

LICENSEE EVENT REPORT EVALUATION FORM

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EVENT CLASS: LAS - LOST, ABANDONED, STOLEN MATERIAL**LICENSEE / REPORTING PARTY INFORMATION:**

Licensee/Reporting party name:	Team Industrial Services, Inc.		
License number :	42-32219-01		
Docket number :	030-35252		
Licensee's City of record :	Alvin		
Licensees State of record :	Texas		
NRC regulated?	Yes	If so, what Region?	IV
Working under reciprocity?	No		

EVENT INFORMATION:

In what City and State did the event occur?	Hammond, IN
Event date :	4/15/2011
Discovery date :	4/15/2011
Report date :	4/15/2011
Agreement State reportable?	No
NRC reportable?	Yes
Reporting regulation :	10 CFR 20.2201(a)(i)
NMED Item Number :	n/a

ADDITIONAL PARTIES INVOLVED:

Name :	n/a
License number :	n/a
City :	n/a
State :	n/a

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CONSULTANT INFORMATION (if any):

Consultant name :	n/a
Company :	n/a
Who hired consultant?	n/a

DEVICE INFORMATION:

Manufacturer :	QSA Global
Model number :	Delta 880
Serial number :	D4264

RADIATION SOURCE INFORMATION:

Isotope :	Ir-192	
Activity :	15.9 Ci	
Manufacturer :	QSA Global	
Model number :	A424-9	
Serial number :	66411B	

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NARRATIVE EVENT DESCRIPTION:

Licensee prepared two radiographic exposure devices for shipment to QSA Global on 4/13. Devices were picked up by Federal Express on the afternoon of 4/13. The licensee received e-mail notification on 4/14 that one of the packages had arrived at QSA. RSO contacted carrier to check status of second package and was informed package was delayed but would be delivered later that day. On 4/15 RSO still had not received email notification on second exposure device, so contacted QSA global (recipient) and carrier. Package was identified as lost by carrier and RSO made the required notification to the NRC. Package was found later in the afternoon on 4/15 and returned to the licensee by the carrier.

CORRECTIVE ACTIONS:

RSO investigated event with carrier and was able to determine the device was being held at the carrier's Chicago location, due to loss of the original paperwork. Carrier used the markings on the package to identify a old shipping paper that they used to return the device to the licensee. Licensee took no corrective actions to prevent recurrence, as the paperwork provided was appropriate and the licensee procedures were followed. Carrier error resulted in the temporary "loss" of the exposure device.

RECOMMENDED FOLLOWUP:

Was a reactive inspection conducted?	No	If so, inspection report number :	
Is LER recommended for closure?	Yes		
Is this NMED Item Number recommended to reflect "complete"?	n/a		

LER Evaluator:	Branch Chief or Designee Review:
Name: <u>Matthew P. [Signature]</u> Date: <u>27 June 2011</u>	Name: <u>[Signature]</u> Date: <u>7/5/2011</u>