rights to ask for these credentials when they are approached by someone attempting to perform an inspection. No violations were cited.

File closed.

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

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

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

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

File closed.

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

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

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

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

File closed.

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

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

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

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

File closed.

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

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

File closed.

## **Incidents Opened in a Previous Quarter and Closed in Third Quarter 2010**

### I - 8757 - Possible Abandoned Radioactive Material - Concept Phoenix Diagnostics LP - Katy, Texas

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

File closed.

## Complaints Opened Third Quarter 2010

### C - 2269 - Laser Registration - Beautiful You Laser Spa - Pharr, Texas

On July 8, 2010, the Agency received a complaint alleging that an unregistered individual was commercially performing laser hair removal at a private residence. The complainant had hearsay information that a person had possibly received minor burns. An on-site investigation was performed by the Agency on July 15, 2010. The investigation revealed that an individual had purchased an intense pulsed light (IPL) /radio frequency (RF) system and an RF cavitation unit through eBay directly from a company in China. Neither of the machines had the required Food and Drug Administration labeling showing they were certified as complying with design, labeling, and manufacturing standards. The individual used the IPL device on a human and was not under the supervision of a practitioner of the healing arts. Following the on-site visit, the individual closed her business and, at a later date, disposed of the devices. The information concerning possible burns could not be substantiated. Two violations were cited.

File closed.

### C - 2270 - Laser Physician Supervision - Rain Skin and Body - Harker Heights, Texas

On July 26, 2010, the Agency received an anonymous complaint concerning a laser hair removal establishment in Harker Heights, TX. The complaint stated that there was inadequate physician supervision of the use of a laser and intense pulsed light device. The complainant alleged that burns had resulted from hair removal and photo rejuvenation procedures. The Agency conducted an on-site investigation on August 11, 2010. The establishment had one Class 4 laser and one intense pulsed light device and both were being used for hair removal and other procedures. The LSO confirmed that he had a contract with a physician. The complaint concerning lack of supervision by a practitioner of the healing arts could not be substantiated. The investigation was unable to substantiate the complaint of burns as a result of the use of the laser on humans. No violations were cited.

File closed.

### C - 2271 - Potential Exposure to Individual - San Benito Animal Hospital - San Benito, Texas

On July 30, 2010, the Agency received an anonymous complaint regarding scatter radiation to employees at a veterinary clinic in San Benito, TX. The complaint alleged that employees' hands could be seen in the outer field/perimeter of the x-rays taken by digital x-ray machine. On September 9, 2010, the Agency conducted an unannounced on-site investigation. A broad sampling of x-rays were inspected and images of human hands holding animals without wearing required protective devices were observed. The investigation also revealed that the owner/veterinarian had purchased the business, including a digital x-ray machine, in July 2010 and had failed to register within 30 days as required. The complaint was substantiated. Two violations were cited.

File closed.

## Complaints Opened Third Quarter 2010

### C - 2272 - Laser Registration - Ideal Image - Austin, Texas

On August 2, 2010, the Agency received a complaint stating that the facility was using lasers for hair removal, but was not registered with the Agency. On August 11, 2010, the Agency performed an unannounced investigation at the facility. It was determined that the facility was not registered with the Agency. The complaint was substantiated. One violation was cited.

File closed.

### C - 2274 - Not Registered for Radiation Generating Device - Clifford J. Breaud, DDS Inc. - Lubbock, Texas

On August 6, 2010, the Agency received a complaint that a dentist was performing x-rays after his registration had been revoked. An Agency inspector performed an inspection at the facility on August 11, 2010. The investigation confirmed that the registration had been revoked, equipment evaluations had not been completed as required, and three additional violations were cited. The complaint was substantiated.

File closed.

### C - 2275 - Regulatory Violations - Gene Gant - Houston, Texas

On August 10, 2010, the Agency received a complaint alleging that a U.S. Food and Drug Administration (FDA) Form 2579 had been fraudulently prepared. The FDA Form 2579 is to be prepared by the person installing a radiation machine, and it is subsequently sent to the Agency. The preliminary investigation determined that an individual who installed the equipment did so without a Certificate of Registration from the Agency as required. The individual was being pursued by the State's Office of the Attorney General (OAG) at that time. Copies of the documents collected were submitted to the OAG and to a representative of the Food and Drug Administration. On October 1, 2010, a determination was made that the x-ray registrant whose machine was installed by an unregistered service provider had violated the rule requiring the use of registered service providers. Therefore, the investigation into this complaint was to be re-opened. On October 25, 2010, the Agency conducted an unannounced investigation at the registrant's facility where the dental machine had been installed. The Agency informed the registrant that the person who installed the equipment was not licensed by the Agency to service x-ray machines. The Agency cited one violation against the registrant for failure to have someone properly licensed by the Agency install the x-ray machine.

File closed.

## Complaints Opened Third Quarter 2010

### C- 2276 - Inadequate Credentialing - Breast Diagnostics of North Texas - Southlake, Texas

On August 19, 2010, the Agency received a complaint alleging that an individual reading mammography films had not read enough mammography images to maintain the required proficiency level. The individual was responsible for reading mammography films at two locations and the complaint stated that the number of readings reported from one of the locations may include readings that are dated during a time frame the individual was out of this country. A meeting was held on August 24, 2010, with a member of the Mammography Accreditation Group and the manager of the Mammography Inspections Group to determine the best course of action for the complaint. During that meeting, it was determined the individual had not been credited with the number of reads needed to perform this duty unsupervised. The individual was able to provide records to the Agency demonstrating the required hours for proficiency had been completed. No violations were cited.

File closed.

### C - 2277 - Response to Public Concern - Various Auto Painters - Dallas and Houston, Texas

On August 3, 2010, the Agency received an allegation referred to them by the Nuclear Regulatory Commission. It was alleged that a device manufactured by the 3M Company containing radioactive material and designed for use in the auto-painting industry was not being properly controlled in automotive shops located in Houston and Dallas. The Agency contacted the complainant for additional information. The complainant could not provide any specific information on the device, but stated that he believed the device had a radioactive sticker on it and therefore, it contained radioactive material. He stated that he was a paint salesman for DuPont Paint for automotive applications and had encountered several instances in the Dallas and Houston areas where he had observed improper storage or disposal of the devices. The complainant was unable to specifically name locations where he had observed the devices. The Agency contacted several individuals at 3M including the Material Safety Data Sheet coordinator and a member of its Regulatory Affairs Group. None of these individuals knew of any devices manufactured by 3M for use in the automotive paint industry that utilized any type of radiation. Several auto dealers in Dallas, Houston, and Austin were contacted and their automotive paint managers were interviewed. None of these individuals knew of any device that had utilized any source of radiation. A search of 3M's automotive paint application web site did not find any reference to the use of any source of radiation in any painting application. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2010

### C - 2278 - Radiation Exposure to Member of General Public - Orange, Texas

On September 7, 2010, the Agency received a complaint from an individual who was concerned that he and his mother were being exposed to radiation from radiography operations being performed on neighboring property. The Agency performed an on-site investigation on September 13, 2010. The inspector found that the residence was located approximately 250 feet from the closest location where radiography had been performed. A review of the daily radiation logs of the radiography company indicated that the 2 millirem boundary never exceeded 70 feet from the work area and never extended past the fence between the two properties. The complaint was not substantiated. No violations were cited.

File closed.

### C - 2279 - Laser Registration - Bella Medical Spa - Marble Falls, Texas

On September 17, 2010, the Agency received a complaint from an individual regarding safety practices of a facility using lasers for hair removal at a medical spa in Marble Falls, Texas. The complainant was contacted for more information. Most of the complainant's concerns were outside the scope of Radiation Control's laser regulations. The complainant was informed that he/she could contact the Texas Medical Board concerning those issues. The complainant also stated that the medical spa may not be registered for its laser. An unannounced on-site investigation was conducted on October 13, 2010. The investigation confirmed that there were Class 4 lasers in use and the facility was not registered with the Agency. The complaint was substantiated. One violation was cited.

File closed.

### C - 2280 - Improper Storage of Radioactive Material - National Inspection Services LLC - Crowley, Texas

On August 20, 2010, the Agency received a complaint from a regional inspector. The inspector stated that several radiographers had informed him that a radiography company may be in violation of regulations because it was allowing technicians to store radiography cameras at their place of residence when working away from the company's main location. An on-site investigation was conducted on September 20, 2010, by the Agency. The licensee stated that the technicians are allowed to store their cameras in their trucks at night at their residences. The technicians are required to survey the outside of the truck to make sure that no exposure limits for members of the public are exceeded. The surveys are completed and documented prior to the technician leaving the job site. A review of these surveys indicated that it would be unlikely that anyone would receive more than 2 millirem in any one hour, or greater than 100 millirem in a year from this practice. The licensee stated that the current program would be changed to better track the times and locations of the cameras when not located in the normal storage location. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened Third Quarter 2010

### C - 2281 Thorium Oxide for Experiments - Conscious Alchemy, LLC - Spring, TX

On September 28, 2010, the Agency received a call from a distribution company reporting that a customer using a health company name who had previously ordered 250 grams of thorium oxide, a general license product, was now ordering an additional kilogram. The distribution company was concerned that the customer may be using the material in health products. After contacting the customer, it was determined that the powder was used to coat material on a metallic substrate for experiments related to a fuel economy invention. The customer did not expect to need any additional thorium oxide for experiments. The complaint was not substantiated. No violations were cited.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

\* Health and Safety Code Chapter 241.051(d)

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 - 2235 - Regulation Violations - Ruiz Testing, Inc. - San Antonio, Texas.

On December 18, 2009, the Agency received an anonymous complaint alleging that the licensee was allowing radiography to be performed by unqualified personnel. The complainant also alleged that sources were being transported in vehicles without operational alarm systems and in unlocked transport cases. The allegation contained the names of individuals conducting radiography operations. A search of the Agency's database found that two were trainees, one was certified by another state and had received reciprocity from the State of Texas, and the remaining individuals were certified by Texas as radiographers. An on-site inspection by the Agency found that the radiography cameras and crank out devices showed signs of use but were in good working order. The drive cables were flexible and the connectors appeared in good condition. A review of five months of the licensee's records did not reveal any instance where the radiography crews did not hold the credentialing required to perform radiography. Maintenance records indicated that cameras and support equipment were conducted in a timely manner and were satisfactory. The licensee did possess one new radiography truck, which did not have an installed alarm system, but interviews conducted with the radiation safety officer and two radiographers indicated the truck had not been used for transporting sources. Interviews also indicated that they were knowledgeable on the requirements for transporting sources using the truck without alarms if it became necessary. The complaint was not substantiated.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010**

### C - 2237 - Regulation Violations - Gulf Coast Cancer Center - Houston, Texas

On November 17, 2009, the Agency received a phone call from an anonymous caller who filed a complaint against the licensee/registrant. The complainant provided an email containing allegations and locations where the violations were allegedly committed or existed. The Agency conducted unannounced onsite investigations at all of the license and registration authorized sites involved in the complaint. Several violations were cited for deficiencies under the certificates of registration, but no violations involving radioactive material use were observed. Some allegations of violations of their certificate of registration were substantiated, but no allegations pertaining to radioactive material use were substantiated.

File closed.

### C - 2238 - Regulatory Violations - One Step Diagnostic - Houston, Texas.

On November 17, 2009, the Agency received a phone call from an anonymous caller who filed a complaint against the licensee/registrant. The complainant provided an email containing allegations and locations where the violations were allegedly committed or existed. The Agency conducted unannounced onsite investigations at all of the license and registration authorized sites involved in the complaint. The investigation did not produce any evidence to substantiate the complaint. No violations were cited.

File closed.

### C - 2242 - Unregistered Laser - Skin by Ann Webb - Austin, Texas

On February 11, 2010, the Agency received an email from an individual who alleged that her previous employer was performing laser hair removal and may not be registered with the Agency. The individual stated that the employer did not post signs in areas where lasers were being used and that the individuals operating the intense pulsed light device had not been trained to use it. An on-site investigation conducted by the Agency found that the facility was not registered with this Agency. The investigation also found that the rooms utilizing lasers were not posted with the required signs, the inspections of safety glasses had not been documented, and none of the applications of lasers to humans had been supervised by a licensed practitioner of the healing arts. A total of six violations were cited. The complaint was substantiated.

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010**

### C - 2244 - Uncredentialed Technologists - Sherman Medical - Sherman, Texas

On February 25, 2010, the Agency received a call from an individual who stated that the registrant was allowing x-ray devices to be operated by uncredentialed individuals. An Agency inspector performed an inspection at the facility on April 14, 2010. The inspector found that three individuals who operated x-ray equipment were not credentialed. The registrant was cited for the violation. The complaint was substantiated.

File closed.

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

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

File closed.

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

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

File Closed.

## Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010

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

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

File closed.

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

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

File closed.

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

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

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

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

File closed.

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

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

File closed.

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

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

File closed.

## **Complaints Opened in a Previous Quarter and Closed in Third Quarter 2010**

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

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

File closed.

### C - 2265 - Burns Caused By Medical Device - Prevention First PA - Dallas, Texas

On February 9, 2010, the Agency was contacted by an individual who stated that she had received multiple burns to her legs, an arm, and face during a thermage treatment in a Dallas, Texas doctor's office. It was determined that this Agency does not have any regulatory authority over this type of device. The complaint was referred to the Agency's drugs and medical devices group and the Texas Medical Board for further investigation. No violations were cited.

File closed.

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

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

File closed.

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

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

File closed.