

Date: January 6, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9402A

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 the Region I staff on this date.

Facility:

Zynaxis Cell Science, Incorporated
371 Phoenixville Pike
Malvern, Pennsylvania 19355

Licensee Emergency Classification:

Notification of Unusual Event
 Alert
 Site Area Emergency
 General Emergency
 Not Applicable

Docket No.: 030-30915

License No.: 37-28318-02

Event No.: 26568

Event Location Code: MAT

Subject: 24-Hour Notification of Possible Skin Overexposure (Corrected Copy)

Zynaxis Cell Science, Incorporated (Zynaxis) is a small firm that is authorized by a specific license to possess and use byproduct materials (millicurie amounts of seventeen different radioactive isotopes) for the purpose of research and development, and for manufacturing and distribution of reagent kits. The licensee is also authorized by a specific license to possess an irradiator containing 678 curies of Cesium-137.

On November 30, 1993, an inspection was performed at the licensee's facility by Region I. The inspector discovered that a personnel contamination incident involving Samarium-153 occurred on July 26, 1993, but had not been evaluated. Licensee representatives stated that they would perform an evaluation of the skin dose that resulted from this incident.

On January 5, 1994, a representative of Zynaxis notified the Headquarters Duty Officer, in accordance with 10 CFR 20.403(b)(1), that a preliminary investigation indicated that a research worker may have received a radiation overexposure to the skin of 146 rems. The initial exposure of the skin occurred on July 26, 1993 when the skin of the middle finger of the worker's left hand became contaminated with radioactive material when he opened a vial containing 50 microcuries of Samarium-153 in a 0.16 milliliter solution. The licensee representative stated that appropriate radiation safety procedures were followed during the opening of the vial and that they believed the skin contamination was caused by a breach of the protective gloves worn by the individual. The licensee attempted to decontaminate the individual, but discontinued decontamination efforts when the individual's skin became irritated by repeated washings. The licensee representative stated that this is a conservative estimate and that they will perform a more detailed evaluation of this incident including the use of more detailed information regarding the event and the application of calibration data to the survey measurements that were made at the time of the event.

The Commonwealth of Pennsylvania has been notified.

Region I is prepared to respond to media inquiries. This information is correct as of 2:00 p.m.

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PNO-I-94-002 PDR

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