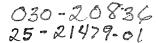
INDUSTRIAL TESTING



PO Box 30316 · Billings, MT 59107 · Ph: (406) 839-2013 · Fax: (406) 839-2015

www.mtstestinggroup.com

REFCEIVED JUL 2 0 12009 DNMS

June 23, 2009

US Nuclear Regulatory Commission

Washington, DC 20555-0001

License #25-21479-01

To Whom It May Concern,

This report is being filed under 10 CFR 30.50b2. At 2:30 pm on June 22rd, 2009 Ray Sierra, Radiographer to Mattingly Testing Services, forgot a radioactive exposure device(s/n 4486) with IR-192 (s/n N 798) on the tailgate of his x-ray truck. Ray Sierra initially signed out (s/n4486) for the purpose of conducting Radiographic operations in Billings, MT for Williston Basin Interstate Pipeline, off of Shiloh road. He picked his assistant up in the parking lot of Kohls, and it was his assistant Shawn King that noticed and asked Ray why his tailgate was down. Ray then remembered that after conducting initial surveys he forgot to secure and lock down the source in its proper location before leaving the shop. After suspecting that it fell off the tailgate in MTS' driveway both Ray and Shawn backtracked towards the shop. In route to the shop, at 2:50 pm, Ray called the main MTS office and notified Mark Ficek, (president of MTS) of the incident, and that he was headed back to the shop to look for the exposure device. At 2:50 pm a neighbor of MTS found the exposure device on the side of the gravel road at junction of Andrews lane and Medicine Man trail, 1/2 mile from MTS' shop. He noticed the side placard warning label to immediately contact civil authorities if found, and dialed 911. A sheriff happened to be on another call approximately ½ mile away and was able to respond immediately. The sheriff met Ray Sierra at MTS' shop at 3:10 pm to return the exposure device. At 3:10 pm Ray Sierra conducted a survey of the exposure device. No visible dents, or scratches appeared on the exposure device after the incident. Ray Sierra proceeded to use the exposure device later that day and concluded that it had

received no damage from the fall. No member of the public or MTS personnel received any amount of radiation exposure from the entire incident.

Corrective actions taken:

MTS has determined that this was an oversight by Ray Sierra, and there was no willful misconduct. MTS also recognizes there has not been any previous incidents of this nature involving Ray Sierra. MTS has scheduled Ray Sierra to take an additional 8hrs of Radiation Safety Training, as well as be subjected to a practical examination.

Incident report by,

Ray Sierra

1 an Als / Written by Mark Ficek