NRC Public Meeting, Erwin Town Hall, Erwin, TN
September 30, 2014, 6:00-8:30 p.m.

Questions/Comments for the NRC

Session 1

1. Spreadable Contamination – NRC Integrated Inspection Report (70-143/2014-003) and **Notice of Violation**, July 30, 2014, **and** Unplanned Medical Treatment Reporting, NRC Integrated Inspection Report (70-143/2013-005), January 28, 2014.

2. Special Inspection Report 70-143/2014-006, August 29, 2014, (Event Report 50208), involving "an employee observed by an NFS supervisor to be improperly operating two valves identified as key safety devices," and the failure of NFS to make a report in accordance with federal regulations. Status of "Apparent" Violation.

3. NFS Safety Culture and the 2007 and 2010 Confirmatory Orders

Spreadable Contamination

Comments: NRC Integrated Inspection Report (70-143/2014-003) and Notice of Violation. While the violation was for not reporting two "spreadable contamination" events to the NRC, the spreadable contamination itself is an even greater concern.

For the sake of everyone here who does not know about this, on October 17 and October 29, 2013, (nearly a year ago) two NFS workers were injured and had "spreadable contamination" on their clothing and skin. They were transported by ambulance, in one case, to a "local" hospital, and in another case, to a "regional" hospital.

Comments:
The first accident on October 17 involved a security officer who lost consciousness and fell to the floor in a contamination controlled area. It was determined that he had contamination on his lower pant leg and that section of his pants was removed. The back side of his body was not surveyed. At the "local" hospital, it was determined that he had contamination 7 times the background reading for the instrument measuring the contamination. The hospital staff removed his clothing and put them in a bag for return to the plant. The re-suvey of the pants at the NFS plant indicated contamination **12 times the background reading**. Spreadable contamination was present on the officer's clothing when he was at the hospital, therefore, NFS should have notified the NRC within 24 hours, but they did not.

The second accident on October 29 involved a maintenance mechanic, working in a radiological work site on an upper roof, fell to a lower roof breaking his leg. Surveys indicated that he had contamination on his clothing and the skin of his leg – a level **7 times more than background**.

(Contamination on the skin is considered spreadable because outer layers of the skin die and fall off). The worker was transported by ambulance to a "regional" medical center. The contamination on the skin was NOT removed. Once again, the medical staff removed the contaminated clothing and put them in a bag for return to the plant. And, again, NFS did not notify the NRC in accordance with federal regulations.

Questions:

For the October 17 accident, was the "local" hospital Unicoi County Hospital? What was the diagnosis of the security officer? Why did he collapse? What is a contamination controlled area?

For the October 29 accident, was the "regional" hospital Johnson City Medical Center? If not, which hospital was it? What is a radiological work site?

For each event and facility, what exposure did the ambulance driver and medical personnel have?

Comments:

We first find this mentioned in a January 28, 2014 inspection report, which stated, for the October 17, 2013 event involving the security officer, "the licensee reported contamination was found on the officer's clothing at the hospital, but on further analysis, the licensee reported detectable transferrable contamination was not found."

And for the October 29, 2013 event involving the maintenance mechanic who fell off the roof and broke his leg, the licensee reported no contamination was found on the mechanics skin or coveralls at the hospital, but the smear results on the hospital floor indicated the presence of removable contamination." "At the time of the radiation protection exit meeting, the licensee evaluated the contamination as naturally occurring radioactive material."

Then, we read the July 30, 2014 inspection report and find that the workers DID have spreadable contamination on them. It appears that the licensee did not tell the Senior Resident Inspector the truth. And, according to the NFS reply to violation, they finally reported the two events in July 2014 – just a couple of months ago. And now, the public is finding out about it nearly a year later. Unbelieveable!

Special Inspection Report

Comment: The special inspection report **is not complete** because it never explains "why" the operator put the box end wrench on the spring loaded valve. All the report says is that "the primary cause of this event was the operator's failure to follow procedure requirements for the proper operation of the safety related valves."

We see in the report that on:

"June 11, a flow restriction requiring operators to hold open the Area B spring return valves for several minutes was documented in the Corrective Action Program (CAP)."

"June 16, the Area B pure ammonium hydroxide supply strainer was replaced, tested, and verified to fill one batch in 50 seconds. "

Comment: It is very puzzling to me why someone would do this for a column batch fill time of 50 seconds. It makes no sense.

Questions:

Why did the operator do that (rendering all safety systems inoperable) when it took only 50 seconds to fill one batch? Was there an expectation that it would take long than usual? Was holding the valves open with a box end wrench something the operator did routinely?

Was the operator not told that the repairs had been made? If not, why not? Was there another obstruction in the system?

Was the operator accustomed to work-arounds and substandard equipment? Because, we see on page 8 of the report that "a small population of other valves was found to have been modified with plastic pipe or tape around the handles, or operated with leveraging devices to ergonomically assist operators."

Comment: Isn't this the company that in June 2013 dedicated a new $30 Million dollar facility and in February this year (2014) received $300 Million dollars of government contracts – yet their workers have to tape up handles and jury-rig valves to make them easier to operate.

Questions:

What is the status of the current "Apparent" Violation? Will we see a monetary fine to accompany the violation?

And whatever violation you do finally issue, will we see the licensee make more empty promises and talk their way out of it, as you have allowed them to do in the past?

NFS Safety Culture

Comments: I go back to the first Independent Safety Assessment – the SCUBA I Report conducted in 2007. (The date of the report was February 18, 2008). On Page 28, under "Resources," it states: "This Safety Culture Component does not meet regulatory expectations. **The NFS organization has become accustomed to tolerating recurring equipment problems, operational burdens & workarounds, degraded equipment conditions and degraded infrastructure issues.**

And then the second Independent Safety Assessment, SCUBA II, dated June 21, 2010, which stated:

Safety Culture initiatives were mandated by NRC Confirmatory Order to NFS, Feb. 21, 2007. NFS made promises to the NRC, which in return agreed not to pursue a number of pending escalated enforcement issues (p. 147). **However, NFS did not comply with the 2007 Confirmatory Order**. NFS made only nominal progress in improving safety culture since the 2007/2008 (SCUBA I) findings. Findings are essentially a **repeat** from 2007/2008 (p.2). (I was not aware that federal regulations were negotiable).

NFS continues to tolerate recurring equipment problems, operational burdens and workarounds, and degraded infrastructure issues (p. 49). Rather than improving its safety culture and performance, NFS has continued to divert its resources to pursue new business opportunities (p. 52).

And in October and November 2010 there were two major accidents at NFS that shut the plant down for three months January-March 2011.

Yet another Independent Safety Assessment was done in March 2013, (dated June 19, 2013). Report stated:

"the current March 2013 survey results do not differ from last year's survey results (March 2012), thus suggesting no change during the past year."

The report stated that out of the 10 Nuclear Safety Culture traits examined, **NFS was *Unacceptable* on four of the ten, and that "NFS appears to benchmark to minimum standards rather than to excellence."**

That does not suggest an improved safety culture to me.

Confirmatory Orders

Questions:

And didn't I recently see a letter from Joe Henry asking that the 2010 Confirmatory Order be closed? And, what is the status of the 2007 Confirmatory Order given to NFS after the 9 gallon spill of High-Enriched Uranium on March 6, 2006? I don't think nearly enough safety improvements have been made to close either of them. This is simply business as usual.

Session 2

1. NAS Cancer Study.

Question:

What can the local public do to provide information and/or assist in the NAS Cancer Study, and who would be the NAS point of contact for public input?

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