UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

DRAFT

November 8, 1993

MEMORANDUM FOR: Dwight D. Chamberlain, Acting Director
Division of Radiation Safety and Safeguards

FROM: Charles L. Cain, Acting Deputy Director
Division of Radiation Safety and Safeguards

SUBJECT: REGIONAL ACTIONS TAKEN AFTER RECEIPT OF COPIES OF DIANE CURRAN LETTERS DATED SEPTEMBER 28, 1993

There were three letters from Diane Curran dated September 28, 1993. One of these was addressed to Ben B. Hayes, Director of OI, and the second to David C. Williams, NRC Inspector General. A third letter was addressed to John C. Martin, EPA Inspector General. The letters transmitted a NACE report, "Silent Sirens," dated September 28, 1993.

Copies of these letters and the report were received in the Region IV office by fax from NMSS during the morning of September 30, 1993. It is believed that copies were immediately distributed to Joe Callan, DRSS Division Director, and members of the AIT that reviewed the subject SFC event. These team members were Bill Fisher, Linda Kasner, and Mike Vasquez. Others in the Region IV office no doubt also received copies that day. It is presumed that Joe informed the Region IV Regional Administrator of the submittal.

Joe Gilliland, Region IV Public Affairs Officer, recalls that he was faxed copies of the letters by a newspaper on September 29 and provided copies to several staff members including the Allegations Coordinator and DRSS and OI staff members.

Joe Callan convened a meeting of the AIT members to discuss the submittal within several days of its receipt. This meeting concluded that the submittal contained no information regarding the event that the team was unaware of. Because the letters were directed to OI and the IG, the division determined that no regional action should be taken other than to prepare to answer questions that would be posed by these two offices.

The submittal was also discussed with members of the Low Level Waste Management Branch, NMSS, during the week of October 4, 1993. The purpose of the discussion was to determine whether NMSS or the regional office should respond. Mr. James Shepherd, the SFC project manager, informed Linda Kasner that NMSS did not intend to prepare a response to Ms. Curran.

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CHRONOLOGY OF EVENTS
RESULTING FROM THE CHEMICAL RELEASE AT
SEQUOYAH FUELS CORPORATION

11/17/92 Chemical release event occurs. AIT is dispatched to site. The team is led by W. L. Fisher, and members include G. M. Vasquez, L. L. Kasner, and C. H. Robinson (NMSS). The inspection is conducted November 17-21, 24, and 25, 1992. A public exit briefing is held November 25. (Inspection Report 92-30 is issued 12/18/92.)

11/18/92 A CAL is issued to SFC confirming that they will investigate the incident, brief NRC staff on the findings, and obtain NRC concurrence before restarting the plant.

11/23/92 SFC announces in a letter to the NRC that it will not resume UF6 production and will eventually cease DUF4 production.

12/8/93 SFC issues letter to the NRC outlining a corrective action plan.

12/8/92 Inspection 92-31 commences. This inspection, conducted December 8-11, 16-17, and 23, 1992, confirms that the licensee's corrective actions have been implemented and that they are effective. (Inspection Report 92-31 is issued 1/21/93.)

12/9/92 A public meeting is held at the SFC site during which the licensee's corrective action plan is discussed. Who else there?
NMSS - Mike Tokar. RIV / NMSS

12/11/92 Based on the results of the initial segment of Inspection 92-31, the licensee is notified that three outstanding issues need to be addressed before NRC will authorize restart of the DUF4 facility. These issues include -

1. resolving operational as well as hardware related deficiencies ("work arounds")

2. providing assurance that DUF4 operators will comply with facility operating procedures

3. describing the level of oversight planned by licensee management during the initial restart period.

The licensee responds to these issues by letter dated 12/14/93. These issues are further reviewed by an NRC inspector on 12/16-17/92. At that time two outstanding issues remain to be completed. By letter dated 12/22/92, SFC provides a further response to the NRC.

12/11/92 NRC's medical consultants issue their report.

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ENCLOSURE 7

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

NOV 17 1993

MEMORANDUM FOR: James L. Milhoan, Regional Administrator

FROM: Dwight D. Chamberlain, Acting Director
Division of Radiation Safety and Safeguards

SUBJECT: REGIONAL ACTIONS TAKEN AFTER RECEIPT OF COPIES OF DIANE CURRAN LETTERS DATED SEPTEMBER 28, 1993, AND NOVEMBER 4, 1993, REGARDING SEQUOYAH FUELS

Per your request during a meeting on November 8, 1993, this memorandum provides a summary of regional actions related to the captioned subject.

There were three letters from Diane Curran dated September 28, 1993. One of these was addressed to Ben B. Hayes, Director of OI, and the second to David C. Williams, NRC Inspector General. A third letter was addressed to John C. Martin, EPA Inspector General. The letters transmitted a NACE report, "Silent Sirens," dated September 28, 1993, relating to the chemical release event at Sequoyah Fuels Corporation (SFC) which occurred on November 17, 1993.

Copies of these letters and the report (minus appendices) were received in the Region IV office by fax from NMSS during the morning of September 30, 1993. It is believed that copies were immediately distributed to Joe Callan, DRSS Division Director, and members of the Augmented Inspection Team (AIT) that reviewed the subject SFC event. These team members were Bill Fisher, Linda Kasner, and Mike Vasquez. Others in the Region IV office no doubt also received copies that day, and the Region IV Regional Administrator was informed of the letters.

Joe Gilliland, Region IV Public Affairs Officer, recalls that he was faxed copies of the letters by a newspaper on September 29 and subsequently provided copies to several staff members including the Allegations Coordinator and DRSS and OI staff members.

On October 6, Joe Callan convened a teleconference of the AIT members to discuss the letters. During this meeting the various allegations raised in the report were reviewed to determine whether any new information was presented. This meeting concluded that, based on an initial review, the letters contained no new technical information regarding the event. Because the letters were directed to OI and the IG, the division determined that no immediate regional action should be taken other than to prepare to answer questions that would be posed by these two offices.

The letters were also discussed with a member of the Low Level Waste Management Branch, NMSS, during the week of October 4, 1993. The purpose of the discussion was to determine whether NMSS or the regional office should

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respond. Mr. James Shepherd, the SFC project manager, informed Linda Kasner that NMSS had no assigned action and was not planning to prepare a response.

At the request of OI, this matter was discussed at a Region IV Allegation Review Panel (ARP) meeting on October 25, 1993. The ARP decided to rereview the matter on November 1, 1993. At the November 1 meeting it was discussed that the initial DRSS review did not identify any new technical issues and the review was continuing. The panel's decision was that no further action by Region IV staff was warranted at this time.

The ARP again met on November 8, 1993, to review another letter from Ms. Curran dated November 4, 1993. This letter was addressed to Ben B. Hayes, Director of OI. The panel discussed actions proposed by DRSS to develop a position/response for the points identified in the letter. These actions are on going and are expected to be completed by the end of November 1993. This was to be used for review with OI and for a possible response. It was again noted that this letter appeared to contain no technical information which had not been previously addressed by the AIT and followup inspections. The panel agreed with the proposed actions.

Attached is a chronology of events relating to the chemical release event which occurred at Sequoyah Fuels Corporation on November 17, 1992.

Dwight D. Chamberlain

Dwight D. Chamberlain, Acting Director
Division of Radiation Safety and Safeguards

Attachment:
As stated

cc:
L. Williamson, OI

CHRONOLOGY OF EVENTS
RESULTING FROM THE CHEMICAL RELEASE AT
SEQUOYAH FUELS CORPORATION

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11/18/92 A CAL is issued to SFC confirming that they will investigate the incident, brief NRC staff on the findings, and obtain NRC concurrence before restarting the plant.

11/23/92 SFC announces in a letter to the NRC that it will not resume UF6 production and will eventually cease DUF4 production.

12/8/92 SFC issues letter to the NRC outlining a corrective action plan.

12/8/92 Inspection 92-31 commences. This inspection, conducted December 8-11, 16-17, and 23, 1992, confirms that the licensee's corrective actions have been implemented and that they are effective. (Inspection Report 92-31 is issued 1/21/93.)

12/9/92 A public meeting is held at the SFC site during which the licensee's corrective action plan is discussed. NRC staff members from Region IV and NMSS are present.

12/11/92 Based on the results of the initial segment of Inspection 92-31, the licensee is notified that three outstanding issues need to be addressed before NRC will authorize restart of the DUF4 facility. These issues include -

1. resolving operational as well as hardware related deficiencies ("work arounds")

2. providing assurance that DUF4 operators will comply with facility operating procedures

3. describing the level of oversight planned by licensee management during the initial restart period.

The licensee responds to these issues by letter dated 12/14/93. These issues are further reviewed by an NRC inspector on 12/16-17/92. At that time two outstanding issues remain to be completed. By letter dated 12/22/92, SFC provides a further response to the NRC.

12/11/92 NRC's medical consultants issue their report.

12/17/92 Commissioner Curtiss visits the site. NACE, media representatives, and the Region IV Regional Administrator are in attendance.

12/21/92 Licensee briefs the Commission during a public meeting regarding its future plans and financial assurance resources for decommissioning the facility.

12/23/92 An NRC inspector confirms that final corrective actions have been completed, and a CAL is issued authorizing restart of DUF4 production based on the findings of Inspection 92-31 and confirming continuation of the UF6 in standby mode indefinitely.

1/29/93 Inspection Report 92-32 issued. This inspection, conducted December 28-31, 1992, and January 3-6, 1993, identifies six apparent violations:

1. Failure to follow a procedural caution statement requiring a slide gate valve to a previously used digester to be closed if the digester to be placed in service is not the same as the one used to mix the most recent batch.

2. Failure to ensure, in accordance with the facility contingency plan, that the control room was sealed to prevent entry of external contamination from the process area.

3. Two examples of a failure to follow contingency plan requirements to don respiratory protection.

4. Failure to follow contingency plan requirements to account for all personnel responding to an emergency.

5. Failure to follow contingency plan requirements to sound the air horn signal to alert facility personnel to an emergency condition.

6. Failure to promptly classify the event in accordance with the contingency plan.

2/10/93 SFC briefs the NRC staff in Rockville, Maryland, concerning future decommissioning plans and plans for completing DUF4 operations.

2/16/93 SFC letter to the NRC notifies of SFC decision to terminate activities involving licensed activities and attaches SFC's Preliminary Plan for Decommissioning.

3/2/93 Open enforcement conference held with licensee at the RIV office.

3/25/93 NRC issues NOV and Proposed Imposition of Civil Penalty - $18,000. The NOV cites a single Severity Level II problem. (The base

civil penalty of $8,000 was mitigated 50% as a result of the licensee's corrective actions. The penalty was escalated 75% due to poor past performance. The fact that SFC had knowledge of equipment problems that, if corrected, might have precluded the event, warranted an additional escalation of 100%.)

4/26/93 SFC issues letter transmitting full payment of civil penalty.

6/11/93 NRC issues letter to SFC acknowledging payment and disagreeing with the SFC conclusion that no other credible scenario could have resulted in greater personnel injury.

6/25/93 NRC letter to SFC stating that the licensee's site will be included on the Site Decommissioning Management Plan (SDMP) list.

7/6/93 SFC ends production of DUF4.

7/23/93 SFC letter requests exemption from contingency (emergency) plan based on a reduced inventory of hazardous materials on site.

10/20/93 SFC letter requests withdrawal of request for exemption from contingency (emergency) plan.

Note: A total of 15 inspections have been performed at SFC since the event.

CHRONOLOGY OF OI ACTIVITY
REGARDING THE CURRAN LETTER

9/29/93 OI:RIV received letter dated 9/28/93 from RIV (Gave copy to Hayes in R:IV)

10/5/93 An informal conversation was held between Williamson (OI:RIV) and Vasquez regarding 11/17/92 event. Vasquez indicated that there were no wrongdoing issues identified as a result of an inspection on the 11/17/92 incident.

10/21/93 Discussed 9/28/93 letter with Murphy (OI:HQ). He was informed that OI:RIV had talked with Vasquez and no wrongdoing issues cited. Murphy said he would have Hayes call Curran. OI:RIV requested that information go to Allegation Review Panel (ARP).

10/21/93 OI:RIV scheduled before ARP for 10/25/93.

10/21/93 Discussed letter with Cain and Kazner (RIV) and they indicated that:

(1) Event subject to six week AIT
(2) SFC closed for six weeks
(3) Several public meetings held
(4) Enforcement conference in March 1993
(5) Several violations cited
(6) Civil penalty issued - $18,000
(7) SFC closed

Cain/Kazner/Wise agreed to ARP

10/25/93 ARP held and no apparent wrongdoing issues were cited.

11/1/93 RIV RE-ARP-DRSS agreed to review 9/28/93 letter and determine if new safety issues exist.

11/5/93 RIV:DRSS requested that OI obtain copies of the attachments to Silent Sirens. RIV had the Silent Sirens report since 9/30/93, but did not note attachments.

11/8/83 OI:RIV and RIV staff meet to discuss 9/28/93 letter. Prepared response to Congressional inquiries.

OI:RIV received 11/4/93 letter.

RIV ARP-DRSS agreed to review specific issues in 11/4/93 letter and will advise OI of potential wrongdoing.

11/9/93 OI received attachments to Silent Sirens and gave them to RIV staff.

DRSS preparing draft chronology and will respond to each allegation

11/12/93 OI:RIV received copy of letter to Chairman Selin from Congressman Synar. Copy provided to RIV:DRSS.

CHRONOLOGY OF OI:HQ ACTIVITY
REGARDING THE CURRAN LETTERS

9/29/93	Hayes in OI:RIV for Field Office Director's Meeting. Obtained copy of Curran letter dated September 28, 1993, from L. Williamson, OI:RIV Field Office Director.
10/5/93	Upon return to OI:HQ, Hayes received Curran's September 28, 1993, letter, along with Silent Sirens Report and attached documentation. These documents given to Murphy, OI:HQ Operations officer, for OI:RIV to be forwarded for review. After reviewing documents, Murphy recommends that the matter be referred to OI:RIV to be presented to an Allegation Review Panel (ARP).
10/7/93	Hayes agrees that the matter should be referred to RIV for presentation by OI:RIV to ARP.
10/21/93	Curran called OI:HQ for Hayes who was on Travel. Murphy returns call and determines that Curran wants to know status her allegations contained in September 28, 1993, letter. Murphy agreed to get information and have Hayes call her back.
10/21/93	Murphy discussed matter with Williamson who indicates that Curran letter was discussed with RIV staff and no wrongdoing issues were identified. Williamson indicated that matter would be presented to an OI:RIV/RIV ARP. Murphy informed Williamson that this information would be passed on to Hayes so he could call Curran.
10/21/93	Message left for Hayes to call Curran regarding her September 28, 1993, letter when he returns from travel.
10/20-29/93	Hayes on travel.
11/4/93	Hayes contacts Curran and indicates that no wrongdoing issues have been identified in original letter and asks for another letter outlining what she views as the wrongdoing matter.
11/4/93	Letter by Curran is faxed to OI:HQ outlining what Curran views as wrongdoing issues.
11/5/93	Williamson requests that OI:HQ send attachments to Silent Sirens Report to RIV. RIV had September 28, 1993, letter and copy of Silent Sirens Report since September 30, 1993, but did not have attachments to the report. These documents were immediately mailed to OI:RIV. OI:HQ was of the belief that this had already been accomplished.
11/9/93	Williamson notified OI:HQ that the documents that he requested had arrived and had been turned over to RIV for their review.
11/10/93	Williamson informed OI:HQ that the matter is currently being reviewed at RIV and the specific, and if any, wrongdoing allegations require investigation, they will be addressed in OI Case No. 4-93-048.

CHRONOLOGY OF OI:HQ ACTIVITY REGARDING THE CURRAN LETTERS

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ENCLOSURE 11

SEQUOYAH FUELS
A GENERAL ATOMICS COMPANY

December 3, 1993

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Dir:
DD:
A/Dir:
Dan
Art
FOIA
Support
File
Copies to:

Mr. David C. Williams
Inspector General
U.S. Nuclear Regulatory Commission
4350 East-West Highway
Bethesda, Maryland 20814

Mr. Ben B. Hayes
Director
Office of Investigations
U.S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, Maryland 20850

Mr. John C. Martin
Inspector General
U.S. Environmental Protection Agency
401 M. Street S.W.
Room NE 301 (A109)
Washington, D.C. 20460

Dear Gentlemen:

By letters dated September 28, 1993, Ms. Diane Curran, Counsel to Native Americans for a Clean Environment (NACE) forwarded to you a report entitled "Silent Sirens: Report of Native Americans for a Clean Environment's Investigation into the Ineffectiveness of Emergency Planning and Federal Oversight to Prevent or Protect the Public from the November 17, 1992, Accident at the Sequoyah Fuels Corporation Uranium Processing Facility in Gore, Oklahoma."

Enclosed, for your information, is a response to that report prepared by Sequoyah Fuels Corporation (SFC). As discussed in the enclosed response, SFC believes that the assertions and allegations in the NACE report are incorrect and misrepresent the facts and circumstances surrounding the November 17, 1992 event at the SFC facility.

Sincerely,

John H. Ellis

John H. Ellis
President, SFC

cc: Hon. Michael Synar
James M. Taylor
Diane Curran
Robert Bernero, USNRC
James Milhoan, USNRC

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HIGHWAY 10 & I-40 PO BOX 610, GORE, OKLAHOMA 74435 (918) 489-5511 FAX: (918) 489-2291

A Response by Sequoyah Fuels Corporation

to NACE's "Silent Sirens" Report

Sequoyah Fuels Corporation (SFC) has completed a careful review of NACE's so called "assessment" of the investigation by the NRC and EPA titled *Silent Sirens, Report of Native Americans for a Clean Environment's Investigation Into the Ineffectiveness of Emergency Planning and Federal Oversight to Prevent or Protect the Public From the November 17, 1992 Accident at the Sequoyah Fuels Uranium Processing Facility in Gore, Oklahoma*. Our conclusion is that the report is based on a selective extraction of information from the public record combined with assumption, unsubstantiated allegation, and insinuation, and constitutes a disgraceful misrepresentation of the facts. In its report, NACE has fabricated a conspiracy of cover-up and deceit without basis in fact and without a reasonable attempt to ascertain the truth.

SFC will make no attempt here to rehash those issues that have been previously analyzed and reported in numerous publicly available communications between the NRC and SFC made during the months following the November 17, 1992 NO_2 release at SFC. The conclusions reached by the NRC and SFC and the bases for those conclusions are amply documented in the record and are sound. However, SFC cannot leave unanswered the accusations of improper or incompetent conduct which NACE has callously and unfairly leveled against our employees, the NRC, and the staff at Sequoyah Memorial Hospital.

In the following pages, SFC provides responses to the most egregious statements made in the NACE report. The page numbers and a brief synopsis of NACE's allegations are provided before each answer.

Page 7&8 - *"John Ellis... improperly left the site during the accident." "..it appears that Mr. Ellis was not trained in his emergency planning responsibilities." "The AIT also failed to note that Health and Safety Manager Scott Munson... was also absent from the plant." "The absence of two out of four alternate emergency response directors during the accident should have been a matter of serious concern to the NRC." "Moreover, if these either (sic) of these individuals left intentionally during the accident, their departure should have been cited as a serious deficiency in the emergency response."*

Mr. Ellis was, in fact, in the Onsite Emergency Response Center (EOC) during the early stages of the event and did not improperly

leave the site. Mr. Richard Parker, the Manager of Operations, and first alternate Emergency Director, had taken charge as Emergency Director. Since Mr. Ellis had not been "certified" as Emergency Director, (he had been trained but had not yet participated in his final training drill), and Mr. Parker was more experienced with SFC's emergency procedures, Mr. Ellis very properly did not relieve Mr. Parker. It was only after Mr. Ellis was satisfied that the source of the release had been identified, the release was abating, and proper actions were being taken, that he elected to leave the site to personally observe the path of the plume, and, if necessary, to advise the Emergency Director if changes to the response actions were needed. Mr. Ellis had a car radio-telephone and a pager and was, therefore, able to be contacted by the Emergency Director at any time. He also stopped in Gore to brief the Mayor on the event and then immediately returned to the plant. This was not a violation of any SFC procedure.

NACE also alleges that Mr. Munson was absent from the site based on a notation in the logs about a radio contact. This is wrong. Mr. Munson was in the EOC, with the Emergency Director, when he was making the radio calls to which NACE refers. The purpose of the radio transmissions was to obtain dreager tube air sample results from the H&S technicians taking the measurements inside the restricted area. At no time during the event did Mr. Munson leave the site.

In any event, the Contingency Plan only required that *one* Emergency Director be present in the EOC. The purpose of having multiple alternates is to ensure *one* is available to relieve as quickly as possible. There were multiple alternates available at the start of the event.

NACE's allegations are irresponsible and publicly malign the competency, if not the integrity, of two of SFC's senior officials. As the allegations are without basis in fact, the subsequent complaints of lack of NRC concern about absent Onsite Emergency Directors are completely unfounded and without merit.

Page - *"NACE members visited the Sequoyah County Sheriff's Office and spoke to a secretary there, who stated that on March 17, 1993, SFC official Gary Barrett .... without the permission of the Sheriff, removed Controlled Copy # SC5001 of the Off-Site Emergency Management Plan, stating it was outdated. A new plan was provided in its place. The secretary also stated that in-person removal and delivery of emergency plans was unusual, as this is usually done through the mail. The Sheriff subsequently retrieved Controlled Copy # SC5001 from SFC." "This sequence of events raises questions as to whether ... SFC learned from the NRC that NACE had raised a question about the matter and attempted to conceal the problem."*

".. if indeed SFC later attempted to hide that fact based on information provided to it by the NRC..."

Page 16 - *"..the Sheriff's Office dispatcher's log contains no record of any contact by SFC on the morning of November 17." A copy of the Contingency Plan in the Sheriff's Office "contains handwritten notes indicating that the Sheriff's Office received an initial notification message from SFC at 9:20 am on November 17." "Oddly, the times are not written in military notation, as is the custom of the Sequoyah County Dispatcher.... thus raising the question of who made the time notations, when they were made, and for what purpose."*

Through a sequence of unfounded accusations, NACE has implied that:

1) The Sequoyah County Sheriff's Office was using the wrong version of the Contingency Plan,

2) SFC personnel never notified the Sequoyah County Sheriff's office of the declaration of a Site Area Emergency as required by SFC's Contingency Plan,

3) SFC personnel falsified its notification records to falsely indicate the Sheriff's Office was called,

4) SFC personnel later attempted to cover-up one or more of these "facts" by adding notations to the Sequoyah County Sheriff's emergency manual, and

5) SFC made the cover-up attempt because it learned from someone in the NRC Staff that NACE was "investigating" and might uncover one or more of these "facts".

Mr. Billy Reid, SFC's QA Manager, interviewed Sequoyah County Sheriff Teddy Eubanks and his secretary (Ms. Stone) on October 1, 1993. Ms. Stone told Mr. Reid that she recalled that Mr. Barrett delivered new copies of the plan on March 17, 1993, and that he reviewed the individual page changes with personnel in the office on that date. Mr. Barrett was implementing a routine manual update (due in part to organization changes at SFC). The control numbers for these manuals were SCS-001 through SCS-005 (not SC5001). The secretary further stated she recalled that shortly thereafter, their office received a telephone call from "some lawyer", (they did not recall the name), who told them to get back the old pages from SFC. They called Mr. Barrett who returned the old pages after noting on the cover sheet "Out of Date 3-17-93".

With respect to the handwritten notations on the plan pages in the Sheriff's Office, it would have been a simple matter for NACE to do

as SFC did and call Mr. Crutchfield, the dispatcher on duty whose name appears in SFC's records, to find out if he had made the notations or not. (NACE refers to this record in its report.) In a conversation on October 5, 1993 with Mr. Reid, Mr. Crutchfield confirmed that the time notations on the page from the Emergency Plan are his notations.

Furthermore, SFC contacted the Oklahoma State Highway Patrol on September 29, 1993. An Officer there confirmed that their logs show they were notified of SFC's Site Area Emergency at 0942 on November 17, 1992 by the Sequoyah County Sheriff's Office. This action was in accordance with Appendix B, section 3.1.6 of the Offsite Emergency Management Plan and Procedures Manual. Since the Sheriff notified the Highway Patrol, he must have in turn been notified by SFC as SFC's log and Mr. Crutchfield's notations indicate. Thus the Sheriff was notified as stated in SFC's log entry. Since the contact did occur, and can be so easily proven, there would be no reason for SFC to attempt to falsify the record.

Thus, NACE has again publicly, and wrongly, attacked the integrity of SFC and NRC employees without any factual basis.

Page 10 - "There was no basis for SFC's classification of the November 17th accident as a Site Area Emergency.

This issue was fully reviewed by the NRC during its investigation and is discussed in various NRC inspection reports and SFC submittals. The classification as a site area emergency was correct.

Page 11 - "NACE was informed by Shirley Worley, a Webbers Falls resident, that the kindergarten class was outside on the playground during the accident and a neighbor's child came home early from school with a complaint of irritated breathing. (Notably, this school is closer to the SFC plant than the Carlile School, which was purchased by SFC and closed because of its proximity to the plant.)

In a correction dated October 4, NACE stated that it had "since learned that the person who provided the information regarding the Webbers Falls school was not Shirley Worley, but Shirley Wooten."

According to the authors of the NACE report, the Wootens believe they were exposed to nitrogen dioxide fumes. Mr. Wooten is alleged to claim he "observed the plume pass over the school and head towards the town of Gore." This observation does not correlate with other observations of the plume.

First, according to USGS maps of the area:

1) Webbers Falls school is located about 2.8 miles west of SFC on a bearing of 280°T.

2) Gore lies northwest of SFC on a bearing of about 310°T at a distance of about 2.7 miles.

3) For the plume to "pass over the school and head towards the town of Gore", the plume would have to change course by more than 90 degrees and move northeast (030°T).

4) Records show the wind at SFC was from the southeast (153°T). (NRC Inspection Report 40-8027/92-30 at 8.)

It was well established during the investigation that the plume was observed leaving the site in a northwesterly direction. SFC's employees took measurements on the ground in Gore as the plume was observed passing overhead. (Those measurements showed the concentration on the ground to be less than detectable in Gore.) A number of observers reported the plume paralleling highway 10 towards Gore. The tree farm workers who reported being inside the plume were working in an area on a direct line between SFC and Gore. Finally, two men working at a sand and gravel site west of the tree farm (on the northeast shore of the Arkansas river) told Dr. Yancy they did <u>not</u> see the plume. (Mitchell and Coleman Report at 8, Attachment 4 to Silent Sirens.) The area in which they were working is nearly in a direct line between SFC and Webbers Falls.

SFC does not believe, and the facts do not support the allegation, that the plume passed over the Webbers Falls school.

NACE is also incorrect about the proximity of Webbers Falls School and Carlile School to SFC. Carlile School is 1.25 miles from SFC; considerably closer than Webbers Falls school. SFC leases the facility as a laboratory and training facility.

All of the locations discussed above are plotted in the attached Figure 1. A similar figure is included in Attachment 13 to NACE's report.

Page 12 - "The control room may have been evacuated during the accident."

SFC's records clearly show the control room was <u>not</u> evacuated during the November 17 event. The Senior Shift Supervisor and the control room operators donned supplied air respirators and remained in the control room conducting a prompt, safe shutdown of the UF6 and DUF4 plants. That the Onsite Emergency Response Organization assembled in the lunch room *in no way* implies the operators were forced to abandon the control room. NACE goes on to state that SFC should have declared a General Emergency given the "fact" that the control room had to be evacuated. Since the control room did not

have to be and was *not* evacuated, NACE's assertion lacks factual basis and is without merit.

Page 17 - "A woman at the Quik-Stop called the Gore Police...and was told that the Police Department didn't know, and had been trying unsuccessfully to contact the SFC plant. This communication failure is not discussed in any of the NRC's inspection reports."

NACE does not specify who the woman was who allegedly made the call, at what time the call was made, or who provided NACE with the information. Further, NACE does not indicate if this information was made available to the NRC during the NRC's investigation. On the other hand, as discussed above, clear records are available showing that SFC and the Sequoyah County Sheriff's Office carried out their notification responsibilities, which included notification of the Gore Police Department. NACE apparently has chosen to ignore those records, or at the least NACE made no reasonable effort to obtain them.

NACE's allegation of "communication failure" therefore ignores the recorded facts in favor of unsubstantiated hearsay. Its subsequent implication of inadequate NRC concern for "this communication failure" is without merit.

Page 20 - "Apparently, the SFC Officials did not go to the plume to measure concentrations inside it, but drove 'in front of it'. This suggests that SFC had an opportunity to measure the plume but chose to measure in advance of the plume."

The plume was observed 100-200 yards <u>above the ground</u>. Therefore, it was impossible to measure the plume "inside it" without an aircraft. SFC's employees drove to the nearest location they could reasonably reach "in front of the plume", and measured the air as the plume passed overhead. The purpose of these measurements was to determine the level of NO_2 at ground level.

NACE's allegation of improper action by SFC is without basis in fact.

Page 17 - "A full day after the accident occurred, SFC representative Pam Bennett falsely told press representatives that the accident caused "no injuries."

NACE refers to articles printed on November 18 and 19th in local newspapers. Ms. Bennett's comments were based on information available to her at the time she made her comments. Since the articles appeared in print on the 18th and 19th, Ms. Bennett's

statements would have been made on the 17th and 18th. Although several SFC workers with minor symptoms of NO_2 exposure had been sent as a precautionary measure to be checked by Dr. Anderson (a local private physician employed by SFC from time to time to treat SFC personnel), reports available to Ms. Bennett at the time she made her statements indicated these persons had not suffered any "injury". NACE notes that one female employee was treated by the site nurse but NACE fails to point out that this employee was treated because she had hyperventilated. NACE also fails to note that the tree farm workers who reported symptoms did not see a physician (Dr. Yancy) until November 19, after Ms. Bennett's statements to the press. Therefore this information was unavailable to her at the time of the press release. (NRC Inspection Report No 40-8027/92-30, page 18.) Accordingly, Ms. Bennett did not provide false information to representatives of the press.

Page 18 - "When Mr. [Rick] Williams told the emergency room receptionist [at Sequoyah Memorial Hospital] of his symptoms, she called SFC, and then told Mr. Williams that SFC confirmed that there had been a release but that it was nothing to be concerned about and he should go home." "..thus raising the question of whether SFC's 'training' of the hospital staff involved an unwritten agreement to substitute SFC's judgment (issued over the telephone) for the independent judgment of the hospital staff regarding the type of care required for accident victims"

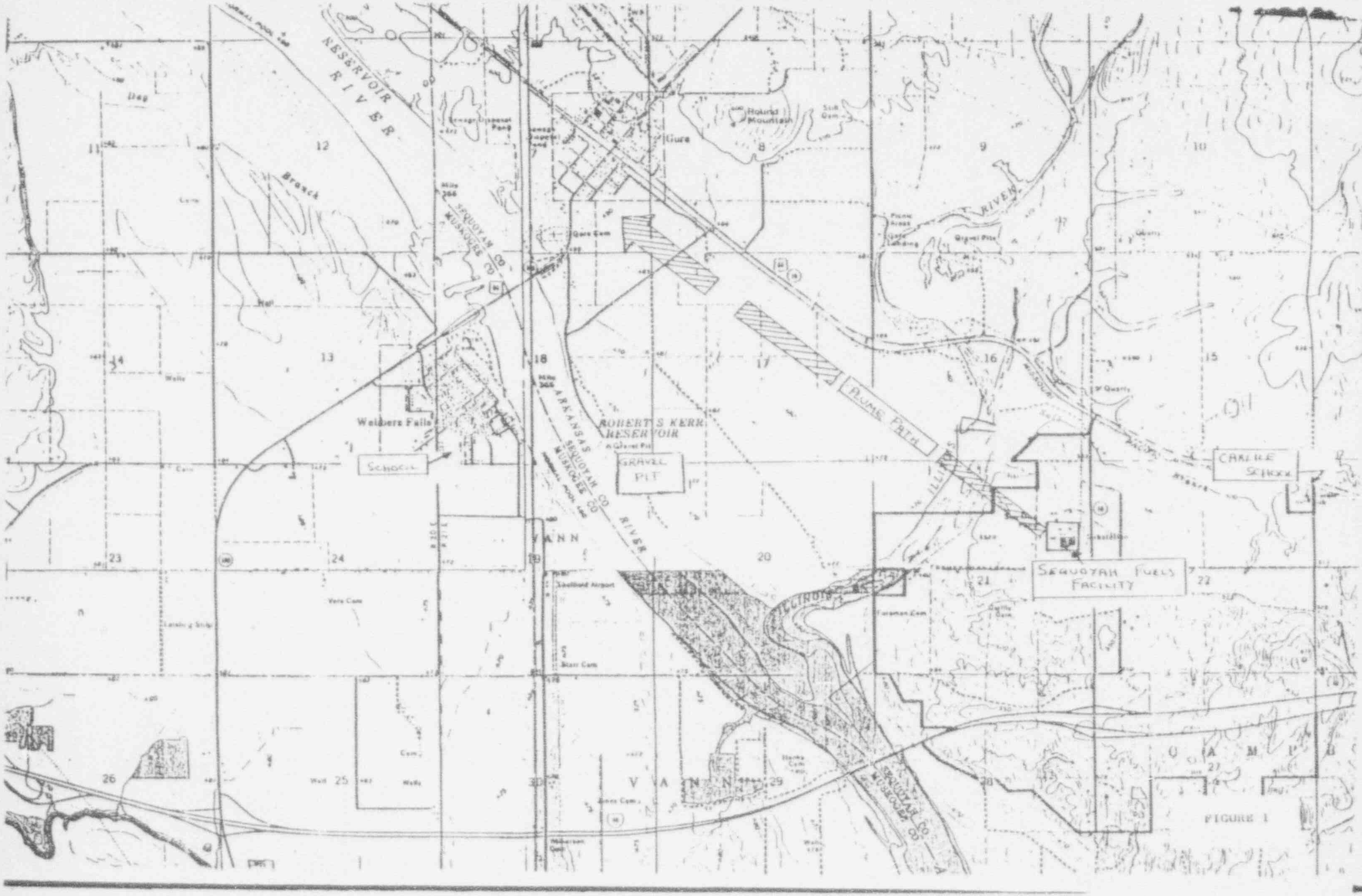
SFC is unaware of any objective evidence available to document this story other than the inquiry addressed to Dr. Anderson by Ms. Kasner (NRC) referenced by NACE. We note that in the referenced notation, Dr. Anderson replies that he had not heard of the incident.

As discussed below, SFC has agreements with Sparks Hospital and Sequoyah Hospital and provides training to these facilities with regard to proper handling and care of radiologically contaminated patients. SFC does not in any way participate in the medical diagnosis or treatment of patients and expects the hospital staff to take action to treat symptoms based on their medical training and direct observations.

Page 27 - "Mr. Leer stated that training [of Sparks Hospital employees] has not been provided by SFC since 1986.

SFC has records of training given by Dr. Carl Bogardus of the University of Oklahoma Health Sciences Center, Department of Radiological Sciences, to employees of both Sparks Memorial Hospital and Sequoyah Hospital in Sallisaw. The latest training prior to the November 17, 1992 event, is documented in a report by

Dr. Bogardus dated November 21, 1991. We note that Mr. Leer is Vice President of Corporate Services and may not be familiar with the training provided annually by Dr. Bogardus. Further, we note that NACE did not discuss training provided to Sequoyah Memorial Hospital which is the facility where accident victims requiring hospitalization would be taken first. NACE's statement that "virtually complete lack of training for Sparks employees raises questions..." is an allegation based solely on unsubstantiated assumption.



RESERVOIR
RIVER
Branch
Round Mountain
Gore
RIVER
ILLINOIS
SEQUOYAH CO
MUSKOGEE CO
Webbers Falls
SCHOOL
ROBERT S KERR RESERVOIR
ARKANSAS
RIVER
GRAVEL PIT
PLUME PATH
VANN
SEQUOYAH FUELS FACILITY
CARLILE SCHOOL
V A N N
C A M P B

FIGURE 1