HARMON, CURRAN, GALLAGHER & SPIELBERG
2001 S STREET, N.W.
SUITE 430
WASHINGTON, D.C. 20009-1125

DIANE CURRAN
6935 Laurel Avenue Suite 204
Takoma Park, MD 20912
TELEPHONE (301) 270-5518 FAX (301) 270-5029

TELEPHONE
(202) 328-3500
FAX
(202) 328-6918

December 21, 1993

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

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

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

Dear Messrs. Williams, Hayes, and Martin:

By letter dated December 3, 1993, John H. Ellis, President of Sequoyah Fuels Corporation ("SFC"), responded to a report and request for investigation which Native Americans for a Clean Environment ("NACE") filed with your offices on September 28, 1993, 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." While cavalierly accusing NACE of submitting a "disgraceful misrepresentation of the facts" and of "fabricat[ing] a conspiracy," Mr. Ellis' letter fails to address numerous issues raised in the report and resolves only a few minor concerns. For the great majority of the issues, Mr. Ellis' letter does nothing to controvert the evidence presented by the report which shows that both SFC's and the NRC staff's responses to the November 17 acci-

9402240347 940131
PDR COMMS NRCC
CORRESPONDENCE PDR

dent were seriously deficient and dangerous to the public's health and safety. Thus, an in-depth investigation of the accident by your agencies continues to be urgently needed.

With respect to the individual issues raised in Mr. Ellis' letter[1], NACE responds below:

1) The Silent Sirens report criticized SFC for failing to ensure that the Senior Vice President, John Ellis, was trained for his post as Onsite Emergency Director. SFC concedes this point. Ellis letter at 2. Mr. Ellis, who was the primary Onsite Emergency Director, "had been trained but had not yet completed his final training drill," and thus was not certified. Id. (emphasis added). Yet, SFC argues that since an alternate Emergency Director was available, it does not matter that Mr. Ellis, who was listed as the primary Onsite Emergency Director by SFC's Contingency Plan, was not qualified to assume the duties of his position, more than six months after his employment with SFC began.

SFC's argument mocks the importance of emergency planning and confirms that SFC did not take its responsibilities in this regard seriously. The availability of alternative Emergency Directors does not lessen the seriousness of Mr. Ellis' lack of training. The other alternates are positions of descending rank and responsibility. Clearly, under the Contingency Plan, the role of primary Emergency Director was to be held by a very high ranking official with a high level of responsibility for the

---

1 NACE notes that Mr. Ellis' letter does not even address the following serious issues involving SFC's inadequate response to the accident: Failure to seal control room (Silent Sirens report at 14); Deficient equipment for onsite communications and emergency notification (Silent Sirens report at 21); Unavailable safety equipment (Silent Sirens report at 23); Inadequate emergency training for employees (Silent Sirens report at 25); and Inadequate offsite exercises (Silent Sirens report at 28). With respect to the misclassification of the accident as a Site Area Emergency rather than a General Emergency, SFC's two-sentence response lacks any substantive content, merely stating that the "issue was fully reviewed by the NRC" and that the "classification as a site area emeregency was correct." Ellis letter at 4.

plant. Moreover, the purpose of providing a list of alternates is to have available other individuals in case the primary person is away or is otherwise physically unavailable -- not because the primary person is untrained and unqualified. Finally, SFC's failure to train Mr. Ellis violated the basic principle of preparedness underlying NRC emergency planning regulations. Under the time pressures of an accident, safety is jeopardized when management has to take the time to evaluate whether someone who is listed in the plan as an available Emergency Director is actually qualified to assume the post.

SFC argues in mitigation that Mr. Ellis did not leave the site until he was "satisfied that the source of the release had been identified, the release was abating, and proper actions were being taken." However, while the source of the release may have abated when Mr. Ellis left the site (at about 9:10 a.m. according to the AIT Report), the chemical plume was still potent and was moving toward the town of Gore. Thus, Mr. Ellis left at a time when important decisions about offsite notification and recommendations for protective measures needed to be made. Although SFC asserts that Mr. Ellis was available by car radio-telephone and pager, that was no substitute for taking full responsibility for directing the accident response from the Emergency Response Center, as intended by the Contingency Plan.[2]

Finally, SFC's concession that Mr. Ellis was not fully trained at the time of the accident raises other questions. Did the NRC grant SFC's March 30, 1993, request to use the accident as a substitute for a biennial exercise (see Silent Sirens report, Attachment 18); and if so, did SFC rely on Mr. Ellis' participa-

---

[2] NACE also asserted in the Silent Sirens report that Health and Safety Manager Scott Munson, who was an alternate Onsite Emergency Director, "appeared" to have left the site, because he contacted Robert Jones "by radio." Silent Sirens report at 8. According to SFC, Mr. Munson made this radio contact from within the plant. Ellis letter at 2. If this is the case, then it appears that Mr. Ellis was the only one out of four alternate Emergency Directors who improperly left the site. Nevertheless, the important fact remains that Mr. Ellis should have been trained, should have been available to serve as Onsite Emergency Director, and should not have left the site.

tion in the accident response as grounds for certifying that he is now fully trained for the responsibilities of Onsite Emergency Director? This surely would be an absurd result. NACE also questions why, if the NRC knew that Mr. Ellis was not fully trained, it did not cite SFC for this violation. Finally, it is not clear from the AIT whether Mr. Ellis was following the instructions of Mr. Parker, who was the Onsite Emergency Director during the accident, when he left the site. Was Mr. Ellis acting as a subordinate to Mr. Parker, as he should have been, or was he acting on his own initiative?

2) In the Silent Sirens report, NACE raised questions regarding whether the Offsite Emergency Management Plan used by the Sequoyah County Sheriff's office during the November 17 accident was up to date, and noted that a SFC employee had personally removed the plan in its entirety on March 13, 1993. In response, SFC claims that it was "implementing a routine manual update" when it changed the plan on March 13. Ellis letter at 3. However, SFC does not state whether the new plan issued to the Sheriff's office on March 13 was a recent update, or whether it contained updates that should have been issued earlier. Thus, SFC has not resolved NACE's concern regarding whether the plan used by the Sheriff's office on November 17, 1992, had been properly updated and was current at the time of the accident.

SFC also states that at the request of an unidentified lawyer, the "old pages" of the Offsite Emergency Management Plan, which had been removed by Mr. Barrett, were returned to the Sheriff's office. Ellis letter at 3. However, as stated in the Silent Sirens report, NACE understands that the entire plan was removed from the office and replaced with a new one; and that subsequently the entire plan, not just some "old pages," was returned.

NACE also notes that the secretary that NACE spoke to regarding SFC's removal of the plan from the Sheriff's office was not Ms. Stone, whom SFC interviewed, but Sharon Burroughs.

3) Following the 1986 accident, the issue of offsite notification was of paramount importance to Congress, the NRC, and the public. Yet, as NACE observed in the Silent Sirens report, the NRC's inspection reports following the 1992 accident did not evaluate whether SFC followed the offsite notification procedures in its Contingency Plan, which require SFC to contact the

Sequoyah County Sheriff's office dispatcher. Moreover, various documents contained conflicting information regarding whether that notification took place, and if so, at what time. Silent Sirens report at 16.

SFC provides some information in response to NACE's concern, but fails to address troubling questions that continue to suggest problems with the handling of offsite notification procedures. In its response to the Silent Sirens report, SFC claims that it interviewed the dispatcher, Rick Crutchfield, who informed SFC that he had made notations in the Offsite Emergency Management Plan (Attachment 22 to Silent Sirens report) of a contact by SFC at 9:20 a.m. However, in March of 1993, NACE director Lance Hughes contacted the Sequoyah County dispatcher's office to request a copy of the dispatcher's log for November 17, 1993. When he noticed that no call from SFC was recorded in the log for that morning, he inquired to the dispatcher on duty if the dispatcher's log was the only place the call would be recorded. The dispatcher responded yes. Mr. Ellis' letter does not explain why Mr. Crutchfield's log contains no record of the call. Moreover, SFC does not state whether Mr. Crutchfield himself was called, as required by the Contingency Plan.

SFC does not explain the discrepancy between the two documents which purport to show the time that the dispatcher received notification of the accident. SFC states that the handwritten notations on the Offsite Emergency Management Plan are those of the dispatcher, Rick Crutchfield. Ellis letter at 4. These notes indicate that the dispatcher received notification of the accident at 9:20 a.m. However, the copy of Page 7 of SFC's Contingency Plan Implementing Procedures which NACE obtained through the Freedom of Information Act (Attachment 20 to the Silent Sirens report) contains handwritten notes indicating that the dispatcher was notified at 9:30 a.m. No explanation is provided for this discrepancy.

Moreover, under either scenario, an inordinate amount of time passed before the notification procedures were completed. If the notes in the Offsite Emergency Management Plan are correct, they show that Mr. Crutchfield waited an inexplicably lengthy period after receiving the initial notification at 9:20 before he passed the message on to other county officials. The County Civil Defense Director was not notified until 9:35 -- 15 minutes after the notification of Mr. Crutchfield, 25 minutes after the decla-

ration of a Site Area Emergency, and 35 minutes after the plume was observed to be leaving the site at 9:00. The Sequoyah county Sheriff was not notified until 9:36, the County Health Department was not notified until 9:37, and the Oklahoma Highway Patrol was not notified until 9:39. (According to Mr. Ellis' letter (page 4), the Oklahoma Highway Patrol was notified at 9:42.) By that time, little or nothing could be done in the way of protective measures.

If SFC notified the dispatcher at 9:30, as indicated by the CPIP, the notification itself was a full 30 minutes after SFC saw the plume leave the site and a full 20 minutes after it declared a Site Area Emergency -- again, so late as to be ineffective to provide adequate time for implementation of protective measures.

4) In a letter supplementing the Silent Sirens report, NACE described the experience of Shirley Wooten and her family, who were at the Webbers Falls School during the November 17 accident. Mr. Wooten told NACE that he observed the plume pass over the school and head toward the town of Gore. Mr. and Mrs. Wooten both said that as a result, they and their granddaughter suffered adverse health effects directly after the accident. Letter from Diane Curran to David C. Williams, et. al (October 4, 1993).

According to SFC, the available facts regarding the direction of the prevailing wind in relation to the location of the school "do not support the allegation, that the plume passed over the Webbers Falls school." Ellis letter at 5. SFC contends that the plume took a straight course from the plant to the town of Gore, and could not have travelled as far as Webbers Falls, given the recorded wind direction. However, the information provided by SFC is insufficient to counter the real possibility, as supported by the observations and evidence of injuries sustained by the Wooten family, that the plume spread to Webbers Falls.

NACE asked Kevin Gurney, an atmospheric scientist with the Institute for Energy and Environmental Research, who holds a Masters Degree in Atmospheric Science from the Massachusetts Institute of Technology, to review SFC's response regarding the movement of the plume. According to Mr. Gurney, it would have been quite possible for the plume to fan out as far as the town of Webbers Falls. In his opinion, even if the centerline passed over Gore, the plume could have spread laterally as much as a mile or two from the centerline, depending on a number of

meteorological factors. The principal factor is known as "stability," i.e., the rate of change in the air temperature as a function of vertical distance. Other factors include wind speed, wind direction, air temperature, and the height and temperature of the emitted NO2 as it left the plant. These factors may also affect the vertical movement of the plume, which may rise and fall depending on weather conditions. In Mr. Gurney's view, although SFC has provided data on the speed and direction of the wind, SFC has not provided sufficient information about the otner factors which would be necessary to make a valid assessment of whether and how far the plume dispersed. Mr. Gurney is available to discuss his opinion with you.

SFC also selectively cites the Mitchell and Coleman report for the proposition that if the plume had passed over Webbers Falls, it would have been noticed by workers who were working in a sand and gravel pit between the plant and Webbers Falls. Ellis letter at 5, citing Mitchell and Coleman Report (Attachment 4 to Silent Sirens report) at 8. SFC irresponsibly fails to note that, as also described by Mitchell and Coleman, the sand and gravel workers were "sand blasting" at the time of the accident, and were wearing both eye protection and respiratory protection equipment. Id. at 8. Thus, not only was it likely that the workers were enveloped by sand and dust, but they were wearing protective equipment that undoubtedly significantly impeded their ability to observe, or even to smell, the plume.

5) Under the Contingency Plan, the control room serves as the Onsite Emergency Center, from which the accident response is directed, including accident control, communications, and technical support. See Contingency Plan, § 6.1. As discussed in the Silent Sirens report at 12-13, the evacuation of the control room is one of the occurrences which automatically would have required the declaration of a General Emergency, and the sounding of the offsite sirens to warn the public.

In the Silent Sirens report, NACE cited two documents, apparently generated by SFC, which indicate that, contrary to the descriptions of the accident provided in NRC inspection reports, the control room was evacuated during the accident. Id. at 12. These documents consist of notes stating explicitly that the control room was evacuated (Attachment 16), and a Draft Event Description which states that an SFC official brought radios from the control room to the Onsite Emergency Response Organization in the lunchroom at 9:10 and 9:20 a.m. Attachment 13.

In response, SFC conclusorily asserts that "SFC's records clearly show the control room was not evacuated during the November 17 event." Ellis letter at 5 (emphasis in original). However, SFC does not state what "records" it is relying on; it does not challenge NACE's belief that the two documents which contradict this view are SFC records; nor does it address the contents of those documents or provide any explanation of why either of those documents is not credible. Thus, SFC provides absolutely no concrete information to contradict the evidence in these documents that the control room was evacuated.

Moreover, the explanation provided in Mr. Ellis' letter is inconsistent with other reports of the accident, and raises more questions than it answers. SFC claims that the Senior Shift Supervisor and control room operators "donned supplied air respirators and remained in the control room conducting a prompt, safe shutdown of the UF6 and DUF4 plants." Ellis letter at 5. However, as discussed in the Silent Sirens report at 13 and note 6, the control room was contaminated with NO2 gas and there were only two respirators. More respirators had to be retrieved from a remote location in the plant. How did the control room personnel manage to stay in the contaminated control room while these respirators were being obtained?

SFC claims that the Onsite Emergency Response Organization "assembled" in the lunch room. However, SFC does not state when the assembly took place; nor does SFC state whether or when the Onsite Emergency Response Organization actually went to the control room. Moreover, the Draft Event Description states that radios were brought from the control room to the lunch room twice, both at 9:10 and 9:20. Why did SFC find it necessary to remove radios from the control room -- the seat of communications according to the Contingency Plan -- and bring them to the lunch room? Was it because -- as indicated by the record -- the control room, where the equipment was intended to be used, was not habitable? SFC does not explain.

6) In the Silent Sirens report, NACE reported that a woman at the Quik-Stop, a convenience store in Gore, called the Gore Police Department to find out if something had happened at the plant, and was told that the Police Department didn't know, and had been trying unsuccessfully to contact the SFC plant. This communication failure was not discussed in any of the NRC's inspection reports.

In response, SFC again conclusorily states that "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." Ellis letter at 6. However, SFC does not identify those records. Nor does SFC state when or by whom the notification of the Gore Police Department took place. NACE notes that another document relied on by SFC -- the copy of the Sequoyah Fuels County Sheriff's Offsite Emergency Management Plan, whose annotations were allegedly written by county dispatcher Rick Crutchfield -- indicates that even the Sequoyah County Sheriff was not notified by the dispatcher until 9:36 a.m., between 11 and 26 minutes after two SFC technicians left the SFC plant and went to the town of Gore to measure the plume. See Inspection Report 92-30, Appendix at 10. Thus, it is quite likely that at the time local residents observed the team of technicians measuring the plume near the Gore Quik-Stop, the Gore Police Department had not yet been notified, as it should have been.

Finally, NACE does not know the identity of the woman who called the Police Department from the Gore Quik-Stop; the conversation was overheard by Ed Henshaw, who was listening on his police scanner. Mr. Henshaw is available to confirm what he heard.

7) In the Silent Sirens report, NACE noted a number of problems with poor monitoring of airborne contaminants, including the fact that the SFC technicians who attempted to monitor the plume offsite appeared to have measured "in front" of it, rather than inside it, thus raising questions about the adequacy of SFC's monitoring measures. Id at 19-20. In its response SFC states, for the first time, that while the officials went to the front of the plume, they waited until the plume "passed overhead" before taking the sample. Ellis letter at 6. However, according to the AIT report, the plume was not visible to these technicians when they were in Gore. Inspection Report 92-20,, Appendix at 10. Thus, it is difficult to understand how they would have known that the plume was "overhead."[3]

---

[3] We also note that SFC did not address the other problems with air monitoring that were raised by NACE. See Silent Sirens report at 20-21.

8) In the Silent Sirens report, NACE faulted SFC representative Pam Bennett for falsely reporting to the press that the accident had caused no injuries. Id. at 17-18. SFC responds that information regarding "injuries" was not available to Ms. Bennett when she made these statements on November 17 and 18. Ellis letter at 6-7.

However, the record shows that SFC did have information regarding injuries when Ms. Bennett made her statements on November 17 and 18. As discussed in the Silent Sirens report, directly after the accident an SFC nurse saw four employees and two contract workers, who complained of sore throats, congestion, chest tightness, nausea and vomiting, and eye irritation. Id. at 17. One individual, "Mr. Dan Howard, who was in the control room" during the accident, "was initially treated for coughing and shortness of breath."[4] Mitchell and Coleman Report at 7.

SFC also claims that none of the tree farmers visited a doctor until November 19. However, as discussed in the Silent Sirens report at 18-19, tree farm worker Rick Williams did visit a hospital emergency room on November 17, and was turned away, apparently on the advice of SFC.

NACE believes that the reason that SFC reported there were no injuries was not that it was unaware of the individuals who had been examined and/or treated during and directly after the accident. Instead -- as denoted by its use of quotation marks around the word "injury" (Ellis letter at 7) -- SFC conveniently and arbitrarily defined the term "injury" as excluding any kind of injury that did not involve permanent damage to life and limb. In fact, as indicated in Mr. Ellis' letter, SFC still considers the adverse effects suffered by SFC workers as a result of the accident -- i.e., nausea, vomiting, eye irritation, and shortness of breath -- to be "minor symptoms." Id. Thus, at the NRC enforcement conference on March 2, 1993, SFC continued to

---

4 SFC falsely asserts that "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." Ellis letter at 7. The Silent Sirens report does not refer to this employee, but to Mr. Howard, who was treated for symptoms consistent with NO2 exposure. See Silent Sirens report at 18, Mitchell and Coleman Report at 7.

maintain that the accident had caused no injuries. Indeed, an NRC inspector commented to Lance Hughes during a meeting following the enforcement conference that SFC was still "denying the injuries" caused by the release. Accordingly, SFC's assertion that the accident caused no injuries appears to have been a matter of corporate policy rather than Ms. Bennett's ignorance. Such a policy shows an egregiously arrogant and dangerous attitude by SFC toward its responsibility to protect the public from the adverse effects of its operation.

9) In the Silent Sirens report, NACE relates the experience of Rick Williams, a tree farm worker who was injured by the NO2 plume and was turned away from the Sequoyah Memorial Hospital on the advice of SFC. SFC denies any knowledge of the incident, and states that it in no way participates in the diagnosis or treatment of patients at the hospital. Mr. Williams and his wife, who accompanied him to the hospital, are ready and willing to discuss with the NRC and the EPA their experience at the hospital. It should also be possible to examine the hospital's telephone records to determine whether a long-distance call was made to SFC on the afternoon of November 17.

10) At page 27 of the Silent Sirens report, NACE reported on a conversation with Peter K. Leer, Vice President of Corporate Services for Sparks Regional Medical Center, in which Mr. Leer stated that annual training promised by SFC for Sparks medical personnel had not been provided since 1986. SFC claims that it "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 and Sequoyah Hospital in Sallisaw." Ellis letter at 7. According to the Ellis letter, the latest training prior to the November 17 event is documented in a report by Dr. Bogardus dated November 21, 1991. SFC states that Mr. Leer may not have been aware of the training because his position might not cover that area; however, when NACE director Lance Hughes interviewed him, Mr. Leer deliberately called in the administrator of the Emergency Room. Mr. Hughes showed her a copy of the letter from Mr. Leer to SFC (Attachment 28 to Silent Sirens report) which discusses the training agreement between SFC and the hospital. He asked her if the letter was a true representation of whether the hospital personnel received annual training from SFC. The emergency room administrator stated no, and that it would be unlikely that the hospital would allow SFC to train its personnel, since SFC had no

medical expertise. However, she made no mention of Dr. Bogardus or the University of Oklahoma. Thus, NACE had a sound basis for questioning whether any training had taken place at that hospital since 1986.

NACE is concerned that if the administrator of the Sparks Regional Medical Center emergency room was unaware of radiological training at the hospital, there may be some deficiencies in the training program, i.e. that it was irregular, that only a few people were trained, or that it was not very comprehensive. Thus, the NRC OI and IG's offices should request that SFC produce its training records regarding the two hospitals, in order to verify that the alleged training did take place and was sufficiently comprehensive.

Please call me if you have any questions regarding this letter.

Sincerely,

Diane Curran
Counsel to NACE

cc: Hon. Mike Synar
James M. Taylor, NRC
Robert Bernero, NRC
James Milhoan, NRC
Maurice Axelrad, Counsel to SFC

Dir: ✓
DD:
A/Dir: ✓
Dan ✓
Art
FOIA
Support
File Ltr. RIV
Copies to:

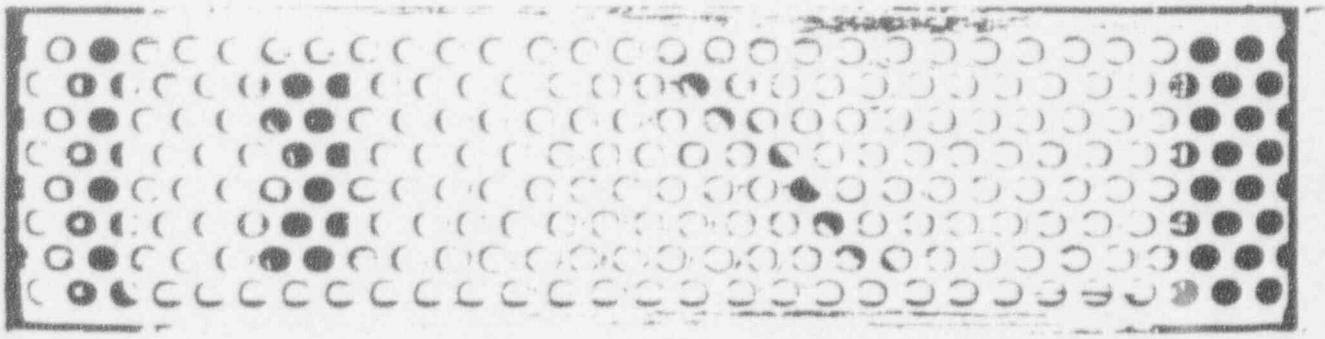
December 21, 1993

U.S. NRC

To Messrs. Williams, Hayes, Martin, and Axelrad:

A copy of this letter was faxed to you this morning. Please note that this hard copy contains corrections to clerical errors on page 5 (1st full paragraph, 3rd line from bottom), and page 6 (3rd full paragraph, 7th line from top).

Dave Cox



U.S. NRC
'93 -3 AM 11:24

December 30, 1993

Dan,

Before responding to the Curran letter, I asked Mike Vasquez if there was a requirement that the SFC Contingency Plan be given to off-site agencies. He made inquiries and reviewed their license.He said that SFC is required to have a Contingency Plan but they are not committed to provide the plan to off-site agencies, however as a matter of courtesy, SFC provided Contingency Plans to various agencies.He said there was not a regulatory requirement to provide off-site agencies with revised Contingency Plans or off-site emergency management plans.Mike provided a summary of a converstation he had with Gary Barrett, SFC's Contingency Plan Coordinator, regarding this issue and the training of off-site medical personnel.

The inspection report that you asked for is in draft review and will be available mid January 94.

Len —
FYI

RECORD OF CONVERSATION

December 14, 1993

Person Making Call: Michael Vasquez

SUBJECT: ACTIONS SFC HAS TAKEN TO ENSURE OFF-SITE AGENCIES HAVE UPDATED COPIES OF THE SFC CONTINGENCY PLAN

I called Gary Barrett, SFC's Contingency Plan Coordinator and Safety Engineer. I asked whether offsite agencies have the Off Site Emergency Management Plan or the Contingency Plan and how had they been updated. Gary told me that the local off site agencies primarily have only the Off Site Emergency Management Plan. He told me that he generally hand-delivers revisions to the plan to the off site agencies to maintain rapport and ask if they have any questions.

He stated that he last delivered copies of plan revisions last March, including to the Sheriff's department. NACE's Silent Sirens report made mention of his trip to the Sheriff's department. (He was obviously sensitive to NACE's report.) He explained that the Sheriff's department maintained several copies of the plan (he thought something like 5 copies). When he delivered a revision to the plan in 1992 to the Sheriff's department, he noticed that one of the copies of the plan had not been updated, a couple were missing, and there was writing in one of the copies. In discussions with the administrative assistant at the Sheriff's department, named Crystal, they did not need all the copies they had. So, they decided that Gary would bring up-to-date copies of the plan and take back some of the others.

When Gary went back in March 1993, a new sheriff had taken office and another administrative assistant was there. So, as planned, he took back some of the plans and left up-to-date copies.

Gary said that he kept the old copies in his truck for about a couple of months or a few weeks. Then, one day the Sheriff's department called and asked for the copies he had taken. So, he returned them, thinking that there was some records retention requirement that the county had and Gary thought that they would be filed somewhere.

I asked Gary to clarify: He stated that he does normally hand-deliver the revisions (rather than just mail them) and just leaves the revisions there for their admin staff to update the books. The only exception is the Mayor of Gore, who asked that Gary actually update the book. So, the only book he routinely looks at, to see that it's up-to-date, is the Mayor's. He does not actually know how well the other agencies are maintaining their books.

Gary said that he's also the one that provides the training to these off-site agencies, except the medical training, which Dr. Carl Bogardus provides. Dr. Bogardus provides training to both Sequoyah County Memorial Hospital in Sallisaw and Sparks Regional Hospital in Ft. Smith, on an annual basis. Dr. Anderson, the company-contracted physician, recently became associated with another clinic and may not practice as much at Sequoyah County Memorial as in the past, but the company still contracts with him. Dr. Bogardus normally documents the training he conducts by letter to SFC.

Gary's training to offsite agencies includes a review of Appendices of the Off Site Emergency Management Plan that applies to that agency. The appendices provide the instructions for the actions that particular offsite agency should perform during various emergencies. Training is documented by having the individuals sign a paper that says they've been trained and they understand the training. When asked when training was last conducted, he said he'd have to look up the records to find out the specific dates. So, he said he would call me back later with that information.

I asked if any of the off site agencies have controlled copies of the Contingency Plan and Gary replied no. The agencies that have uncontrolled copies include: Coast Guard; Chief, Radiation and Special Hazard Service, OSDH; Administrative Director of the the County Health Department; County Emergency Management Agency; Director, Oklahoma State Civil Defense; and the Civil Defense Director for Muskogee County.

I asked if he knew whether SFC was actually required to provide the Off Site Emergency Management Plan to the off site agencies. He originally thought a requirement existed in the Contingency Plan, but then stated he never really thought about whether there was an actual requirement for the Off Site Emergency Management Plan. Updating the plan was one of the responsibilities he inherited when he took the job and so he does it.

We also discussed some clarifications to SFC's plans to dry-pipe parts of the fire protection system in the plant (he was not available during the inspection for this information).

ENCLOSURE 16

RECORD OF CONVERSATION

January 6-7, 1994

Person Making Call: G. Michael Vasquez

SUBJECT: LOCAL OFFSITE AGENCY REQUIREMENTS AND RESPONSIBILITIES UNDER SARA TITLE III

Through the Region IV agreement state officer, I contacted the state of Oklahoma, to get a better idea of the requirements for emergency planning under SARA Title III. In the state, I was eventually referred to Larry Gales and Monty Elder of the Oklahoma Department of Environmental Quality (DEQ). Ms. Elder explained that SARA Title III requires the Local Emergency Planning Committee (LEPC) to develop contingency plans based on the information that the facilities provide. The individual facilities have no requirements to develop contingency plans (i.e., Sequoyah Fuels Corporation has no requirement under SARA Title III to develop a Contingency Plan). Also, she said that if the facility has a plan, there are no requirements under SARA Title III for the facility to provide updates to the local offsite agencies. However, facilities have annual reporting requirements to describe the type and quantity of certain listed chemicals (HF, ammonia, and NO2 were three on the list), as well as other information that aids the LEPC in developing its Contingency Plans. Further, the facility must submit information to the the state on an annual basis, under Community Right to Know.

In the state of Oklahoma, the LEPC's are the counties, with members of the LEPC coming from several local agencies - health department, civil defense, and others. The LEPC obtains the information from different facilities and makes it publicly available. The facility must designate someone with whom the county and state can contact for Emergency Planning purposes. The facility must provide information about the chemicals it has onsite each year, to both the LEPC and the local fire department.

Ms. Elder gave the name of Sherry Holman as the LEPC coordinator for Sequoyah County. When I attempted to reach Ms. Holman, I was told that she no longer worked there and I was told that Bob Bates was now the LEPC coordinator. (I have spoken with Bob through my past inspection responsibilities at SFC, so we were familiar with each other.)

Bob, formerly with the county health department, is now working with the Department of Environmental Quality (DEQ) there in Sequoyah County. Bob verified that they do maintain a list of hazardous chemicals and substances in the county. Other facilities, including SFC, have submitted Contingency Plans and the LEPC has essentially adopted the other plans to make one big county-wide plan. With SFC, he clarified that the LEPC adopted the Offsite Emergency Management Plan, not the Contingency Plan. He was aware of the difference between the two plans - that the Contingency Plan mainly dealt with onsite response, but he recognized there were some things (e.g., emergency action levels) with which the LEPC would also be interested.

When Sherry left the agency, he became the head of the LEPC, so he was not very clear about some of the history of the development of the Offsite Emergency Management Plan. He stated he remembered that Sherry and Jesse

Deer-in-Water (NACE) worked quite a bit with Gary Barrett (SFC's Contingency Plan Coordinator) on SFC's Offsite Emergency Management Plan a few years ago.

With regard to SFC's Offsite Emergency Management Plan, he stated that SFC has been submitting revisions to local agencies. At first, SFC would submit copies to the county, but sometimes the county was not timely in mailing them to the other local offsite agencies. Also, in the past some agencies have not been as diligent about updating their books with the revisions that were provided. He said that as a result, SFC began submitting the revisions directly to the local offsite agencies. I asked and he verified that SFC has provided the local offsite agencies with revisions, but that it was the responsibility of the local offsite agencies to update their own books.

In fact, Bob verified that a while back (on more than one occasion), somehow SFC got wind that not every agency's books were the same (some were updated and some not). So, SFC replaced the old books with new, up-to-date books. Again I asked and he clarified that, even though it was not SFC's responsibility to go in and update the books that these offsite agencies had, SFC went beyond the call of duty and provided copies of all new updated plans, and took back the old ones.

When I described the situation that NACE described in Silent Sirens regarding the Sheriff's department, Bob stated that he thought that Gary was taking back an old outdated copy and replacing it with an up-to-date copy.

(NOTE: This seems to verify the information that Gary Barrett (SFC) provided to me during an earlier telecon. It sounded like the local offsite agencies have been struggling with keeping their plans updated and that they may be continuing to deal with this issue. But it makes sense to me that the responsibility for physically inserting updates into the plans rests with the local agency and not SFC.)