

May 22, 2001

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-01-018

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 II staff (Atlanta, Georgia) on this date.

Facility

Licensee Emergency Classification

Studsvick Processing Facility

Notification of Unusual Event
Alert

Erwin, Tennessee

Site Area Emergency

Dockets/License: TN-R-86011

General Emergency

X Not Applicable

Subject: REPORT OF SITE CONTAMINATION

On May 21, 2001, the NRC Operations Center was notified by the State of Tennessee Division of Radiological Health (DRH) that a spill had occurred at the licensee's facility on May 18, 2001. The licensee was authorized for the receipt, possession, processing, storage, handling and shipment of radioactive waste resins under a Tennessee Agreement State license. During routine operations at the facility, approximately four cubic feet of waste material was spilled from one of the process vessels, reportedly due to overpressurization of the vessel. The vessel was shut down and the facility evacuated. It was estimated that 29 millicuries of activation and mixed fission products were released during the spill. The material was released into a controlled area. There were no environmental releases. The building remained at a negative pressure relative to the environment during the event. The HVAC system was shut down after the spill, as was the thermal system to the process vessel.

During the initial response and investigation of the event, five individuals (license employees) were slightly contaminated as confirmed by nasal swipes. In-vivo counting of these individuals was planned for Wednesday, May 23, 2001, at Oak Ridge National Laboratory. Temperatures in the area have now decreased enough for personnel to enter and make a thorough physical evaluation. Video cameras recorded the event. A complete investigation and root cause analysis will be performed by the licensee to determine the cause of the event. On May 22, 2001, the Tennessee DRH issued a press release and dispatched an inspector to the site to investigate the event and the licensee's response.

Region II received initial notification of this occurrence by the NRC Headquarters Operations Center. This information presented herein has been discussed with the State and is current as of 10:30 a.m. on May 22, 2001.

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