



**INCIDENT AND COMPLAINT SUMMARIES  
FOR THE  
FOURTH 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  
4th Quarter 2010**

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## Incidents Opened Fourth Quarter 2010

### I - 8790 - Medical Event - Baylor Radiosurgery Center - Dallas, Texas

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 8791 - Regulatory Violation - Nyla C. Gordon, D.D.S - Brownsville, Texas

On October 7, 2010, the Agency received notice from its remote inspection group that a registrant may have fraudulently prepared documents that were submitted to the Agency for an equipment performance evaluation (EPE) on a dental x-ray unit. An investigation of the service provider who performed the EPE was conducted by the Agency on November 5, 2010. An on-site investigation of the dental office was conducted by the Agency on November 16, 2010. Dates on the EPE documents appeared to have been altered to bring the dental office in compliance with Agency regulations. The dental office stated the changes had been made because the service provider wrote the wrong date on the forms. The investigation could not confirm that the documents had been fraudulently prepared. However, the service provider was cited one violation for failing to maintain records of calibration of radiation detection equipment for inspections.

File closed.

### I - 8793 - Transportation Violation - Panhandle Nuclear Rx - Amarillo, Texas

On October 1, 2010, the Agency was notified that the receipt survey of a package received at a Texas hospital exceeded the limits for removable contamination on the external surface. The package had been shipped to the hospital by a nuclear pharmacy licensed by the State of Texas. An on-site investigation was conducted by the Agency on October 7, 2010. The investigation revealed that the nuclear pharmacy technician had packaged and surveyed a shipment of single units for shipment to the hospital and then he drew a bulk sample from a molybdenum generator for the pharmacist. He inadvertently contaminated his left glove while drawing the sample. The technician then picked up the package and transported it to the hospital while still wearing the same gloves he had worn to obtain the bulk sample. This resulted in contamination of the package. The technician waited at the hospital until the package receipt survey was completed. The hospital identified the contamination during the receipt survey and advised the technician. The technician returned to his facility and performed a contamination survey and found his left hand contaminated. He washed his hands and the contamination level of his left hand was significantly reduced, but still above free release limits. The technician's hand was placed in a glove until the radioactive material decayed to less than detectible levels later that same day. A small amount of contamination was found on the steering wheel of the delivery vehicle when surveyed by the licensee; it was decontaminated. The technician's finger ring dosimeter was sent off for processing and the results were 1,538 millirem to his right hand and 1,843 millirem to his left hand. The licensee retrained the technician in contamination control and the proper procedures for handling radioactive material including leaving an area after handling radioactive material. The licensee was cited for the contamination event.

File closed.

## Incidents Opened Fourth Quarter 2010

### I - 8794 - Gauge Shutter Failure - International Paper Company - Queen City, Texas

On October 21, 2010, the Agency received a "Notice of Reciprocity" from an out-of-state licensee. The notice stated that the out-of-state licensee was replacing two "stuck shutters" for one of the Agency's licensees. The Agency contacted its licensee. The licensee stated that one shutter had failed in the closed position on October 20, 2010. The licensee stated the second shutter scheduled to be repaired had not failed, but it was found to be difficult to operate and the licensee opted to have it replaced along with the shutter that did fail. Repairs were made to the shutters on October 22, 2010. The licensee provided additional training for staff on the performance of routine gauge inspections and shutter checks as corrective action. No violations were cited.

File closed.

### I - 8795 - Gauge Shutter Failure - Ticona Polymers, Inc. - Bishop, Texas

On October 25, 2010, the licensee was locking one of its fixed gauges out of service when it discovered that the gauge shutter was stuck in a partially open position. The gauge was an Ohmart Vega model SH-F2-45 gauge containing 0.06 curies of cesium (Cs) - 137. The licensee reported that there was no risk of additional exposures to any personnel. A service provider repaired the gauge shutter on October 26, 2010. The service provider stated that the cause for the failure was excessive build up of bird droppings on the shutter operating mechanism which clogged the mechanism. The licensee stated that they were working with the manufacturer to determine an appropriate action to prevent a recurrence of the problem. No violations were cited.

File closed.

### I - 8796 - Transportation Event - FedEx Express - El Paso, Texas

On November 9, 2010, the Agency received a notification from the Radiation Safety Officer (RSO) for a shipper of radioactive materials. The RSO stated that a package received at a nuclear pharmacy in El Paso (Licensee-A) had been crushed during delivery and contamination was found inside the package. The package was originally delivered to another Texas licensee (Licensee-B) on November 6, 2010. According to the courier, the outer package did not appear damaged when it was delivered to Licensee-B. The Type A package contained two indium (In) – 111 vials with a total activity of 10.63 millicuries at the time of shipment on November 5, 2010. During transit, the package had been crushed and one of the vials of In-111 broke inside its thin-walled lead pig. Upon receipt by Licensee-B, a removable contamination survey of the outside of the package was performed and no removable contamination was detected. The package was rejected by Licensee-B and returned to Licensee-A. The transport vehicle was surveyed for removable contamination, but none was detected. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2010

### I - 8797 - Radioactive Material Identified At Landfill - Christus Santa Rosa Hospital, San Antonio, Texas.

\* Health and Safety Code Chapter 241.051(d)

No violations were cited.

File closed.

### I - 8798 - Radiography Source Disconnect - Team Industrial Services - Alvin, Texas

On November 22, 2010, the Agency received notice from the licensee that it had experienced a radiography source disconnect on November 21, 2010. The equipment was reportedly inspected prior to use and passed all checks including tolerance testing of the connector mechanism on the drive cable. On the 25th exposure, after two and a half hours of work, the drive cable and source assembly failed to retract into the camera. Multiple attempts to retract the source were unsuccessful as evidenced by mechanical indications and radiation surveys. Barriers were established at a 2 mR/hr dose rate, shielding was stacked on the source, and an individual authorized for source retrieval was contacted. The source was retrieved. No exposure limits were exceeded during the event. The radiography camera, guide tube, and cranking device were sent to the manufacturer for inspection, but no cause was determined for the failure. No violations were cited.

File closed.

### I-8799 - Source Abandoned Down Hole - Schlumberger Technology Corporation, Sugarland, Texas - Garza County

On November 22, 2010, the Agency was notified of an irretrievable well logging source that had been abandoned downhole at a site in Garza County. Fishing efforts for the source had commenced when the tool string broke leaving one 1.7 curie cesium (Cs) -137 source in the clay formation while another source was safely recovered. The source was abandoned in accordance with Railroad Commission rules. The well was plugged with 200' of red dyed cement to 3,620' topped with an upside down drill bit as a deflection device. The required warning plaque was ordered by the licensee and will be placed at the well head. No violations were cited.

File closed

## Incidents Opened Fourth Quarter 2010

### I - 8800 - Transportation Event - Protechnics Division of Core Lab - La Salle County, Texas

On November 26, 2010, the Agency was notified that a well-logging truck had been involved in a traffic accident which resulted in the death of the driver. The radioactive material onboard the vehicle included 240 millicuries of iridium (Ir) -192, 160 millicuries of scandium (Sc) - 46, and 320 millicuries of antimony (Sb) - 124, stored in DOT Type A containers inside an overpack. The overpack was thrown from the vehicle and the lid opened up several inches. U.S. Border Patrol personnel who responded to the accident performed an initial survey and determined there was no radiation hazard. The licensee responded and verified there had been no release of radioactive material. The licensee transported the material to their licensed facility in Alice, TX. It was determined there had been no threat to public health as a result of the incident. No violations were cited.

File closed.

### I - 8801 - Damaged Device Containing Radioactive Material - Bed Bath and Beyond - Austin, Texas

On November 19, 2010, the Agency was contacted by a contractor licensee from California requesting reciprocity to work at a store in Austin to remove and dispose of a tritium exit sign (TES). The store was contacted by the Agency and questioned about the work involving the TES. The store manager stated that the exit sign was mounted on a pole coming down from the ceiling. An employee was working on the top of a storage rack in the area of the sign and knocked it loose from the pole and it fell to the floor. The employee picked the sign up, placed it into plastic bags, took the sign to a storage locker, and locked the door. A contractor was contracted to clean up any contamination and dispose of the sign. The contractor stated that two tubes had broken in the sign. It was estimated that a maximum of 1.5 - 2.0 curies of tritium would have been released. The contractor prepared the sign for shipment and disposal. The contractor surveyed appropriate areas of the store and the highest removable tritium contamination levels found were 214 dpm/100 cm<sup>2</sup>. Bioassay samples were collected from the two store employees involved in the event. Both samples indicated that the committed exposure was less than 1 millirem. The personnel received additional training on the proper handling of TES and a company wide inventory of TES was conducted. No discrepancies were reported. No violations were cited.

Filed close.

### I - 8802 - Patient Treatment Error - Oncology Hematology Consultants PA dba Center for Cancer and Blood Disorders - Fort Worth, TX

On December 16, 2010, the Agency was informed by the registrant's Radiation Safety Officer (RSO) that the registrant had inadvertently failed to administer treatment to an intended area. While the disease had been noted on both sides of a specific region in the patient, only one side was treated. The error was caught on a routine follow-up visit and the patient was informed at that time. Although there was no evidence of recurrence, the physician decided to complete treatment of the other side as originally intended. The RSO had all staff review responsibilities for identifying the correct area to be treated for external beam therapy. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2010

### I - 8803 - Equipment Malfunction - H & H X-Ray Services Inc - Flint, Texas

On December 17, 2010, the Agency was notified by the licensee that on December 10, 2010, the locking device on a QSA model 880 camera containing 97 curies of iridium (Ir) – 192 failed to activate. The radiography crew (Crew-A) had completed operations on one location at a site near Lufkin, Texas, and was moving to a new location at the same site. The radiography camera with the cranking device and guide tube still attached were placed in the dark room of the radiographers' truck. The licensee stated that a survey was conducted to verify the source was in the fully-shielded, locked position. As the radiographer was driving to the new location, he passed about 5 feet from another group of radiographers (Crew-B) from the same licensee. As Crew-A passed by Crew-B, Crew-B's alarming dosimeters alarmed. Crew-B stopped Crew-A and told them that their alarms had gone off. Crew-A went to the camera, picked up the crank for the camera, and found that the source had moved from the locked position approximately one quarter of a turn. The radiographer cranked the source back to the fully-shielded position and secured the camera for transportation. The Agency conducted an on-site investigation at the licensee's facility. The investigation determined that the locking device operated for the six days between the event and the day the Radiation Safety Officer for the licensee was informed of the event. The licensee tested the camera and found the locking device to be operating properly. The locking device was dismantled and all parts were found to be in good working order. It was determined that the radiographers had not properly retracted the source to the locked position. The radiographer's dosimetry was processed and neither had exceeded a dose limit. The radiographers were released from their employment with the licensee. The radiographer was cited for four violations.

File closed.

### I - 8804 - Missing Equipment Containing Radioactive Material - Lockheed Martin Aeronautics Company - Fort Worth, Texas

On December 22, 2010, the Agency received a written report from the company stating that they could not locate 84 tritium exit signs containing an estimated total of less than 630 curies of tritium. The signs had been boxed in preparation for return shipping to the manufacturer in February 2010, but were being held until they could be repackaged to conform with the manufacturer's packaging requirements. In November 2010 the company decided to repackage and ship the signs but they could not locate them. The company searched its facility and investigated all potential routes by which the signs could have left the premises. During the investigation, the manufacturers/distributors of the signs were contacted by the company for assistance in determining the serial numbers of signs supplied to their facility. Serial numbers were available for only 17 of the signs. It was discovered that there were 23 additional signs that were unaccounted for, thereby raising the total number of missing signs to 107. The current (decay-corrected) total activity of those signs is approximately 625 curies. The company had an evaluation conducted that considered the most likely scenarios--incineration by its hazardous waste disposal vendor, burial in the municipal landfill, or the signs are still on the company's premises. According to the evaluation, no dose exceeding regulatory limits to any member of the public would result from any of these scenarios. The company determined the cause of the incident was lack of communication and handling the signs outside of their normal hazardous waste procedures. The company stated that in the future all hazardous items will be processed through their existing hazardous waste management system with no exceptions. It will notify this Agency if the signs are located. No violations were cited.

File closed.

## Incidents Opened Fourth Quarter 2010

### I - 8805 - Badge Overexposure - Midwest Inspection Services - Perryton, Texas

On December 28, 2010, the Agency was notified that a radiographer working for the licensee had exceeded an annual exposure limit. The licensee's Radiation Safety Officer (RSO) stated that the exposure was to the badge only. The RSO stated that he had interviewed the radiographer involved. The radiographer stated that he had dropped his badge while conducting radiography at a location and completed an examination of between 20 to 25 welds before he observed his badge on the ground. The RSO stated that the average exposure to the radiographer in the previous 6 months was 343 millirem and that his work load had not significantly changed. The licensee has assigned a dose to the radiographer of 343 millirem. The RSO stated that the radiographer received additional training on the proper location and method of wearing his dosimetry. The RSO stated that the event was discussed with all company radiographers. No violations were cited.

File closed.

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

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

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

File closed.

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

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

File closed.

## Incidents Opened in a Previous Quarter and Closed in Fourth 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 one 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.

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

### 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 - 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 - 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

## Incidents Opened in a Previous Quarter and Closed in Fourth 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 - 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.

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

### 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 - 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.

## **Incidents Opened in a Previous Quarter and Closed in Fourth 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.

## Complaints Opened Fourth Quarter 2010

### C - 2282 - Laser Injury - BioDerm Skin Care and Laser Center - Arlington, TX

On October 5, 2010, the Agency received a complaint stating that during a laser hair removal procedure the complainant suffered burns and scarring. The complainant claimed the injury resulted from faulty equipment and the technician trainee administering the laser procedure was inexperienced and improperly supervised. The Agency contacted the complainant for more information and conducted an onsite unannounced investigation on October 14, 2010. The investigation revealed that the complainant had received mild, superficial burns and hyper-pigmentation. The complainant had consulted an independent dermatologist to assess her injury. On October 29, 2010, the complainant requested that the Agency stop the investigation and she did not provide investigators with her dermatologist's name, so further investigation into extent of injury could not be accomplished. Information obtained from the complainant and the facility was that the technician was accompanied/supervised by a more experienced technician. The equipment was current on required service and inspection. The complaint could not be substantiated. One unrelated violation was cited.

File closed.

### C - 2283 - Inadequate Credentialing - Alamo Heights Surgicare LP - San Antonio, Texas

On October 6, 2010, the Agency received an allegation that inadequately credentialed registered nurses and/or physician assistants were performing fluoroscopic procedures. The Agency conducted an on-site investigation on October 26, 2010. The investigation revealed that only physicians were performing fluoroscopic procedures. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2284 - Response to Public Concern - Southside Orthopaedic and Rehabilitation - San Antonio, Texas

On October 22, 2010, the Agency received a complaint from an individual concerned that he may have received excessive radiation exposure from a recent x-ray of his foot. The investigation into this complaint revealed that a routine inspection had been conducted by an Agency x-ray inspector on September 22, 2010. The results of the inspection demonstrated that the facility and equipment were in compliance with regulations. A letter was sent to the complainant explaining the recent inspection findings. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

### C - 2285 - Laser Injury - NeoSkin - San Antonio, Texas

On November 4, 2010, the Agency's radiation incident investigators received a complaint that was forwarded to them for investigation from the Agency's drugs and medical devices group. The complaint had been received by them on April 7, 2008. The complaint alleged that a business was using lasers on humans for hair removal and had caused burns to two individuals. The complaint also stated that the business did not have a medical director nor did they have physician oversight of the treatments. Investigation revealed that the company had since gone out of business. The complaint could not be substantiated. No violations were cited.

File closed.

### C - 2286 - Unregistered Laser - Clearstone Laser Hair Removal - Houston, Texas

On November 5, 2010, the Agency received an anonymous complaint stating that a provider of laser procedures for hair removal was operating without proper registration with the Agency and without proper posting of warning signs on the laser treatment room. Additionally, the complainant believed they had received excessive burns from treatment at the facility. Follow-up communications with the complainant revealed there had been no medical treatment for the alleged burns and no photographs had been taken. On December 15, 2010, the Agency conducted an on-site investigation. The investigation revealed there were Class 4 lasers in use since January 2010 and the facility was not registered with the Agency. Additionally, the facility was using improper warning signs and four pairs of protective eyewear were cracked. During the investigation, the owner admitted that one patient had received burns on October 5, 2010, that required medical attention from a physician. The owner would not give the Agency records related to the burn during the on-site investigation. The facility filed its injury report with the Agency on January 5, 2011. Portions of the complaint were substantiated. Two violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

### C - 2287 - Monitoring Not Provided - Banfield Pet Hospital of The Woodlands - Shenandoah, Texas

On November 16, 2010, the Agency received a complaint from a veterinarian that he had not been provided dosimetry while he worked at a veterinary hospital operating an x-ray device. The letter stated that he had requested a badge, but one was never provided. He also stated that other individuals working at the hospital did not always wear their badges when they were in the area of the operating x-ray device. On December 22, 2010, two Agency inspectors performed an unannounced investigation at the registrant's location. A review of the registrant's records confirmed that the complainant had not been monitored for occupational exposure for radiation. The review also found that the registrant did not have personnel monitoring records of occupationally exposed individuals for the last five exposure periods for individuals working at this location. The registrant was cited for the two violations. The complaint was substantiated.

File closed.

### C - 2288 - Regulatory Violations - Woodlake Imaging and Diagnostics - Houston, Texas

On November 16, 2010, the Agency received a complaint alleging that a facility was using an unregistered x-ray machine and committing numerous additional violations. An on-site investigation was conducted on December 14, 2010, subsequent to an inspection five days earlier. Neither the inspection nor the investigation could substantiate any of the allegations. No violations were cited.

File closed.

### C - 2289 - No Physician Supervision for Laser or Intense Pulsed Light Treatment - Natural Skin Creations Day Spa - Houston, TX

On November 16, 2010, the Agency received an anonymous complaint stating that a provider of laser and intense pulsed light (IPL) procedures for skin treatment and hair removal was operating without proper registration with the Agency, without licensed medical practitioner supervision, without properly trained technicians, and without proper posting of warning signs on the IPL/laser treatment room. The Agency conducted an on-site investigation on December 14, 2010. The investigation revealed the facility did not have a contract with, or supervision by, a licensed practitioner of the healing arts, they did not have hazard warning signs posted as required, and they possessed and used a Class 4 laser for which they were not registered with the Agency. The technicians' training did meet the current training requirements. The complaint was substantiated. Two violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

### C - 2290 - Response to Public Concern - Private Residence - Houston, Texas

On November 8, 2010, the Agency received notification from its answering service of a message from an individual that stated "Last night, 11/7 there was a sound like a nuclear reactor up the street. There's plutonium." An Agency investigator attempted to contact the individual three times before finally succeeding on November 15, 2010. The individual stated that there had been a plutonium explosion in her neighborhood last week because she heard a noise. She stated that there was no visible fire or explosion, but that she knew it was plutonium because of the sounds she heard and the way the humming noises propagated. The individual stated that when plutonium explodes, it makes a humming sound that comes in waves because the radiological particles react over and over again, and those are the waves that one hears. She also stated that she has had a problem with plutonium contamination in her home. She stated that she removed it herself when she saw it. She stated that the contamination looked "translucent and waxy" in appearance, and that if one were to listen carefully, one would hear the plutonium humming. She stated that people from the "Harris County Radiation Control" performed a survey a few weeks ago at her home. The investigator asked the her if she was given any results of the survey that was performed. She stated that those performing the survey had a Geiger counter and that "it was clicking." The individual then stated that she knows people in her neighborhood have been poisoned with plutonium because their faces appeared smashed, like they have been put into a press. She stated that this physical manifestation is characteristic of plutonium poisoning. The investigator tried to assure the individual that plutonium is a highly regulated material, and it was not likely that her home was contaminated with plutonium. The investigator stated that they could perform a survey of her residence to determine if any plutonium was present, and she replied that she would appreciate that. The investigator made several unreturned phone calls to the individual to arrange a date and time to survey her residence. On December 15, 2010, two Agency investigators went to the individual's address, knocked on the door, and no one answered the door. One investigator took a radiation survey of the outside of the house and did not detect any radiation above background. The investigators then moved to a public area approximately two blocks from the individual's home and the investigators took a soil sample from the area. On December 23, 2010, the sample was analyzed; no concentrations of any radionuclides above regulatory limits were revealed. The complaint could not be substantiated. No violations were cited.

File closed.

### C-2291 - Uncredentialed Technologists - Rafael De La Flor-Weiss - Spring, Tx

On December 6, 2010, the Agency received a complaint that the office manager and other staff members were performing x-rays at an urgent care center without proper credentials. On December 15, 2010, an unannounced inspection was conducted by an Agency inspector and two investigators. Four staff members were interviewed and records were reviewed. The complaint could not be substantiated. Two unrelated violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

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

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

File closed.

### C - 2293 -Inadequate Credentialing - Emergency Medicine Specialist LLP - Richardson, Texas

On December 14, 2010, the Agency received a complaint stating that individuals performing x-rays for the registrant are not credentialed. The Agency conducted an inspection at the facility on January 11, 2011, and the operators were verified as having proper and current credentials. The complaint was not substantiated. Three non-related violations were cited.

File closed.

### C - 2294 - Radiation Exposure to Member of General Public - Houston Medical Clinic - Houston, Texas

On December 15, 2010, the Agency received a anonymous complaint alleging that an individual had received excessive radiation exposure from an x-ray machine located in a room adjacent to her work station. It was alleged that this exposure resulted in two miscarriages. The Agency conducted an on-site investigation. The investigation revealed that the x-ray machine had not been used since approximately October 2010. The investigation also revealed that due to the type of machine and its positioning in the room, the beam could not have been directed toward the area where the individual worked. In addition, distance from the work station and building structure would have reduced any scatter radiation from the use of the machine to levels below regulatory limits. The complaint was not substantiated. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

### C - 2295 - Inadequate Credentialing - Family Medicine Rural Health Clinic PA - Copperas Cove, Texas

On December 16, 2010, the Agency received an anonymous complaint alleging that the registrant was allowing an employee whose license had expired to take x-rays as well as allowing another individual to take x-rays who was not licensed. The Agency conducted an on-site investigation. Required certifications were current for technicians performing x-ray procedures. The complaint was not substantiated. Three violations, unrelated to the complaint, were cited.

File closed.

### C - 2296 - Unregistered X-ray Equipment - Integrated Pain Associates - Killeen, Texas

On December 20, 2010, the Agency received a complaint stating the facility was operating a C-Arm machine for exposures on humans without proper registration. An Agency investigator found that an application for a certificate of registration from the facility was received by the Agency on December 31, 2010. An on-site investigation was conducted on March 8, 2011. The investigation revealed that the facility had submitted their request for registration on December 6, 2010. They received the C-Arm device in early January 2011, but had not operated the device until January 13, 2011. The C-Arm was surveyed by a licensed medical physicist on January 17, 2011, and required no adjustments. The area where the machine was used was properly posted and current procedures were available. The complaint was not substantiated. No violations were cited.

File closed.

### C-2297 - Inadequate Credentialing - Injury Medical Clinic - El Paso, TX

On December 21, 2010, the Agency received a complaint alleging that staff at a medical clinic was not calibrating their x-ray equipment properly and the staff at the facility was not adequately trained. On January 27, 2011, an Agency inspector performed an on-site inspection at the registrant's facility. The inspector found that the equipment performance evaluations had been completed as required and the inspector was not able to identify any instances where non-credentialed personnel performed a procedure. The complaint could not be substantiated. No violations were cited.

File closed.

## Complaints Opened Fourth Quarter 2010

### C - 2298 - Regulatory Violations - Wilson Inspection X-Ray Services - Corpus Christi, Texas

On December 15, 2010, the Agency received a complaint alleging that a radiography company was performing radiography work at a temporary job site without setting up proper barriers. On December 16, 2010, two Agency investigators performed an on-site investigation. The investigators interviewed the complainant and were informed that the radiography crew was no longer performing radiography for them, but were still on site working for a subcontractor. He also stated that he had observed a second crew performing radiography work about a mile from this location. The investigators found the first radiography crew on the east end of the facility. The crew was sitting in their truck and did not appear to have any work to perform in the near future. The inspectors drove to the second location and there they found a second truck from the licensee sitting on the side of the road. As they drove past, they saw two individuals sitting in the cab of the truck and there were drive cables and a radiography camera on the tailgate of the truck. No one had direct control of the camera. The investigators found that neither radiographer had an electronic alarming dosimeter, that both self-reading dosimeters were off scale, the trainee did not have a copy of his credentials, radiation surveys had not been conducted during radiography operations, and the radiographer trainer was not providing supervision of the trainee as required. The original complaint was not substantiated. The radiographer trainer and the licensee were cited for the violations that were observed.

File closed.

### C-2299 - Uncredentialed Technologist and Other Regulation Violations - Family Medicine Clinic - Lampasas, TX

On December 16, 2010, the Agency received a complaint alleging that non-certified technicians were being required to take x-rays of minors, that there was no technique chart available for children, and that x-rays were being ordered by not only the doctor and nurse practitioner but also by nurses and medical assistants. The complaint further alleged the exposure to patients was uncertain, the films and cassettes don't match, the exposure settings were being doubled to take x-rays, and the staff was working with three or more technique charts to take x-rays. The agency conducted an on-site investigation. The investigation revealed that a Non-Certified Technologist (NCT) had taken x-rays of a minor that were outside the scope of her certification. It was also found that entrance exposures to the chest exceeded regulatory limits. The issues of films and cassettes not matching, practice of simply doubling settings, and multiple technique charts being in the control room were addressed with the registrant in regard to best practice. The complaint was substantiated. Three violations were cited.

File closed.

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

### C - 2194 - Allegation of Abandoned Radioactive Material - Trace Life Sciences Inc. - Denton, Texas

On April 16, 2009 an email complaint was received by the Agency alleging the licensee had abandoned radioactive material at its facility. An Agency inspector was sent to the facility to determine if there were any potential risks to the health and safety of the public. The inspector found that the facility was adequately secured and ascertained there was no eminent threat to the public. The Agency learned that the licensee has been experiencing financial difficulties and is seeking additional financial investment. After many months of observations and negotiations, a business and decommissioning plan has been submitted with a licensing and fee payment schedule agreed upon. The complaint was not substantiated and no violations were cited.

File closed.

### C - 2241 - Regulation Violations - DFW MRI LP - Dallas, Texas

On February 2, 2010, the Agency received a phone call from an anonymous source with a long list of very detailed violations on a variety of radiation producing machines against the registrant. The facility has computerized tomography (CT) and radiographic machines and the complaint was submitted by a person who described himself as a "concerned technologist". According to the complainant, the violations had been occurring since July 2009. On October 10, 2010, the Agency conducted an investigation/inspection at both of the registrant's licensed sites. No violations were cited.

File closed.

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

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

File closed.

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

### 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.

### 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 in a Previous Quarter and Closed in Fourth Quarter 2010**

### 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 - 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.