7-31-64 18 pgs

JUL 31 1964

MEMORANDUM FOR CHAIRMAN SEABORG
COMMISSIONER HUNTING
COMMISSIONER PALFREY
COMMISSIONER RAMEY
COMMISSIONER TAPE

SUBJECT: CRITICALITY ACCIDENT AT UNITED NUCLEAR CORPORATION'S RECOVERY FACILITY

There is attached a preliminary report prepared by the Director of Compliance regarding the criticality accident which occurred at United Nuclear Corporation's Scrap Recovery Facility, Wood River Junction, Rhode Island, about 6:06 p.m., Friday, July 24, 1964.

We plan to reproduce the report as an information paper for distribution to AEC Divisions and Operations Offices.

In addition to the investigation being conducted by the Division of Compliance the following actions have been or are planned to be taken within the immediate future.

1. A notice has been sent to the five firms which are licensed for uranium scrap recovery requesting that they conduct a prompt and thorough review of all administrative and operating procedures and equipment in their facilities.

2. The Division of Compliance is scheduling immediate inspections of these firms.

3. The Division of Materials Licensing is conducting a comprehensive review of the files relating to these five licensees particularly with respect to internal management procedures.

4. In accordance with our established procedure for investigating radiation incidents of this type (copy attached) I propose to appoint a committee

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JUL 31 1964

of experts to (a) review the information being gathered by the investigation, (b) advise whether additional investigation should be conducted and if so, in what particulars, (c) review and comment on the information developed as a result of the investigation with respect to such matters as the nature of the incident, its cause or causes, and matters to be considered in order to minimize or preclude similar incidents.

I have asked Dr. David B. Hall, K Division Leader at Los Alamos Scientific Laboratory, if he would be willing to serve as chairman of the committee. He has agreed subject to the concurrence of the Laboratory. Dr. Richard L. Doan, Director, Division of Reactor Licensing, will serve on the committee. Further, I plan to ask the following persons to serve as members of this committee:

Dr. Wayne C. Bills, Director, Nuclear Technological Division, Idaho Operations Office
Mr. Floyd L. Culler, Director, Chemical Technical Division, Oak Ridge National Laboratory
Mr. Clarence L. Schuske, Director, Division of Nuclear Safety, Dow Chemical Company, Rocky Flats, Colorado.

All of the above mentioned persons are employed either by the Atomic Energy Commission or one of its contractors.

Findings of the committee will be forwarded to the Commission.

I would like to discuss this matter with the Commission at the next information meeting.

(Signed) HLP

Harold L. Price
Director of Regulation

Attachments:
1. Memo fr. L. D. Low to H. L. Price dated 7/31/64
2. Immediate Action Directive dtd. 6/7/63

OFFICE ▶	REG	REG				
SURNAME ▶	CHenderson:aw	HLPrice				
DATE ▶	7/31/64	7/ /64				

Form AEC-318 (Rev. 9-53) U. S. GOVERNMENT PRINTING OFFICE 16—62761-8

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Harold L. Price
Director of Regulation

JUL 31 1964

Lawrence D. Low, Director
Division of Compliance

PRELIMINARY INFORMATION CONCERNING CRITICALITY ACCIDENT AT UNITED NUCLEAR CORPORATION'S U-235 SCRAP RECOVERY FACILITY, WOOD RIVER JUNCTION, RHODE ISLAND - LICENSE NO. SNM-777

About 6:30 P.M., Friday, July 24, 1964, the Director, Division of Operational Safety, received a telephone call from Mr. R. C. Johnson who identified himself as an official of the United Nuclear Corporation, New Haven, Connecticut. He said he was calling from home and that he was reporting a criticality accident that happened at the plant at 6:00 P.M., Friday. He said he had no details but he understood the accident occurred when an employee was pouring a liquid from a container of safe geometry to one of unsafe geometry. He said the operator who was involved was "sick". He furnished telephone numbers for his home and the United Nuclear Corporation plant in New Haven, Connecticut. He said he was leaving for the plant. (Mr. R. C. Johnson is Manager, Chemical Operations, United Nuclear Corporation.)

Subsequent telephone conversations with United Nuclear Corporation officials indicated that: the accident was at their scrap recovery plant at Wood River Junction, Rhode Island; about five employees were in the facility at the time of the accident; the plant was evacuated at the sound of the radiation alarm initiated by the accident; and one employee was believed to be seriously irradiated and was being hospitalized at Rhode Island Hospital, Providence.

United Nuclear Corporation has an AEC license authorizing the operation of their Wood River Junction facility for the recovery of uranium from unirradiated U-235 scrap and solutions.

Two inspectors from the Division of Compliance, New York City, and two representatives from the New York Operations Office Radiological Emergency Assistance Team were sent to the plant. One of the Division of Compliance representatives arrived at the plant about 3:30 A.M., Saturday, and the other arrived at the hospital in Providence about the same time. The Radiological

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Emergency Assistance Team arrived at the plant early Saturday morning and remained until mid-morning. All of these personnel were to render assistance; assess the condition of the plant and plant area (on and off-site) from a safety standpoint; and assure that safe follow-up steps were being taken. In addition, Compliance personnel initiated their investigation of the accident.

On Saturday morning an AEC consulting physician, John B. Stanbury, M.D., of Boston arrived at the hospital to provide advice and assistance. (Dr. Stanbury is one of the consultants, under contract with the Division of Compliance, who is retained to provide advice and assistance and participate in the investigation of radiation incidents.)

The following information has been reported by AEC personnel from the scene of the accident as it developed. It is very preliminary information which is subject to further investigation and verification. It will be some time before all information is gathered and the reports are written and evaluated.

The criticality accident occurred while an employee, Mr. Robert Peabody, an operator, was pouring liquid from a cylindrical polyethylene bottle, approximately 5 inches in diameter and 48 inches in length and having a capacity of about 11 liters, into a chemical makeup tank approximately 18 inches in diameter and 25 inches in depth. The geometry of the bottle is such as to assure against criticality for uranium-bearing solutions of any concentration. The tank is normally used for making up a process wash solution of sodium carbonate. (It is not certain at this time as to what solutions or amounts of fissile material were in the bottle or the tank at the time of the accident.) When nearly all the liquid in the bottle had been poured into the tank, the nuclear chain reaction occurred. When the accident occurred and the radiation alarms sounded, four others were in the building. (These four were: [redacted] All evacuated immediately to the emergency shack about 200 yards from the facility. [redacted] then called an ambulance and notified the plant manager, Mr. Holthaus, and other company officials. Ex 6

Mr. Peabody, who poured the liquid into the tank, stated, in substance, the following on Saturday morning. (He appeared to be lucid although he was in some state of shock.) He said he was pouring the liquid from the bottle into the tank and when

he had poured about 10 of the 11 liters he saw a "flash". He said he was knocked backward a few feet and fell to the floor. He said he got up immediately and ran from the building, removing his clothing as he went. It was learned from him and from other sources that he was taken from the emergency shack by ambulance to go to Westerly Hospital at 7:00 P.M. Reportedly a police car contacted the ambulance by radio and diverted it to Rhode Island Hospital. One of the employees who was in the building at the time of the accident accompanied him in the ambulance. The total radiation dose received by Mr. Peabody has been estimated by Dr. Stanbury to be about 7,000 rems. Mr. Peabody's condition grew progressively worse on Saturday and Sunday and he died at about 7:20 P.M., Sunday, July 26, 1964, approximately 49 hours after the accident.

The [redacted] arrived at the plant about 6:30 P.M. (Friday). He and Mr. [redacted] who was one of the five in the building when the accident occurred) surveyed around the building and probed various entries to the building, using radiation monitoring equipment that was in the emergency shack. They then left the building; got high range monitoring instruments from Civil Defense personnel who had arrived at the scene in the meantime; and re-entered the building, reportedly to assure that no further chain reaction could take place. Mr. [redacted] says they probed their way with their instruments and proceeded to the room on the third floor where the accident occurred. He said [redacted] stayed at the doorway and he, Mr. [redacted] entered the room. He said he shut off the agitator and took the cylindrical bottle from the tank and threw it on the floor, all of which, he says, took about 5-10 seconds.* He said they then went to the first floor and drained some of the liquid from the third floor using a column already connected to the tank. They drained liquid into about five one-gallon receptacles. (Later, these receptacles were observed to be filled to varying amounts.) Mr. [redacted] says this operation took them about five minutes.* Both men then left the building and returned to the emergency shack. Reportedly the entire operation took them about 40 to 45 minutes,* which included surveying and probing outside as well as inside the building.

Ex6

* These times are at best rough estimates.

Mr. [ ] together with the [ ] employees who were in the building at the time of the accident, and [ ] who arrived at the plant after the accident, went to the hospital in a police car about 8:30 P.M. [ ] had participated in limited radiation survey work in the building.) All were decontaminated, examined, and released. They returned to the plant site about 2:00 A.M., Saturday. Ex. 6

When the film badge processor reported the film badge results they stated: [ ] read 300 plus rems; Mr. Peabody's read 300 plus rems; [ ] read 45 rems; [ ] read 2.5 rems; [ ] read 1.8 rem; and [ ] read 0.27 rem. [ ] did not have a film badge when he accompanied Mr. [ ] on re-entry to the building because it had been left on the clothing he removed immediately after the accident. As a result of the film badge readings, Messrs. [ ] returned to the hospital on Sunday. [ ] also returned to the hospital at the same time because he did not have a film badge when he did some survey work in the building after the accident. All were examined, and in light of the high film badge reading for [ ] both he and [ ] were admitted. Messrs. [ ] were released after examination; however, they were scheduled for periodic re-examinations and blood samples. Ex. 6

Later Sunday night, the film badge processor reported that the film badge readings were in error. He reported a corrected reading of 50 rems for [ ] instead of 300 plus rems, and 2 to 3 rems for [ ] instead of 45 rems.

As of Thursday, July 30, 1964, Dr. Stanbury reported on the condition of Messrs. [ ] On the whole, the blood count data have been normal or within normal limits of variation. As to blood chemistry, the level of uric acid in both men is slightly elevated. Dr. Stanbury said the values for uric acid are consistent with, but not necessarily related to or symptomatic of, radiation exposure. As of 5:15 P.M. Thursday both men were in Boston to be examined in the whole body counter at Massachusetts Institute of Technology. The examination of [ ] was in progress. Dr. Stanbury said a preliminary telephone report indicated some sodium 24 activity for [ ] but he did not have any values. [ ] had not been examined. Ex. 6

Radiation levels reported by United Nuclear Corporation after the initial survey made a few minutes after the accident showed about 50 mr/hour at the emergency shack approximately 200 yards from the plant building. About an hour later this level dropped to about 10 mr/hour.

The Radiological Emergency Assistance Team took measurements Saturday morning and reported gamma radiation levels adjacent to the building were about 0.1 milliroentgen per hour. About 20 yards from the building, radiation levels above background were not detectable. Alpha radiation surveys made between the building and a dirt road running north and south parallel to the front of the building showed in the order of 100 counts per minute alpha radiation in several bare spots. The road is about 200 feet from the building. The road, which is in line between the shack and the building, gave readings of approximately the same level. A telephone pole, on the edge of the road roughly 300 feet southwest of the building, gave readings of approximately 200 counts per minute. The level of activity in the roadway decreased to non-detectable levels within approximately 300 to 400 feet, from the telephone pole, north and south along the roadway. The Radiological Emergency Assistance Team left the site Saturday morning after concluding that no off-site hazard existed.

The company has developed detailed plans for systematic decontamination of the facility and for determining, insofar as possible, the magnitude of the nuclear excursion. The company has assembled for these purposes a task force of senior engineers and nuclear experts from its New Haven and White Plains divisions. Mr. W. L. Allison, Quality Control Manager, Fuel Division, United Nuclear Corporation, New Haven, Connecticut, is chief of the task force and in charge of all clean-up and technical study operations. Dr. M. M. Shapiro, Manager of Research Operations, Development Division, United Nuclear Corporation, White Plains, New York, is in charge of plans and execution of the technical study and reconstruction of the accident. It is expected that decontamination of the facility will be completed sometime during the first week of August. Dr. Marvin M. Mann, Assistant Director of Regulation for Nuclear Safety, was at the hospital on Sunday and the plant on Monday to provide advice and assure that all proper actions were being taken. He was apprised of the company's plans and organization for re-entry work in the plant and considered them adequate from a safety standpoint.

The licensee issued a public announcement of the accident about midnight Friday. A copy of the text is attached. On Saturday

at 5:30 P.M. the licensee held a press conference. A statement was issued (text attached); questions were answered; and TV crews and reporters were taken into a decontaminated office and guard station area of the facility, where the process and column areas could be observed, to show them that no structural or equipment damage had taken place. (Some news media had referred to the nuclear accident as an "explosion".) Local news media in the Rhode Island area have given full coverage to the accident. It appears to be reasonably factual and in perspective. National news media have given limited and brief accounts of the accident and Mr. Peabody's death. On Saturday, July 25, the Division of Public Information sent an information officer from Headquarters to Providence to assist in handling news media inquiries.

Immediately after the initial notification of the accident was received in AEC, all AEC persons having functional responsibility or interest were notified. The staff of the JCAE were notified and are being kept currently informed.

Additional Compliance inspectors were sent to the plant from New York City. They are observing company activities in the facility and are proceeding with the investigation.

Enclosures:
A. Statement Issued by United Nuclear Corp., 7-24
B. Statement Issued by United Nuclear Corp., 7-25

Statement Issued by United Nuclear Corporation
Friday night, July 24

United Nuclear Corporation's fuel recovery plant at Wood River Junction, Rhode Island, experienced a nuclear criticality accident at approximately 6:00 P.M., Friday. The plant was occupied by four employees at the time, and was immediately evacuated.

Health physics personnel from United Nuclear and the Rhode Island Office of Civil Defense surveyed the area and were able to re-enter the plant at about 9:30 P.M.

Exposed personnel were transferred to Rhode Island Hospital at Providence for examination and evaluation of radiation dosages received. Company officials stated that all contaminated materials were restricted to the third floor of the plant tower and there was no release of radioactive materials outside the plant building.

The accident occurred when a solution containing enriched uranium was poured from a geometrically safe container into a larger vessel, in violation of plant safety procedures.

The accident is being investigated by the New York office of the Atomic Energy Commission. Additional information will be released by United Nuclear after the investigation has been completed.

Enclosure A

Statement Issued by United Nuclear Corporation at 5:30 P.M. Saturday, July 25, at Wood River Junction, Rhode Island

Continued measurements of the area surrounding the United Nuclear Fuel recovery plant here have confirmed that no nuclear matter was spread beyond the plant confines.

Contrary to earlier reports, there was no nuclear explosion. The incident consisted of the fissioning of a solution which produced flash boiling. The radioactive material remained within a localized 25-foot square area of the plant.

The incident has been attributed to human element and not operating procedures or plant design.

Mr. Robert Peabody, who was closest to the radiation burst, is listed as in "fair" condition at Rhode Island Hospital, Providence, where he is being attended by a team of radiation specialists. All other employees were checked at a hospital and released after confirmation that exposures received were minor.

Decontamination of the plant is expected to take several days. The cleaning began Saturday under supervision of United Nuclear officials, with assistance from the Atomic Energy Commission and the Rhode Island Civil Defense personnel.

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Enclosure B

Form AEC-313
(7-61)

Published in advance of incorporation in AEC Manual 0707
File and retain in Manual until superseded.

UNITED STATES ATOMIC ENERGY COMMISSION
AEC MANUAL

IMMEDIATE ACTION DIRECTIVE

DATE: June 7, 1963

IAD NO. 0700-8

SUBJECT: RADIATION INCIDENT INVESTIGATIONS WHICH ARE THE RESPONSIBILITY OF THE DIRECTOR OF REGULATION

This directive establishes policy and assigns responsibility and authority of the Regulatory Staff for radiation incident investigations which are the responsibility of the Director of Regulation.

The attached instructions are to be placed in effect July 1, 1963 by the Regulatory Staff, pending the issuance of a revised Manual Chapter 0707 that is in preparation. AEC Chapter 0707, dated May 22, 1957, is rescinded.

Harold L. Price

Director of Regulation

INSTRUCTIONS IN REGARD TO RADIATION INCIDENT INVESTIGATIONS WHICH ARE THE RESPONSIBILITY OF THE DIRECTOR OF REGULATION

EFFECTIVE July 1, 1963

A. Policy

It is the policy of the Atomic Energy Commission to investigate incidents which involve source, byproduct, or special nuclear materials subject to license or regulation by the Atomic Energy Commission.[1]

B. Objectives

1. To investigate incidents to determine their cause or causes and to ascertain the status of compliance by the licensee[2] with applicable laws and AEC regulatory requirements.

2. To provide prompt and factual information to the public regarding incidents.

3. To provide a basis for the improvement of AEC rules, regulations, guides, and standards for the utilization of materials and facilities.

C. Duties, Responsibilities and Authorities

1. The Director of Regulation appoints committees as provided in Section G.

2. The Director, Division of Compliance, shall:

a. inform the Director of Regulation, the General Manager, members of their respective staffs, and the Director of Inspection of notifications or reports of incidents, as provided in Subsections F. 2. and F. 3.

1/ Attention is directed to the definition of the term "materials subject to license or regulation by the AEC" contained in Subsection D.4.

2/ Attention is directed to the definition of the term "licensee" contained in Subsection D.5.

b. conduct investigations of incidents in accordance with the provisions of Section E and Subsection F.4.

c. prepare and submit reports of or provide information with respect to, results of investigations, as provided in Subsections F.6. through F.11., inclusive.

d. assure that each person who is exposed to radiation as a result of an incident is interviewed by an AEC physician, as provided in Subsection F.5.

e. furnish information and assistance in the preparation and release of public statements on incidents, where deemed appropriate and in accordance with AEC Manual Chapter 3105.

f. assure that appropriate State authorities and Federal agencies are informed of incidents which occur within or under their jurisdiction, and that the Federal Bureau of Investigation is informed of alleged or suspected criminal violations of Federal law, including the Atomic Energy Act of 1954, as amended.

D. Definitions

1. For the purpose of this instruction, an "incident" is any occurrence falling within the definitions below of "Type A" or "Type B" incidents.

2. For the purpose of this instruction, a "Type A" incident is an incident involving source, byproduct, or special nuclear material subject to license or regulation by the AEC which may have caused or threatens to cause:

a. exposure of the whole body of any individual to 25 rems or more of radiation; exposure of the skin of the whole body of any individual to 150 rems or more of radiation; or exposure of the feet, ankles, hands or forearms of any individual to 375 rems or more of radiation[3/]; or

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3/ Intentional exposure of patients to radiation for the purpose of medical diagnosis or medical therapy excluded.

b. the release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 5,000 times the limits specified for such materials in Appendix B, Table II, 10 CFR 20; or

c. a loss of one working week or more of the operation of any facilities affected; or

d. damage to property in excess of $100,000.

3. For the purpose of this instruction, a "Type B" incident is an incident involving source, byproduct, or special nuclear material subject to license or regulation by the AEC which may have caused or threatens to cause:

a. exposure of the whole body of any individual to 5 rems or more of radiation; exposure of the skin of the whole body of any individual to 30 rems or more of radiation, or exposure of the feet, ankles, hands, or forearms to 75 rems or more of radiation[3/]; or

b. the release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 500 times the limits specified for such materials in Appendix B, Table II, 10 CFR 20; or

c. a loss of one day or more of the operation of any facilities affected; or

d. damage to property in excess of $1,000.

4. As used in this instruction, the term "materials subject to license or regulation by the AEC" means source, byproduct, or special nuclear material which is subject to the licensing authority of the AEC, pursuant to Parts 30, 40 or 70, and also other source, byproduct, or special nuclear material while located on site in connection with the operation of a facility licensed pursuant to Part 50.

5. As used in this instruction, the term "licensee" means any person who is subject to the licensing authority of the AEC pursuant to Parts 30, 40 or 70, and any person to whom a license has been issued pursuant to Part 50.

3/ Intentional exposure of patients to radiation for the purpose of medical diagnosis or medical therapy excluded.

E. Investigations

Each investigation shall be designed and executed to determine the facts and circumstances of each incident. In particular, the investigation should:

1. establish the nature, extent, and particulars of the incident.

2. ascertain the cause of the incident.

3. ascertain the status of compliance of the licensee with applicable laws and AEC regulatory requirements.

4. ascertain what action, if any, licensee management has taken, or plans to take, to minimize or preclude similar incidents.

5. provide information which will assist the AEC to determine corrective action appropriate to minimize or preclude similar incidents.

6. provide information which will assist the AEC to improve rules, regulations, guides and standards for the utilization of materials and facilities.

F. Procedure for Investigation and Reporting of Incidents

1. Regulatory Divisions and Regional Offices which receive a notification or report of an incident shall promptly refer such notice or report to the Division of Compliance by telephone with confirmation in writing. Referrals should be made to the Assistant Director for Reactors or the Assistant Director for Materials, as appropriate.

2. The Director, Division of Compliance, promptly shall inform the Director, Division of Licensing and Regulation, of each notification or report of an incident.

3. The Director, Division of Compliance, shall inform the Director of Regulation; Director, Division of Radiation Protection Standards; the General Counsel; the General Manager and appropriate members of his staff, including the Director, Division of Public Information; and the Director, Division of Inspection, of notifications or reports of significant incidents.

4. The Director, Division of Compliance, shall initiate appropriate investigation of the reported incident, which investigation shall satisfy the provisions of Section E.

5. The Director, Division of Compliance, shall assure that each person who, as a result of an incident, is exposed or suspected to have been exposed to a radiation dose in the amounts specified in Subsection D.2.a., is informed by the AEC physician[4/] assigned to assist in the investigation, whether such person should seek medical assistance and that, if such person's physician desires advice and assistance from an AEC physician, such assistance is available upon request.

6. Upon completion of the investigation, the Division of Compliance will prepare a report of the investigation, consisting of investigation details and a summary of the facts, with respect to: the nature, extent, and particulars of the incident; cause or causes of the incident; and the status of compliance of the licensee with applicable laws and AEC regulatory requirements.

7. The Director, Division of Compliance, shall furnish the Director, Division of Licensing and Regulation, reports of investigation concerning each incident investigated pursuant to this instruction.

8. The Director, Division of Compliance, shall advise those informed of the incident pursuant to paragraph F.3., above, of the results of the investigation.

9. The Director, Division of Compliance, shall provide information, as appropriate, to the Director, Division of Licensing and Regulation, with respect to: action taken or planned by licensee management to minimize or preclude similar incidents; information which will assist the AEC to determine corrective action appropriate to minimize or preclude similar incidents; and information which will assist the AEC to improve rules, regulations, guides and standards for the utilization of materials and facilities.

4/ or consultant physician directly responsible to AEC

10. The Director, Division of Compliance, shall furnish the Director, Division of Radiation Protection Standards, information concerning exposure of persons and release of radioactive material to the environment as a result of an incident.

11. The Director, Division of Compliance, shall make investigative information available to any committee which may be appointed pursuant to Section G.

G. Committees

1. Where an incident has particularly significant health and safety or public interest aspects, the results of the investigation thereof may be reviewed by a committee qualified to provide expert opinion and advice.

2. The Director of Regulation will determine, with respect to incidents reported to him pursuant to Subsection F.3. or otherwise brought to his attention, whether a committee should be appointed; will appoint the members; and will designate the chairman.[5/]

3. A committee appointed by the Director of Regulation pursuant to Subsection G.2. will:

a. review information gathered by the investigation.

b. advise whether additional investigation should be conducted, and, if so, in what particulars.

c. review and comment on the information developed as a result of the investigation with respect to such matters as the nature of the incident, its cause or causes, and matters to be considered in order to minimize or preclude similar incidents.

d. prepare a report for the Director of Regulation.

4. The committee may question witnesses and examine documents, equipment, facilities, and sites pertinent to the incident.

5. The Director, Division of Compliance, shall keep the committee fully and currently informed with respect to information and data gathered during and as a result of the investigation.

5/ In accordance with the provisions of 10 CFR 7, "Advisory Boards" (AEC Manual Chapter 0105 - AEC Advisory Boards).

H. Basic Requirements

1. References

a. Licensees are required to submit notification and report of incidents to the Division of Licensing and Regulation and the Division of Compliance in accordance with particular license provisions and Title 10 of the Code of Federal Regulations.

b. Manual Chapter 0703, "Notification, Investigation, and Reporting of Incidents Requiring Immediate Notice to Headquarters," establishes Commission policy for investigation of incidents and, inter alia, provides that the Director, Division of Inspection, conducts investigations of incidents occurring in licensed activities when requested by the Commission (033 d.(2)).

I. Rescinding of Manual Chapter

Manual Chapter 0707, dated May 22, 1957 is rescinded.