PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-97-007

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region IV staff in Arlington, Texas on this date.

Facility	Licensee Emergency Classification
Nuclear Pharmacy, Boise, Idaho	Notification of Unusual Event
Nuclear Pharmacy, Boise, Idaho	Alert
Idaho Falls,Idaho	Site Area Emergency
Dockets: 03032223 License No: 11-27398-01MD	General Emergency
	X Not Applicable

Subject: TRANSPORTATION INCIDENT

At approximately 7:15 p.m. EST, a representative of Nuclear Pharmacy of Idaho reported to the NRC Operations Center that an incident had occurred during transportation of a sodium iodide I-131 capsule. The capsule was calibrated for 370 megaBecquerel (10 millicuries) at 1200 (MST) on January 28, 1997, and was to be delivered to Columbia Eastern Idaho Medical Center in Idaho Falls (also an NRC licensee).

According to representatives of Nuclear Pharmacy of Idaho and Columbia Eastern Idaho Medical Center, the capsule was to be shipped from Boise to Idaho Falls by Horizon Air on January 28 but was delayed in shipment. Horizon Air subsequently shipped the capsule, on Flight No. 2273, on January 29. Radiopharmaceutical doses shipped from the pharmacy to the medical center are normally shipped by Horizon Air and are delivered by taxi from the Idaho Falls airport to the medical center. The package arrived at Idaho Falls and was placed in a cargo area by Horizon Air employees.

Shortly after the package arrived at Idaho Falls, the taxi driver reported to the airport to pick up the package and deliver it to the medical center. A Horizon Air employee retrieved the package from the cargo area and stated that when she picked the package up from the floor, the bottom of the box gave way and all contents of the package fell to the floor. The Horizon employee noted that the lead pig, which is used as shielding and holds a plastic vial containing the capsule, fell out of the box and the lid fell off, spilling the plastic vial holding the capsule. The employee also stated that top of the plastic vial fell off when the vial struck the floor. The Horizon employee, with assistance of the taxi driver, replaced the lids on the plastic vial and lead pig, and attempted to replace the contents of the box as best she could. Both individuals noted that they left a few styrofoam "peanuts" (used as packing material) on the floor, and neither individual noted that the capsule had fallen out of the plastic vial onto the floor.

The taxi driver promptly delivered the package to the medical center and explained to the staff that something was wrong with the box when it arrived at the airport. The medical center staff stated that with exception of one flap on the bottom of the box, everything

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appeared to be intact. The nuclear medicine staff proceeded to perform a package receipt survey and noted that no detectable radiation levels. The contents of the box were inspected and a capsule could not be found. The medical center contacted the pharmacy and received confirmation that a capsule was shipped in the package.

The medical center subsequently contacted Horizon Air and dispatched personnel to the Idaho Falls airport to locate the capsule. Upon arrival at the airport, the Horizon employee who handled the package led the medical center employees to the area where packing materials had fallen on the floor (the material was still present). Using a survey instrument, the medical center employees located the capsule and placed it in a shielded container which was later taken to the medical center. Surveys of the area where the capsule was located identified radiation levels of 4 milliroentgens per hour at a distance of approximately 3 feet from the capsule. Once the capsule was retrieved, removable contamination surveys were performed in the area. Subsequent analysis of the wipe samples revealed only background activity levels (4 disintegrations per minute). Upon examination at the medical center, the capsule appeared to be intact.

The medical center is continuing to followup with Horizon Air to identify individuals who may have walked through the cargo area while the capsule was on the floor (a period of approximately 2 hours). Based on information provided by the Horizon employee and surveys performed in the cargo area, it is not expected that any individual received a significant dose since airport employees had not spent any significant time in the cargo area while the capsule was present.

The state of Idaho has been informed.

Region IV received initial notification of this occurrence by telephone at approximately 6:15 p.m. (CST) on January 29. Subsequent telephone reports were received by NRC from Nuclear Pharmacy of Idaho and Columbia Eastern Idaho Health Services, Inc., on January 30, 1997. Region IV has informed NMSS. NMSS plans to inform the Department of Transportation of this incident.

This information herein has been discussed with both licensees and is current as of 1:30 p.m., January 30, 1997.

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