

Is it really safe?

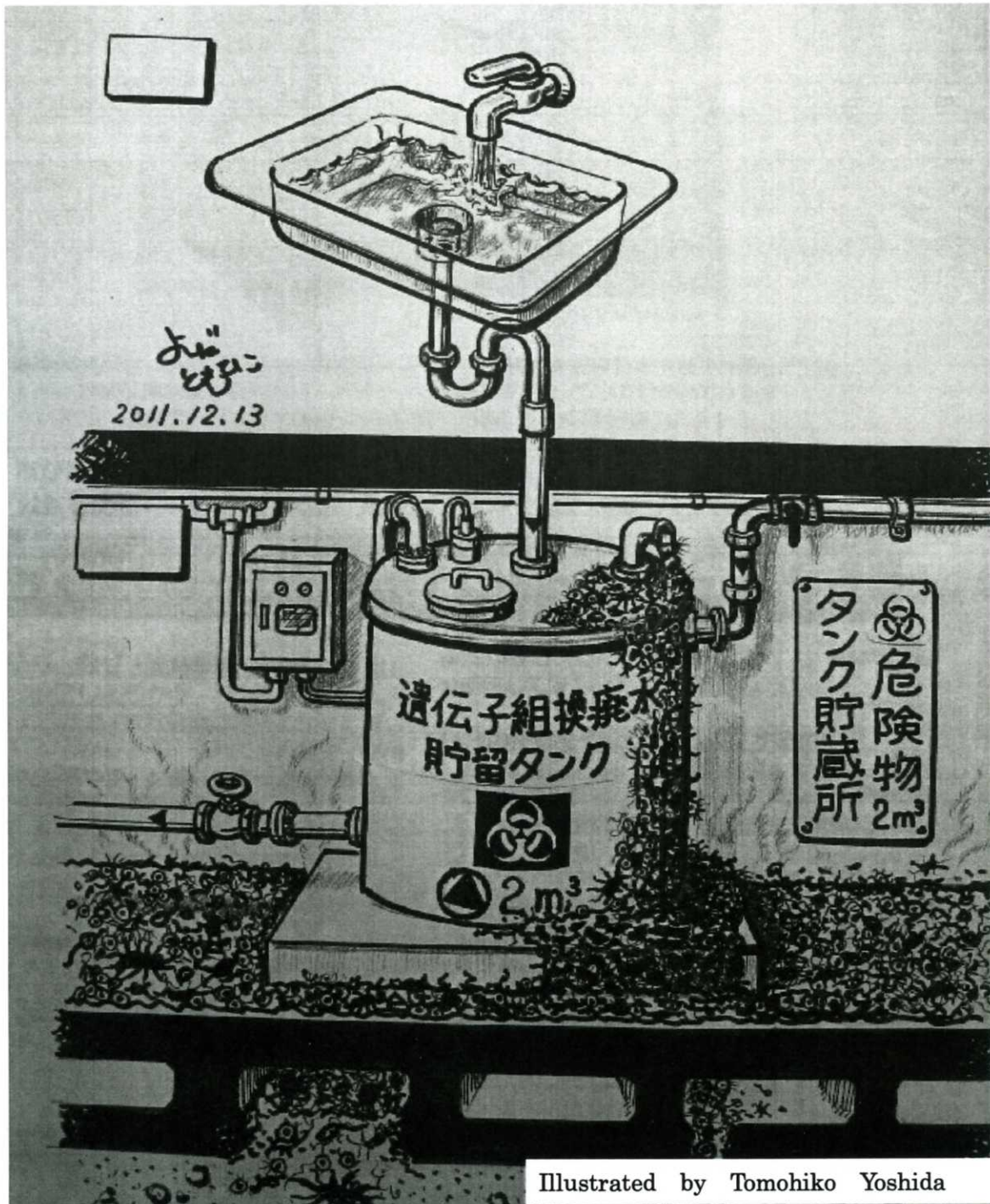
2011/12/15

Questioning about Takeda's New Research Facility at Shonan Coast

Issued by Tackling Takeda Group <http://www.shounan.biz/>

TEL: 090 6317 5547 Masuo Kobayashi

Accident occurred: GMO wastewater leak



Illustrated by Tomohiko Yoshida

Takeda Shonan Research Center caused a major accident less than one month after its start.

Wastewater contaminated with GMO (genetically-modified organisms) leaked

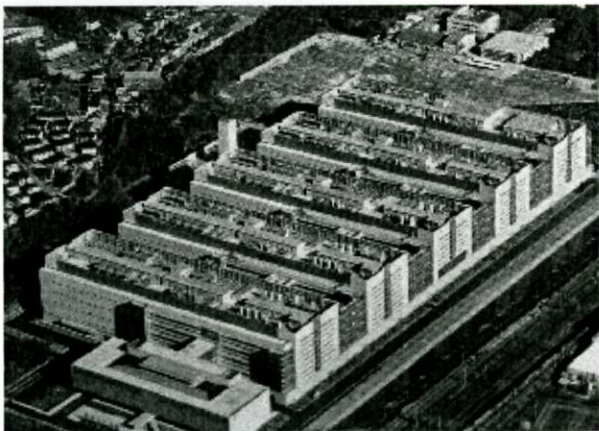
Takeda Pharmaceutical Company's Shonan Research Center, located in the border of Kamakura and Fujisawa City, Kanagawa Prefecture, started its operation in November 2011. Less than a month later, on early morning on Nov. 30th, a big accident occurred when a wastewater tank was overflowed.

<Summary of GMO wastewater leakage >

This is a summary of a release issued by MEXT (Ministry of Education, Culture, Sports, Science and Technology) on December 2nd.

At the Shonan Research Center, there is a laboratory on the 4th floor and water drains to a wastewater tank on the 1st floor. As a researcher forgot to turn off a faucet at the laboratory, about 2 cubic meters of water kept running into the wastewater tank for six hours from 1 a.m. to 7 a.m. on Nov. 30th. As a consequence, the wastewater tank was overflowed and one cubic meter of wastewater containing baculovirus, GMO coliform bacteria and salmonella leaked out. Contaminated wastewater made the entire 1st floor wet. In addition, it also made the basement floor wet.

<Reaction of MEXT>



What MEXT did after received an accident report from Takeda on Nov. 30th:

- 1) MEXT sent their staff to the site of accident for investigation. They confirmed that Takeda used sodium hypochlorite on the contaminated floor for sterilization.
- 2) Wastewater which contains baculovirus, GMO coliform bacteria, and salmonella should be treated with P1 level preventive measure. MEXT pointed out that wastewater leakage inside a research center was

seriously inappropriate.

3) MEXT instructed Takeda to look for potential contamination of surrounding facilities, and to sterilize them if necessary.

The ministry also warned Takeda to investigate the cause of the accident and to develop preventive measures.

<Delay of reporting to local authorities and residents>

Takeda reported the accident to Fujisawa City and Kamakura City on December 1st, only after MEXT's on-site inspections. Based on this report, city administrative investigators and Tackling

Takeda Group went to the accident site. We strongly believe that Takeda should have reported the accident to local authorities and residents the day the accident occurred, and Takeda neglected to do so.

<Information>

This Extra issue is made based on the MEXT on-site inspection report, interviews of officials of Environment Department of Fujisawa City, and documents of Fujisawa City Council. We have found many discrepancies between what we have found and an accident report released by Takeda on Dec. 12th. We will look into all points and report our findings in the next issue.

-Masuo Kobayashi, president of Tackling Takeda Group, and Ken Kunieda, chief editor of TTG.

Two major human errors

1st Human Error

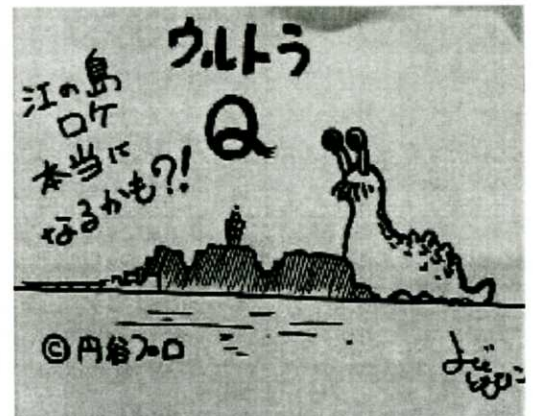
This accident occurred due to carelessness. A researcher who stayed up late forgot to turn off a water faucet and nobody checked it. This is something even a 1st grader should be able to do. There was no system of double checks. Serious questions arose here. Takeda's safety management strategy should be questioned.

In addition, leakage of wastewater totaled to 1 cubic meter in 6 hours. This means 46cc, equal to the amount of one cup, leaked every second. This is not a small amount and cannot be forgiven as a careless mistake.

2nd Human Error

Why did the security guard not have a key for the research center when alarm went off? What does Takeda concern? Safety or security? When he could not get into the building, why did he make a phone call to the manager right away? We can only conclude that Takeda lacks safety consciousness

and Takeda needs to review its crisis management.



Illustrated by Tomohiko Yoshida

<Comments from Dr. Hideo Arai,

special lecture of Hideo Arai (Representative of the Citizen's Center for Biohazard Prevention (CCBP))

"This accident has brought to light that Takeda's "24 hours safety surveillance system" is extremely questionable and not functioning. How can it be that this accident was not treated until the next morning? Considering this fact and we think Takeda is lacking safety management.

Dec. 14, 2011

