



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

Prepared by:
Art Tucker, Ray Jisha, and Annie Backhaus

Texas Department of State Health Services
Regulatory Services Division
Inspections Unit
Radiation Branch

* 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 Fourth Quarter 2009

I - 8675 - Failure Of Gauge Shutter - Chevron Phillips Chemical Company - Borger, Texas

On October 1, 2009, the Agency was notified by the licensee's Radiation Safety Officer (RSO) that while conducting a routine shutter check on an Ohmart/Vega Corp. SHF1 nuclear gauge containing 20 millicuries of cesium (Cs) – 137, the shutter failed to close. The RSO stated that the gauge had been installed on the side of the vessel in June 2009. He stated that the gauge was stuck open in the normal operating position and a radiation survey conducted in the area indicated that dose rates were normal. He stated that there was no other damage to the gauge. The manufacturer was contacted and scheduled to perform repairs and training on October 21, 2009. An on-site investigation was done on October 22, 2009, by the Agency. The investigation found that the gauge had been repaired by the manufacturer on October 20, 2009, and was operating properly. The cause for the failure was determined to be a build up of debris that had accumulated during the repairs done to a chute located above the gauge. The RSO stated that a protective device would be installed over the gauge to prevent a recurrence of this event. No violations were cited.

File closed.

I - 8676 - Wrong Body Part Treated With External Beam - Mayhill Cancer Center, dba Denton Regional Radiation Oncology - Denton, Texas

On October 1, 2009, the Agency was notified by the registrant that a patient had received 13 of 25 fractions from a linear accelerator external beam radiation treatment delivered to the wrong site before the error was caught. The patient had undergone biopsies on the same day. However, the pathology report erroneously read that one site (Site-A) contained cancer while the lesion in the other site (Site-B) was benign. The therapist read the mislabeled report and noted a recent scar on Site-A and mistook it for the area requiring treatment. Because of the simulation and scar on Site-A, the dosimetrist was led to believe that the intent was to treat Site-A (which was actually benign), so the plan was developed for the wrong site. Treatment began on September 15, 2009, and was continued until the error was caught on October 1, 2009. By that time, the patient had received 13 fractions of 180 centigray for a total of 2,340 centigray to Site-A. The event was reported to the patient and referring physician and a number of policies and procedures were developed to prevent recurrence. As the event was reported in a timely manner, no violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8677 - Lost Neutron Generators - Hotwell US LTD - Houston, Texas

On June 29, 2009, the licensee received a new shipment of two tritium well logging tools from their manufacturer in Austria. The tools each contain a 1.8 curie tritium (hydrogen-3) sealed source inside a 15,000 psi pressure housing. These tools were slated for sale and delivery to a wireline company out of Billings, Montana. After arriving at the facility in Houston, the tools were checked and shipped via common carrier to the wireline company. One tool arrived on July 1, 2009. On July 6, 2009, the wireline company verified to the licensee that the other tool had been received. On October 13, 2009 the wireline company reported to the licensee that after a general inventory of equipment, they could not locate one of the tools. The licensee alleged that the common carrier never delivered the tool and found that the package containing the tool was last tracked to Memphis, Tennessee. On October 19, 2009, the licensee notified the Agency via telephone that the tools had been found at the common carrier's warehouse in Salt Lake City, Utah. The tools were shipped to the wireline company in Billings, Montana, from the warehouse on October 21, 2009, and their arrival was confirmed by the common carrier on October 22, 2009. No violations were cited.

File closed.

I - 8678 - Source Disconnect - Fugro Consultants Inc. - Pasadena, Texas

On October 15, 2009, the Agency was notified that on October 14, 2009, a radiography licensee experienced a source disconnect with radiography camera while working at a temporary field site. It was stated that the radiographers failed to connect the source tube to the exposure device prior to making an exposure. This presumably allowed the source to be pushed out onto the ground against the wall of a shooting bay. This action caused the source to disconnect. When the radiographer retracted the drive cable, the source was left loose on the ground. The employees then secured the area and notified the Radiation Safety Officer (RSO) who is also specifically authorized on the license for source retrieval. The RSO developed a strategy to reconnect the source and then successfully crank it back into the exposure device. No one involved with this event received an exposure exceeding any regulatory limit. The root cause was determined to be failure of the employees to follow company procedures and they were immediately retrained on the proper protocol. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8679 - Two Sources Lost In Transport - ThruBit - Houston, Texas

On October 16, 2009, the Agency was notified by the licensee that a 1.78 curie cesium (Cs) - 137 source, and a 10.8 millicurie californium (Cf) -252 source were lost in transport. The sources were picked up by a common carrier on October 14, 2009, for delivery to the licensee's facility in Oklahoma City, Oklahoma. At 1600 hours on October 15, 2009, the licensee was informed by the transport company that the sources had not arrived in Oklahoma City. The licensee's Radiation Safety Officer (RSO) contacted the transport company and was informed that they believed the sources had been placed on a truck going to Albuquerque, New Mexico. At about 0300 hours on October 16, 2009, the licensee was notified that the sources were not on the truck which had arrived in Albuquerque. The transport company stated that they would contact all of their facilities and have them look for the packages. The licensee's RSO went to the transport companies facility in Houston, Texas, and searched for the packages, but did not find them. On October 16, 2009, at 1715 hours, the licensee contacted the Agency and informed them that the two sources had been located at the transport company facility in Kansas City, Missouri. The transport company delivered the sources to the licensee's facility in Oklahoma City, Oklahoma, on October 17, 2009. The RSO stated that they are going to use point to point shippers in the future. No violations were cited.

File closed.

I-8680 - Outer Surface Contamination of Package - University of Texas - Port Aransas, Texas

On October 21, 2009, the Agency received a telephone call from the Radiation Safety Officer (RSO) for the licensee. The RSO stated that a package had arrived at their facility in Port Aransas, Texas, and was found to have removable contamination on the outside of the package. The package was shipped as an excepted package and contained vials of sulfur – 35, and did not appear to be damaged. No contamination was detected on personnel involved at the receiving facility. The RSO was not convinced that the contamination came from the package because none of the vials appeared damaged, and the highest contamination levels were located on the outside of the package. It was later determined that the elevated counts in the sample container were a result of chemical contamination resulting in phosphorescence. All samples were at background levels the following day. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I-8681 - Possession of Radioactive Material without Authorization - Gulf Stream Fuels - Bay City, Texas

On October 27, 2009, the Agency received a General License Acknowledgement Self-Evaluation (GLA) Form with the licensee's name marked out in pencil, and a different company name written in above it. Further investigation revealed that the new company entered on the form is not licensed in the State of Texas. A discussion with the current owner of the company representative confirmed this. The company was informed that a permit is required to properly possess the material in Texas. The company did not feel obligated to adhere to this requirement stating that they were in the process of selling the facility. The company was cited for the violation.

File closed.

I - 8682 - Badge Overexposure - GE Healthcare - Pewaukee

On October 30, 2009, the licensee notified the Agency that it had received a phone call from its dosimetry processor informing it that one of their worker's badge read 86,863 millirem for the exposure period of July 1, 2009, to September 1, 2009. The licensee sent a sample of the worker's blood to Radiation Emergency Assistance Center/Training Site (REAC/TS) for analysis. The analysis results were reported as "no statistical difference from background." The worker reviewed his work log for the time period and reported that while setting up a new computed tomography (CT) machine, he had left his dosimeter in his computer bag near the CT table during over 400 scans. The licensee has assigned a dose of "M" for the period which is an average of the last three exposure periods readings. The worker and his manager have received additional instruction on the proper use of personal dosimetry. No violations were cited.

File closed.

I - 8683 - Stuck Gauge Shutter - Ticona Polymers Inc - Bishop, Texas

On October 30, 2009, the Agency was notified by the licensee that a stuck shutter was found during a routine inspection on September 22, 2009. The gauge was stuck in the open position, which is the normal operating position for this gauge. Dose rates in the area were measured and found to be normal. The gauge is a Thermo Fisher model SH-F2 containing 100 millicuries of cesium (Cs) - 137. The gauge is installed on the side of a vessel and does not pose any additional risk to the workers. The licensee contacted the manufacturer to schedule the repair of the shutter. The manufacturer evaluated the gauge and decided that his model was not appropriate for the operating environment. The licensee replaced the gauge with a model designed to withstand the operating environment. The licensee received a notice of violation for failure to report the stuck shutter within the required time frame.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8684 - Shutter Failure - All Star Metals LLC - Brownsville, Texas

On November 2, 2009, the Agency was notified of an event that occurred on October 28, 2009. The licensee submitted its notification to the Agency on October 29, 2009, but it was not received until November 2, 2009. The licensee stated that the shutter on its Thermo NITON gauge that houses a 30 millicurie americium (Am) -241 source failed to properly operate. The licensee stated that the shutter would not open and sent the gauge to the manufacturer. After testing by the manufacturer, it was determined that the gauge suffered an impact that triggered the internal shock sensor, and would not allow the shutter to properly operate. There were no unintended doses to personnel because the shutter would not open to expose the source. The radiation safety officer has received a quote for the repair of the shutter from the manufacturer and it is under consideration by their management.

File closed.

I - 8685 - Shutter Failure -Valero Three Rivers Refinery - Three Rivers, Texas

On November 6, 2009, the Agency was notified that the shutter on a Ronan Engineering level gauge containing 2,000 millicuries of cesium (Cs) - 137 failed to operate properly. The gauge is installed on the top of a vessel that is 16 feet high. The vessel had been taken out of service and the licensee's Radiation Safety Officer (RSO) went to the location to perform a shutter operation check. He found that the shutter could not be fully closed. Dose rates in the area were normal. The RSO's investigation found that as many as four individuals may have entered the vessel while the gauge shutter was not fully closed. A dose rate survey taken between the gauge and the vessel indicated that the dose rates were 150 millirem per hour. Dose calculations for those who had entered the vessel indicated that the maximum exposure any of them could have received was 3.75 millirem. The Agency performed an on-site investigation of the event on January 21, 2010. The inspector found that the dose estimates were based on sound health physics principles. No violations were cited.

File closed.

I - 8686 - Stolen\Found Moisture\Density Gauge - Troxler Electronic Laboratory - Arlington, Texas

On November 4, 2009, while conducting a routine inspection, an Agency inspector found that a Troxler moisture/density gauge was lost during shipment and returned to the licensee the next day, intact and with no damage. Neither the licensee nor the shipper had notified the agency of the event. Both believed that it was not reportable since there was no chance that someone could have received an exposure from it and it was lost for only one day. The licensee also believed that the shipper would be required to make any required notifications. The Agency's investigation revealed that this event did not actually meet reporting criteria. The licensee was informed that it would be its responsibility to notify the agency of any reportable events that occur under its license. No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8687 - Source Retrieval - Wilson Inspection X-ray Services, Inc - Corpus Christi, Texas

On November 10, 2009, an Agency inspector discovered what was thought to be a documented source retrieval incident that should have been reported to the Agency within 24 hours. The inspector reported that the licensee's Radiation Safety Officer (RSO) had to retrieve a source that was stuck out of a radiography camera. Upon further investigation, on November 10, 2009, it was discovered that while performing routine field audits, the RSO lubricated the locking mechanism that was sticking and the radiographers continued to work. The source never stuck out in an unshielded position during the audit. No violations were cited.

File closed.

I - 8688 - Radioactive Material Found in Bar Ditch - Houston, Texas

On November 16, 2009, an Agency inspector reported that an individual had found an object in a bar ditch which the individual stated was labeled as uranium (U) - 235. The inspector retrieved the object. The object was sent to the Agency's main office on November 19, 2009. The object appears to be a weight and is labeled as containing depleted uranium. The manufacturer is also stamped on the object. An isotopic identification was conducted and the radionuclide was identified as shielded uranium. A search for the manufacturer found that they had gone out of business in the 1980s. The object is being stored at the Agency's down hole storage facility in Austin awaiting disposal. No violations were cited.

File closed.

I - 8689 - Lost Gas Chromatograph Source - Celanese, LTD - Pasadena, Texas.

On October 26, 2009, the licensee was performing leak tests and an inventory of licensed sources when it became apparent that a 15 millicurie nickel (Ni) - 63 source housed in a gas chromatograph was not in the location indicated on the source inventory list. A subsequent investigation revealed that, when three laboratory instruments were sent offsite for metal recovery, only three of the four sources contained were removed. By the time of the recovery and after contacting the scrap vendor, it was presumed that the parts including the source were sorted for recycling and melted as part of the metal recovery process. The licensee has modified their procedures to include more restrictive physical and administrative controls along with additional training. No personnel or public exposures occurred so no violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8690 - Possible Lost Source - Howard College Big Spring Campus - Big Spring, Texas

On November 19, 2009, the agency was notified by a service provider that he was contracted to conduct radiation surveys at a college in Big Spring, Texas. It was reported that a retired professor had buried a radiation source at the college in the late 60's. The service provider conducted radiological surveys of the site, which is now occupied by a building. He said the brick on the building yielded increased background readings to about 18 microrem per hour. He made extensive surveys, but found no readings that were significantly above background and posed no exposure risk to anyone. It was reported that the source was obtained by the professor at the time from a former teacher at a science fair in the early 60's and was never used. The service provider stated that there are no records of the source at the college. A copy of the report generated by the service provider was given to the Agency. No violations were cited.

File closed.

I - 8691 - Abandoned Sources - Weatherford International Inc. - Nueces County, Texas

On November 5, 2009, the Agency was notified by the licensee that a 19 curie americium / beryllium (AmBe) - 241 source at a depth of 8,593 feet and a 2 curie cesium (Cs) - 137 source at a depth of 8,604 feet, were abandoned downhole in a well in Nueces County, Texas. Two attempts to retrieve the sources had failed. A plug of 66 feet of red dye cement (RDC) and a whipstock device were placed immediately above the sources. An additional 20 feet of RDC was placed above the whipstock. A cast iron bridge plug was then placed above this followed by an additional 63 feet of cement. The radioactive sources were abandoned according to Railroad Commission regulations. A plaque has been/will be mounted at the well head as a warning that radioactive sources are abandoned in the well and to provide persons reentering the well the radiation control program contact information. No violations were cited.

File closed.

I - 8692 - Badge Overexposure - Longview Regional Medical Center - Longview, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8693 - Stolen Moisture/Density Gauge - H.H. Holmes Testing Laboratory Inc. - Houston, Texas

On December 16, 2009, the Agency was notified that sometime during the previous night, a company truck containing a Humboldt model 5001 EZ moisture/density gauge was stolen from an employee's home. Local law enforcement was notified of the event. On December 21, 2009, the licensee was notified by the Harris County Sheriff's office that the gauge and truck had been found. The gauge was still triple locked to the bed of the truck. No violations were cited.

File closed.

I - 8694 - Radioactive Material Found - CALTEX Holdings - Houston, Texas

On December 17, 2009, the Agency was notified that scrap metal from the decommissioning of paper mill buildings alarmed the gate monitor at a scrap yard. The Agency performed an on-site inspection on December 21, 2009. The inspector determined that the material to be low level naturally occurring radioactive material, radon-226 and progeny. The material was recycled in accordance with applicable regulations. 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 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 Fourth Quarter 2009

I - 8697 - Medical Event - Spohn Hospital - Corpus Christi, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

I - 8698 - Misadministration - Wrong Patient Treated - Memorial Hermann Southwest Hospital - Houston, Texas.

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Incidents Opened Fourth Quarter 2009

I - 8700 - Overexposure - IRIS NDT Inc. - Deer Park, Texas

On November 15, 2009, the Agency was notified by the licensee of an event that occurred while radiography operations were being conducted at a facility in Ingleside, Texas. They had set up their boundaries and had walked the area with the facility personnel to ensure that no individuals were working in the area where the radiography would occur. An announcement was made over the company intercom system for all workers to stay clear of the area set up for radiography. Three minutes into the third seven minute shot, a radiographer noticed an individual exiting a portable trailer inside of the barricades approximately 15 feet from the source. The radiographer immediately went to the camera and cranked the source back to the shielded position. An investigation into the event determined that two individuals had been located inside the trailer during radiography awaiting job assignments. Their trailer was attached to a truck that was running. The personnel in the trailer stated that the engine noise prevented them from hearing the intercom announcement to leave the area. They also stated they did not have a radio in the trailer to hear the announcement. A reenactment of the event was done using OSL badges to record the dose to each of the individuals. The total exposure time for the individuals was also determined. The dose to the individuals was assessed at 25 millirem and 15 millirem. Neither individual exceeded the total exposure limit, but both exceeded the limit of 2 millirems in any hour. An investigation into the event revealed that the licensee's personnel inspected the cab of the truck, but failed to check the trailer. To prevent a recurrence, all personnel entering the facility in Ingleside will be issued a two-way radio, and procedure changes were made to the permit and operating procedures at the facility. The licensee was cited for the violation.

File closed.

Complaints Opened Fourth Quarter 2009

C - 2221 - Unsafe Operation of Computerized Tomography Machine - Prime Diagnostic - Fort Worth, Texas

On October 7, 2009, the Agency received an anonymous phone call alleging that the registrant was not operating its computerized tomography machine in a safe manner. The complainant stated that they were a tenant in the same location, but did not offer any specific information to support the accusation. The facility had been inspected by an Agency inspector on March 17, 2006, after a similar complaint was filed, and a routine inspection was conducted on March 26, 2009. Neither inspection found violations involving the operation of the computerized tomography machine. No additional inspections are warranted. No violations were cited.

File closed.

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

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

File closed.

C - 2223 - Machine Inspections Overdue - Various Registrants - Various Locations

On October 28, 2009, the Agency received a complaint from a registrant during an enforcement conference. The complainant stated that other than him, there are seven veterinarians in his family and they all have x-ray machines. He stated that they are all properly registered with the Agency, but none of them have ever had their machines inspected by the Agency. During a phone interview on December 16, 2010, he would not provide the names of the veterinarians. An initial search on the Texas Board of Veterinary Medical Examiners yielded only one other veterinarian with the same last name as the complainant. On March 10, 2010, an Agency inspector performed an unannounced investigation of the one known sibling of the complainant. The complaint was substantiated because a sibling was found that was not registered with the Agency and therefore had never been inspected by the Agency. Four violations were cited.

File closed.

Complaints Opened Fourth Quarter 2009

C - 2225 - Unregistered X-Ray Device - Onsite Health - Austin, Texas

On October 28, 2009, the Agency received an anonymous complaint alleging that a company was providing dental x-ray services and were not registered with the Agency. The complaint also stated that the "lab" does not have the required shielding. An on-site investigation conducted on November 6, 2009, found that the company was not registered in the State of Texas to provide dental x-rays. The facility does not perform x-rays of any type, but did provided mobile x-ray services. The company filed for registration with the Agency on November 10, 2009. One violation was cited for the failure to register.

File closed.

C - 2226 - Uncredentialed Technologist - Texas Tech University Health Sciences - Lubbock, Texas

On November 2, 2009, the Agency received an anonymous complaint alleging that the registrant is allowing a Licensed Vocational Nurse (LVN) to perform fluoroscopic procedures without being properly credential. The complainant stated that there is no radiation technologist employed at the site, and the LVN administers the fluoroscopic exposures. On November 17, 2009, an Agency inspector conducted an on-site investigation. The inspector was unable to substantiate the complaint. No violations were cited.

File closed.

C - 2227 Regulatory Violations - Stork Testing and Metallurgical Consultants - Houston, Texas

On October 14, 2009, the Agency received a complaint alleging that the licensee was using unsafe equipment in the field as well as storing radioactive material in locations not authorized by its license. An on-site investigation was conducted on November 13, 2009. Two Agency inspectors reviewed maintenance records and operating records. No discrepancies were noted. Two radiographers were interviewed. Both stated that they had never used or been asked to use unsafe equipment. Two radiography cameras and two crank out devices were inspected. Both were in good working order with little visible wear on the connectors. All radioactive material listed on the license was accounted for at this location. The complaint was not substantiated. No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2009

C - 2228- Uncredentialed Technicians - Valley Day and Night Clinic - Laredo, Texas

On October 16, 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 registrant stated that it 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 its facilities. The registrant was cited for the violation.

File closed.

C - 2229 - Contaminated Pipe - Springtown, Texas

On November 6, 2009, the incident investigation program received a telephone call from a complainant stating that there was some radioactive pipe from an old barn in a residential area in Springtown, Texas. The complainant stated that he believes the property manager improperly disposed of the waste, after it was rejected at a scrap metal yard. On December 7, 2009, an Agency inspector performed a survey of the pipe and did not measure any radiation higher than background. No violations were cited.

File closed.

C - 2230 - Regulation Violations - Community Portable X-ray Inc. - San Antonio, Texas

On October 4, 2009, the Agency received an anonymous report that the registrant was storing portable x-ray trucks and were providing mobile x-ray services at a location not listed on their license. On October 19, 2009, an Agency inspector performed an on-site investigation at the location. She talked with the storage facility manager who stated that people were observed taking and returning the registrant's trucks from this location. The inspector was provided a copy of a portion of the rental agreement. The business address for the registrant given on the agreement is in San Antonio, Texas. The complaint was substantiated. The registrant was cited for the violation.

File closed.

Complaints Opened Fourth Quarter 2009

C - 2231 - Unreported Misadministration - Spohn Hospital - Corpus Christi, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

C - 2232 - Regulation Violations - Conam Inspections & Engineering Inc. - Pasadena, Texas.

On December 3, 2009, the Agency received a phone call from a former employee of the licensee. The individual stated that she terminated employment with the licensee on January 26, 2008, but is still getting calls from the security service for the licensee when an alarm occurs at the location where the sources are stored. An on-site investigation was conducted by the Agency on January 28, 2010. The Radiation Safety Officer (RSO) provided documents showing that the complainant was not listed on the contact list provided to the company providing security services during the time stated by the complainant. The RSO stated that they had problems with the previous security company and had signed a contract with a new company on December 3, 2009. The complainant is not on that call list either. The RSO stated that he did not know why the alarm company would have called the complainant unless she had instructed them to do so since she was the daughter of the previous owner. The complaint could not be substantiated. No violations were cited.

File closed.

C - 2233 - Failure to Give Notice of Reciprocity - Unknown Licensee - Decatur, Texas

On December 8, 2009, the Agency received an anonymous complaint from an industrial radiographer in Texas complaining that an unmarked radiography vehicle from Oklahoma was seen performing work in the state of Texas without notice of reciprocity. The inspector stated that the complainant told him they were currently not working and were staying at a hotel in Decatur. The inspector agreed to investigate and determine if they have reciprocity with the state. That same day, the inspector attempted to locate the radiographers at the hotel named by the complainant, but was unable to locate the radiographers. No violations were cited.

Complaints Opened Fourth Quarter 2009

C - 2234 -Uncredentialed Technicians - Diagnostic Outpatient Imaging Partnership - El Paso, Texas

On December 18, 2009, the agency received a complaint alleging that the registrant was allowing uncredentialed technicians to perform mammogram studies. On January 8, 2010, an Agency inspector performed an on-site investigation of the complaint. The inspector found that individuals who were performing mammogram studies were properly credentialed. The complaint could not be substantiated. No violations were cited.

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.

C - 2236 - Uncredentialed Technicians - Bowie Memorial Hospital - Bowie, Texas

* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

Complaints Opened Fourth Quarter 2009

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 on-site 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.

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

I - 8536 - Contamination Found in Uncontrolled Area - Lufthansa Cargo, Dallas, Texas

On August 18, 2008, the Agency was notified by the facility that United States Customs Agents had found radioactive contamination on the floor of a warehouse facility. The contamination was found at a location where a package that had been shipped to Germany had been sitting. The radioisotope was determined to be iridium (Ir) -192. The package was surveyed in Germany after it arrived and found to be free of contamination. The truck used to transport the package from Houston, Texas, to the facility was surveyed by an Agency inspector and found to be contaminated with Ir - 192 also. The truck was taken to a facility which held a radioactive material license in the State of Texas. The facility hired a contractor to decontaminate the affected areas. The areas were located in an area of approximately 400 square feet. There were several contract issues which slowed the decontamination progress. The facility was completely decontaminated and all radioactive material removed on August 27, 2009. On June 10, 2009, a survey of the trailer did not find any contamination and the trailer was released. The source of contamination could not be determined. The licensee is now conducting two independent physical inspections of all packages received at their facility. Customs and Border Protection now performs radiation and radionuclide identification surveys of all packages received at this facility. No violations were cited.

File closed.

Incidents Opened in a Previous Quarter and Closed in Fourth 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.

Incidents Opened in a Previous Quarter and Closed in Fourth 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 mR, 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.

Incidents Opened in a Previous Quarter and Closed in Fourth 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 - 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 an Agency 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 in a Previous Quarter and Closed in Fourth 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 - 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.

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

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.

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 - 8674 - Eye 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 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 in a Previous Quarter and Closed in Fourth Quarter 2009

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 - 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.

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

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 2009. The complaint could not be substantiated. The licensee was cited for two violations.

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, an Agency 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 - 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 in a Previous Quarter and Closed in Fourth Quarter 2009

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 in a Previous Quarter and Closed in Fourth Quarter 2009

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.

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.