PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-I-96-084

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 I staff in King of Prussia, Pennsylvania on this date.

Facility
Dupont-Merck Pharmaceutical Co.
Dupont-Merck Pharmaceutical Co.
331 Treble Cove Road
North Billerica,Massachusetts 01862
License No: 20-28598-01

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: MOLYBDENUM-99/TECHNETIUM-99m SPILL FROM HOLDING TANK

On December 2, 1996, the DuPont Merck Pharmaceutical Company reported to the NRC, in accordance with 10 CFR 30.50(b)(1), that a spill had occurred causing contamination that would require them to restrict access to the spill area. They reported that, at about 2:00 p.m. on Sunday, December 1, 1996, approximately six gallons of effluent liquid containing molybdenum-99 (Mo-99) and technetium-99m (Tc-99m) overflowed from a holding tank onto grass and asphalt behind Building 200 at the licensee's facility. The facility is surrounded by a perimeter fence, and access is attained through a guarded security gate.

The licensee calculated that 50 millicuries of Mo-99 and 97 millicuries of Tc-99m were released in an area of 20 feet by 20 feet. Licensee radiation protection personnel cordoned off and posted the area, which is a location not normally traveled by employees. Radiation levels were reported to be generally 5 to 10 millirem per hour. The maximum radiation level measured was 20 millirem per hour on a metal housing for an air handling system. The licensee confirmed that no personnel were contaminated and no airborne contamination occurred. The licensee has collected rainwater samples and soil samples for analysis to confirm the extent of the spill area, and will report the results when they are available.

The cause of the overflow was determined to be technician error. The liquid level in the holding tank is determined by observation of the transparent tank. The technician checked the tank but observed no liquid level line, and believed the tank to be empty. The tank was full, however, and when the technician attempted to transfer additional liquid to the tank, the overflow occurred and the overflow alarm was activated. The technician immediately shut down the pump and called for assistance. The incident was reported to the Commonwealth of Massachusetts. The Region I Office was notified of this event by the licensee at 4:30 p.m. on December 2, 1996. This PN is current as of 8:00 a.m., December 3, 1996.

Region I Public Affairs is prepared to respond to media inquiries.

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