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UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION  
ATOMIC SAFETY AND LICENSING BOARD

OFFICE OF SECRETARY  
DOCKETING & SERVICE  
BRANCH

Before Administrative Judges:  
Peter B. Bloch, Chair  
Dr. Richard F. Cole  
Dr. Harry Foreman

SERVED DEC 19 1990

In the Matter of  
  
PUBLIC SERVICE CO. OF  
NEW HAMPSHIRE, ET AL.  
  
(Seabrook Station  
Units 1 and 2)

Docket Nos. 50-443-OL-R  
50-444-OL-R

RE: Emergency Planning;  
ALS<sup>1</sup> Patients

ASLBP No. 90-600-01-OL-R<sup>2</sup>

MEMORANDUM AND ORDER  
(Summary Disposition Motion)

MEMORANDUM

In this Memorandum and Order, we have decided to grant Public Service Co. of New Hampshire et al.'s (Licensees') motion for summary disposition of an issue remanded to us by the Appeal Board and the Commission, relating to evacuation time estimates (ETEs) and the preparation of advanced life support (ALS) patients for evacuation in the New Hampshire Radiological Emergency Plan.

<sup>1</sup>ALS = Advanced Life Support.

<sup>2</sup>The case numbers in this Order are correct. Disregard the case numbers contained in the Order constituting this Board.

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I. Background of the Case

In Public Service Company of New Hampshire (Seabrook Station, Units 1 and 2), ALAB-924, 30 NRC 331 (1989), the Appeal Board questioned whether evacuation time estimates (ETEs) in the New Hampshire Radiological Emergency Response Plan (NHRERP) had been adequately derived with respect to consideration of the time necessary to prepare advanced life support patients for transportation.<sup>3</sup> Consequently, the Appeal Board remanded the issue to Judges Smith, Cole and McCollom (now known as "the offsite EP<sup>4</sup> Board").

Before the offsite EP Board acted, the Commission itself issued its immediate effectiveness decision. Public Service Company of New Hampshire, et al. (Seabrook Station, Units 1 and 2), CLI-90-3, 31 NRC 219 (1990). In that decision, in which the Commission authorized the operation of the Seabrook Station, the Commission summarized the Appeal Board's action as follows:

On the basis of our effectiveness review, we agree that the issue identified by the Appeal Board -- whether the ETEs for nonambulatory individuals found in the NHRERP take into account the amount of time it would take to prepare ALS patients for evacuation -- remains unresolved. It is simply not clear that the 40-minute "loading passenger" time found in the NHRERP [footnote omitted] includes

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<sup>3</sup>The Appeal Board's concern relates to the testimony of Intervenor's witness Joan Pilot that ALS patients can not be prepared in any way for the arrival of an evacuation vehicle until after the arrival of the vehicle. ALAB 924, 30 NRC 331 (1989) at 351.

<sup>4</sup>EP = Emergency Planning.

this preparation time as the Licensing Board asserts. . . .<sup>5</sup>

Regarding the requirement that emergency plans include ETEs for each special facility, the Commission also stated, *id.* at 244, that, "We find reasonable the Licensing Board's extensive discussion of this issue in the SPMC decision, LBP-89-32, *supra*, 30 NRC at 421-23."

This Licensing Board notes that in the off-site EP Board's decision, cited by the Commission as "reasonable" and hence continuing to be the law of this case (as it has not been overturned), that Board found that it is not necessary for Applicant to calculate ETEs for "each special population group and special facility" because to do so would be

an impractical, unreasonable, and time-consuming approach to making a PAR, . . . . Tr. 21,552-55; Appl. Reb. No. 16, *supra*, at 62.<sup>6</sup>

In Public Service Company of New Hampshire (Seabrook Station, Units 1 and 2), LBP-90-12, 31 NRC 427 (1990) at 437, the off-site EP Board interpreted the ruling of the Appeal Board and the guidance of the Commission as remanding the issue of the NHRERP's assumptions about the evacuation times for nonambulatory hospital patients. That Board, *id.* at 438-39, identified the following subissues:

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<sup>5</sup>Id. at 243.

<sup>6</sup>Id. at 422, Finding 2.97.

1. How long does it take to effectively prepare an ALS patient for transportation?
2. Would preparation of patients at an early initiating condition, e.g., declaration of an alert, or at an order to evacuate, be medically appropriate?
3. How many ALS patients are there in the EPZ? Where are the ALS patients? Only at Exeter and Portsmouth Hospitals?
4. Would uncertainties in the times available to prepare ALS patients for evacuation produce ETEs that are too inaccurate to be useful in the selection of protective action options?

Following a brief dissertation on the general rules for summary disposition, we shall discuss Licensees' proposed facts upon which it bases its motion for summary disposition and the subissues identified by the off-site EP Board.

## II. Standard for Summary Disposition<sup>7</sup>

Decisions concerning summary disposition are critical. If a motion is too readily granted, intervenors are deprived of their opportunity to cross-examine witnesses and otherwise establish that the licensee has not carried its burden of persuasion on issues of potentially great safety and environmental importance. If a motion is too readily denied, the result is unnecessary delay and hearing expense. In addition, an inappropriate denial of summary disposition

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<sup>7</sup>This discussion was adapted from the discussion in Cleveland Electric Illuminating Company, et al. (Perry Nuclear Power Plant, Units 1 & 2), LBP-82-114, 16 NRC 1909 (1982) at 1911-1913.

may cause the hearing process to concentrate too heavily on unimportant issues and to detract from the time and energy that might be devoted to more important issues.

The Commission's Rules of Practice provide that summary disposition of any matter involved in an operating license proceeding shall be granted if the moving papers, together with the other papers filed in the proceeding, show that there is no genuine issue as to any material fact and that the moving party is entitled to a decision as a matter of law. 10 CFR §2.749(d). The use of summary disposition has been encouraged by the Commission and the Appeal Board to avoid unnecessary hearings on contentions for which an intervenor has failed to establish the existence of a genuine issue of material fact. E.g., Statement of Policy on Conduct of Licensing Proceedings, CLI-81-8, 13 NRC 452, 457 (1981) and Houston Lighting and Power Company (Allens Creek Nuclear Generating Station, Unit 1), ALAB-590, 11 NRC 542, 550-51 (1980). A material fact is one that may affect the outcome of the litigation. Mutual Fund Investors, Inc. v. Putnam Management Co., 553 F.2d 620, 624 (9th Cir. 1977).

When a motion for summary disposition is made and supported by affidavit, a party opposing the motion may not rest upon the mere allegations or denials of an answer but must set forth specific facts such as would be admissible in evidence that show the existence of a genuine issue of ma-

terial fact. 10 CFR §2.749(b). All material facts set forth in the statement of material facts required to be served by the moving party will be deemed to be admitted unless controverted by the statement of material facts required to be served by the opposing party. 10 CFR §2.749(a). Any answers supporting or opposing a motion for summary disposition must be served within twenty (20) days after service of the motion. Id. If no answer properly showing the existence of a genuine issue of material fact is filed, the decision sought by the moving party, if properly supported, shall be rendered. 10 CFR §2.749(b).

In addition to the requirements of 10 CFR §2.749, various Licensing Board and Appeal Board decisions set the standards for summary disposition. The Appeal Board decisions have stated that "summary disposition is a harsh remedy. It deprives the opposing litigant of the right to cross-examine the witness, which is perhaps at the very essence of an adjudicatory hearing." Cleveland Electric Illuminating Company, et al. (Perry Nuclear Power Plant, Units 1 and 2), ALAB-443, 6 NRC 741, 755 (1977). Summary disposition is only authorized where the moving party is entitled to a judgment as a matter of law, where it is quite clear what the facts are, and where no genuine issue remains for trial. In determining such a motion, the record will be reviewed in the light most favorable to the party opposing the motion.

The opposing party need not show that it would prevail on the factual issues, but only that there are such issues to be tried. Pacific Gas & Electric Company (Stanislaus Nuclear Project, Unit No. 1), LBP-77-45, 6 NRC 159, 163 (1977).

Before granting a motion for summary disposition, the Licensing Board must conclude that there is no litigable issue of fact. Power Authority of the State of New York (Greene Count. Nuclear Power Plant), LBP-79-8, 9 NRC 339, 340 (1976). In addition, in an operating license proceeding, where significant health and safety or environmental issues are involved, the Licensing Board should only grant summary disposition if it is convinced that the public health and safety and environment will be satisfactorily protected. Cincinnati Gas & Electric Company, et al. (William H. Zimmer Nuclear Station), LBP-81-2, 13 NRC 36, 40-41 (1981). Even if no party opposes a motion for summary disposition, the movant's filing must still establish the absence of a genuine issue of material fact. Perry, supra, at 753-754.

### III. Consideration of Licensees' Proposed Facts

In their motion for summary judgement on the ALS issue, Licensees have set forth 16 statements of material facts which they say preclude any genuine issues for trial. The Licensees have supported their motion with four affidavits and one hospital plan, the New Hampshire Emergen-

cy Response Plan for Exeter Hospital.<sup>8</sup> The NRC Staff has supported the Licensees' motion and attached one affidavit of its own.<sup>9</sup> The Intervenors have filed their opposition to the motion and provided the Board with four affidavits to counter the Licensees' statements.<sup>10</sup>

Licensees' proposed facts are as follows:

1. A prudent planning basis for the ALS patient census at the time of an emergency would be a total of 35 ALS patients in the entire EPZ (22 at Exeter and 13 at Portsmouth Regional Hospital).
2. This number of 35 would occur during the day on week days.
3. At Exeter Hospital the average preparation time for an ALS is 115 minutes, 70 minutes of which can be accomplished prior to ambulance arrival, leaving a final preparation and loading time of 45 minutes.
4. In the case of Portsmouth Regional Hospital, the average preparation time for an ALS patient is 45 minutes, 10 minutes of which can be accomplished prior to ambulance arrival, leaving a final preparation and loading time of 35 minutes.
5. In accordance with its emergency management plan, Portsmouth Regional Hospital will use internal operational procedures and protocols to ensure 24-hour staffing for emergency conditions.
6. Exeter Hospital commences calling in Staff for an emergency at Seabrook at the Site Area Emergency Classification.

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<sup>8</sup>Licensees' Motion for Summary Disposition With Respect to the "ALS Patient Issue" (June 26, 1990).

<sup>9</sup>NRC Staff Answer in Support of Licensees' Motion for Summary Disposition of ALS ETE Issue (July 16, 1990).

<sup>10</sup>Intervenors' Opposition to Licensees' Motion for Summary Disposition with Respect to "the ALS Patients Issue" (July 31, 1990).



7. The hospital emergency plans for both Exeter and Portsmouth Regional Hospitals provide for initiation of assembly of patients, as medically appropriate, upon receipt of the recommendation to evacuate which will maximize the number of patients available for evacuation upon arrival of the first ambulances.

8. The emergency plans for both hospitals provide for the decision on ALS patients protective actions (e.g., evacuation) to be made by the medical staff on a case-by-case basis and without reference to the ETE for that individual.

9. In the event an ALS patient is not evacuated or is delayed in evacuation, the only other protective action for such a patient is sheltering.

10. Exeter Hospital is located in ERPA F, the shortest midweek daytime ETE for which is 4:40.

11. Exeter Hospital is capable of loading five ambulances simultaneously. Patients will be loaded two per ambulance.

12. The Portsmouth Hospital is located in ERPA G, the shortest midweek daytime ETE for which is 5:35.

13. Portsmouth Hospital is capable of loading three ambulances simultaneously. Patients will be loaded one per ambulance.

14. The last ambulance is estimated in the ETE study to arrive at its assigned special facility 2:13 after the order to evacuate.

15. Towards the end of the evacuation time frame, the last ambulance to evacuate an ALS patient will take 15 minutes or less to proceed from the special facility to the EPZ boundary.

16. The loading of patients will begin before the last ambulance arrives at Exeter Hospital.

Most of Licensees' 16 statements of material fact are not directly challenged by Intervenors. For certain of Licensees' statements, Intervenors would place limitations

on the scope or application of the statements. The most serious challenges to Licensees' proposed statements are:

- the lack of consideration, in this remand, of ALS patients in Massachusetts (addressed under subissue 3 in section IV, infra);
- the use of midweek daytime estimates for preparing and loading ALS patients as compared to times that might be required during off-peak hours when hospital staffs are considerably reduced (addressed under subissue 1 infra); and
- a challenge to the assertion that ETES are useless in the PAR decisionmaking process for ALS patients (addressed under subissue 4 infra).

The Board accepts as its findings each of Licensees' proposed facts, as limited by the following discussion. In particular, the remand was limited to the New Hampshire emergency plan and we therefore understand the proposed statement of material facts to relate solely to New Hampshire. We note that Material Fact 15 applies to any ambulance evacuating ALS patients towards the end of the evacuation time frame, when most of the general public has already left.

#### IV. Findings With Respect to Four Subissues

- A. Subissue (1): How long does it take to efficiently prepare an ALS patient for transportation?

Licensees' affiant Dr. Callahan states that the emergency planning time spent on ALS patients will be 90 min-

utes for preparation, 10 minutes moving and 15 minutes loading, giving a total preparation and loading time of 115 minutes for Exeter Hospital. Callahan at 6. He states that of this 115 minute time period, 70 minutes can be performed prior to the time an ambulance arrives at the hospital. Callahan at 7.

The Intervenors do not present any evidence to contest Licensees' statement of the length of time to prepare and load an ALS patient at Exeter Hospital.

Licensees' affiant Dr. Albertson states that the total time to prepare an average ALS patient at Portsmouth Hospital is 45 minutes.<sup>11</sup> Albertson at 6. He states that 10 minutes of the preparation generally can be accomplished prior to the time the ambulance arrives at the hospital.

The Intervenors present the affidavit of Stanley J. Plodzick, Assistant Administrator of Patient Services for Portsmouth Regional Hospital. Mr. Plodzick does not differ with Dr. Albertson's statements concerning the 45 minute preparation and loading time for patients during the midweek daytime periods. Plodzick at 1 and 2. However, Mr. Plodzick states that at times other than midweek daytime periods, such as evening or at night, staffing levels at Portsmouth

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<sup>11</sup>Dr. Albertson's estimate is "depend[ent] on the patient's condition, the life support equipment required, and how long it takes to stabilize the patient." Albertson at 6. The same is true with regard to the amount of preparation that can be accomplished prior to the arrival of the ambulance. Albertson at 7.

Hospital are too low to allow such efficient patient preparation. According to Mr. Plodzik, the time it would take to prepare and load an ALS patient into an ambulance during the evening or night time would probably be sixty to ninety minutes. Plodzik at 3. The testimony is consistent with that of Dr. Albertson, the Licensees' affiant, who indicates that his 45 minute estimate is dependent on full staffing of Portsmouth Hospital. Albertson at 6-10.

Licensees Statement of Material Fact (5) anticipated Mr. Plodzik's argument, stating that provision has been made for 24 hour staffing of the hospital during an emergency. Dr. Albertson states, at p. 14, that:

. . . [the] Hospital's Emergency Management Plan . . . ensure[s] 24-hour staffing for emergency conditions. The Hospital will use existing internal operational procedures and protocols to ensure appropriate assignment of staff.

Again, Mr. Plodzik's answer does not actually differ with Dr. Albertson's statement about the overall contours of the plan but he offers an important qualifier:

Although the . . . Hospital has an emergency preparedness program that allows for calling in additional staff in the event of an emergency, I do not believe that the activation of that call-in procedure would have a significant impact on reducing the sixty to ninety minute estimated time for preparing and loading ALS patients during the evening and night time.

Plodzik at 4. Taking Mr. Plodzik's assertion in a light most favorable to the Intervenor raises doubt as to whether Portsmouth Hospital staff can always prepare and load its

ALS population as efficiently as Dr. Albertson asserts. Were an emergency to occur during the evening and weekend hours, patient preparation might take longer. However, Mr. Plodzik's argument fails to show why it is material that patient preparation during evenings and weekends might take sixty to ninety minutes.<sup>13</sup>

Even if some reduction in efficiency of preparation and loading of patients were to occur because of reduced staffing and we were to use Mr. Plodzik's off-hours time estimates, this would increase the preparation and loading time by 15 to 45 minutes per patient, which does not demonstrate any consequence with respect to the ability to evacuate ALS patients in about the same time as the general population will be evacuated during daytime hours.<sup>14</sup>

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<sup>13</sup>In responding to a statement filed in support of a motion for summary disposition, a party who opposes the motion must aver specific facts in rebuttal. 10 C.F.R. §2.749(b); Public Service Company of New Hampshire (Seabrook Station, Units 1 and 2), LBP-83-32A, 17 NRC 1170, 1174 n.4 (1983). Further, by virtue of Section 2.749(b), if a motion is properly supported, the opposition may not rest upon mere allegations or denials; rather the answer must set forth specific facts showing that there is a genuine issue of fact. Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-629, 13 NRC 75, 78 (1981); Virginia Electric and Power Company (North Anna Nuclear Power Station, Units 1 and 2), ALAB-584, 11 NRC 451 (1980); 10 C.F.R. 2.749(b).

<sup>14</sup>Intervenors have not provided testimony that raises a genuine issue of fact concerning the ETE for ALS patients being materially longer than that for the general population.

The testimony fails to state how many fewer patients might be expected in the non-peak census at Portsmouth

The last ambulance to arrive at its assigned special facility (either Exeter or Portsmouth Hospital) in daytime hours is expected to arrive 2 hours and 13 minutes after the order to evacuate. Licensees #14. Licensees' uncontradicted Statement #12 permits us to conclude that the shortest midweek daytime ETE in the emergency protective action zone for Portsmouth Hospital (ERPA G) is 5 hours and 35 minutes. The shortest midweek daytime ETE for ERPA F (Exeter Hospital) is 4 hours and 40 minutes which also

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Hospital or how the alleged increase in individual patient preparation times would impact on the total preparation and loading time for ALS patients. Compare Albertson at 10-12. Nor do Intervenor provide any testimony concerning how long it would take for different members of the Staff to begin arriving at the hospital during an extended emergency, under the emergency call-in plan. Albertson at 14; see Plodzik at 4. Presumably, periodic Staff arrivals would reduce patient preparation times. (Note that the ETE for the ERPA in which the Portsmouth Hospital is located is 5 hours and 35 minutes. ETE Handbook, Table 2-1, p. 2-7; ETE Study, Table 10-8, pp. 10-24.)

It is possible (though Intervenor have failed to support the possibility in their affidavits) that the ETE for ALS patients will exceed that of the general population because some few ALS patients may not be evacuated within the time frame of the general population at the time the evacuation takes place. We do not consider even this speculative possibility to be material because: (1) both hospitals are at least 7 miles from Seabrook so that radiation doses will be somewhat dissipated, (2) patients will be evacuated when ready and only a few are likely to be delayed, (3) patients will be sheltered in the effective shelter of the hospital (see p. 23, below, concerning sheltering) during their increased wait, (4) passage through the empty streets of the EPZ after others have evacuated will be speedy, resulting in minimal radiation exposure, and (5) no use will be made of the ETE for ALS patients, as we discuss below.

results in an ALS ETE less than that for the general population.

We conclude that the ETE for ALS patients is favorable compared to that for the general population, even if we accept Intervenor's estimate of the time to prepare patients. Since we also find (in Section D., below) that neither the hospital staff nor emergency planning officials have any use for the ETE with respect to possible evacuation of hospital patients, there is no material issue of fact with respect to the time it takes to prepare ALS patients for transportation. In any event the time to prepare and load ALS patients for transportation following arrival of the ambulance in daytimes-midweek, when the ALS patient load is greatest, is estimated at 35 to 45 minutes (Facts 3 and 4) which comports well with the 40 minute "passenger loading" time found in the NHRERP (v. 6 at 11-26) and the ETE Study at 11-22 and appears to demonstrate that adequate consideration was given to the preparation and loading time of ALS patients.

- B. Subissue (2): Would preparation of patients at an early initiating condition, e.g., declaration of an alert, or at an order to evacuate, be medically appropriate?

It is possible to do limited preparation of patients prior to the ambulance arrival depending on hospital practice and patient condition. There is some difference of opinion con-

cerning this question, but the difference is without substantive effect. Licensees Statement #7 is:

The hospital emergency plans for both Exeter and Portsmouth Regional Hospitals provide for initiation of assembly of patients, as medically appropriate, upon receipt of the recommendation to evacuate, which will maximize the number of patients available for evacuation upon arrival of the first ambulances.

The Affidavit of Betsy Cohen seems to diverge from this point of view. However, she states, at 5, that:

Apart from the advance preparation of a patient's paper work,<sup>15</sup> in many, if not most, instances it would probably not be medically appropriate to prepare an ALS patient at an earlier initiating point. [Emphasis added.]

This statement of Ms. Cohen, particularly when viewed in light of paragraph 4 of her statement (in which she includes detaching patients from life support equipment and substituting portable life support equipment within her estimate of preparation time for an ALS patient), is entirely consistent with Licensees' statement -- which makes no effort to forecast the frequency that would be "medically appropriate" to prepare a patient at an earlier initiating point. Since none of the other affidavits address this

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<sup>15</sup>The Board notes, at the suggestion of Dr. Foreman, that work ought to be done in advance to prepare the patient psychologically for the move. To the extent that Intervenor's witness may have left this work to be done after ambulance arrival, this much additional work can be done in advance.



point, we conclude that there is no genuine issue of fact concerning this issue.

- C. Subissue (3): How many ALS patients are there in the EPZ? Where are the ALS patients? Only at Exeter and Portsmouth Hospitals?

There are, on average, 35 ALS patients in the New Hampshire EPZ at midweek during the daytime (22 at Exeter Hospital and 13 at Portsmouth Hospital).

Underlying the Licensees' estimates of the ALS population is the assumption that only the special facilities located in the New Hampshire EPZ should be counted in the planning basis. The Intervenor do not take issue with the ALS populations for the New Hampshire EPZ.

The Intervenor do take issue with the Licensees' assertion that only New Hampshire hospitals should be relied upon for an estimate of the ALS population. The Intervenor argue that the ALS patient populations of Anna Jaques Hospital (43) and Amesbury Hospital (7) in the Massachusetts EPZ should be included in the ETE planning basis. As support for this assertion, the Intervenor point to language found in Public Service Company of New Hampshire (Seabrook Station, Units 1 and 2), LBP-89-32, 30 NRC 375, 402 (1989) where we said:

In fact, the ETEs presented in the SPMC are for the entire region under study, including both Massachusetts and New Hampshire areas. . . . that NUREG-0654 calls for integrated emergency planning

between contiguous political jurisdictions (NUREG-0654, at 19, 23-24).

Response at 3.

We do not find the Intervenor's argument convincing. ALAB-924 was a remand of the issues evolving from the New Hampshire Radiological Emergency Response Plan. The Appeal Board was concerned that the ETES for ALS patients found in the NHRERP had not received appropriate consideration and the remand was designed to correct any deficiency the Board may find with respect to those ETES. Clearly, the Appeal Board's concern focused on ETES for New Hampshire special facilities. We are therefore persuaded that ALS populations in Massachusetts facilities are not material to the remanded issue.

Most important to this discussion, however, is that the Intervenor has failed to offer any explanation as to how the Massachusetts patients could be material to the remanded issue. They contest the numbers of patients "in the EPZ", but just what does this protest do? Do these patients affect the Licensees' ETES for Exeter and Portsmouth Hospitals? Do they show the plan to be deficient? Just why has this proposition been put before the Board? We are left to guess as to what the significance of the protest is, and we choose not to take this issue to trial on the basis of

guesswork.<sup>16</sup> It has also been amply demonstrated that the number of ALS patients in the New Hampshire EPZ is at a peak during midweek daytime periods. The parties are in general agreement that 35 ALS patients would be the planning number for a daytime midweek situation in the New Hampshire EPZ. Licensees' affiant Dr. Albertson states that the daytime midweek ALS population at Portsmouth Hospital is approximately 13 and "at other times [the] . . . number of potential ALS patients . . . is reduced." Albertson at 4. Similarly, Dr. Callahan states that the patient population at Exeter Hospital reaches a peak during the daytime on weekdays and that "[d]uring other times [the] . . . potential number of ALS patients . . . will most probably be reduced." Callahan at 4.

The Intervenors have failed to shoulder their burden by presenting evidence to controvert Licensees' assertion that ALS populations at Exeter and Portsmouth Hospitals are at

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<sup>16</sup>In responding to a statement filed in support of a motion for summary disposition, a party who opposes the motion must aver specific facts in rebuttal. 10 C.F.R. §2.749(b); Public Service Company of New Hampshire (Seabrook Station, Units 1 and 2), LBP-83-32A, 17 NRC 1170, 1174 n.4 (1983). Further, by virtue of Section 2.749(b), if a motion is properly supported, the opposition may not rest upon mere allegations or denials; rather the answer must set forth specific facts showing that there is a genuine issue of fact. Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAP-529, 13 NRC 75, 78 (1981); Virginia Electric and Power Company (North Anna Nuclear Power Station, Units 1 and 2), ALAB-584, 11 NRC 451 (1980); 10 C.F.R. 2.749(b).

their peak midweek during the daytime. Intervenor's affiant Mr. Plodzik, the Assistant Administrator of Patient Services for Portsmouth Hospital did not address the issue in his affidavit.<sup>17</sup>

Licensees Statement #1, cited above, says that there are expected to be only 35 ALS patients in the entire EPZ and that they will be only at Exeter Hospital and Portsmouth Regional Hospital. Intervenor did not challenge this statement with respect to the portion of the EPZ within New Hampshire.

Intervenor also attempt to raise a question concerning the maximum patient census in the hospitals. However, their affidavits do not support this alleged genuine issue of fact with respect to Licensees Statement of Fact #2. There are two affidavits referenced. One, by Allan DesRosiers, at 8 (page 5), corroborates Licensees' statements about the likelihood of a reduction of ALS patient census (at Essex County Hospital, in Massachusetts) during shifts other than weekdays.<sup>18</sup> The other, by Betsy Cohen, at 7 (pp. 2-3),

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<sup>17</sup>Intervenor's affiant Allan DesRosiers, the President of Anna Jaques Hospital located in the Massachusetts portion of the EPZ, states that with regard to his hospital, "there is likely to be some reduction in the ALS patient census . . . at night[] and on weekends" at his hospital. DesRosiers at 8.

<sup>18</sup>Mr. DesRosiers challenges only the time estimates for preparing patients during the different shifts. His time estimates are based primarily on staff availability in relationship to expected patient census. His concern is of scarcity of staff during evening and weekday shifts.

states that for Amesbury Hospital the census on weekday evenings stays at approximately seven, which is the daytime peak. Consequently, her testimony corroborates the use of the daytime census as a maximum, even though she describes a very different hospital in a different state.<sup>19</sup>

- D. Subissue (4): Would uncertainties in the times available to prepare ALS patients for evacuation produce ETEs that are too inaccurate to be useful in the selection of protective action options?

To answer a question concerning the usefulness of ETEs in selection of protective action determinations, we need to look at the procedures in place under which the determinations of protective action are made. First, it is uncontested that the ultimate decision whether to shelter or evacuate ALS hospital patients during an emergency rests with the medical personnel at the hospital. Callahan at 5; Albertson at 5,15; Bonds at 7,18; Callendrello at 9.

Initial notification to the Hospitals of an emergency at Seabrook will be at the Alert stage and will be via telephone from the local (Exeter or Portsmouth) Emergency Response Organization. See NHRERP, vol. 26A/Rev.2, p. 10 and vol. 33/Rev. 3, p. 3.9-2 resp. The information related at that time will be the Emergency Classification Level of

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<sup>19</sup>Her testimony also concentrates on patient preparation time, arguing for longer times on evening and weekend shifts.

the ongoing incident at Seabrook. A tone-alert radio serves as an additional means of notification and is automatically activated as part of the Public Alert and Notification System (PANS). (Exeter Hospital Support Plan, p. 9). Any changes in the classification of the accident will also be made by telephone from the local Emergency Response Organization.

The Emergency Classification Levels in order of severity are:

- A. Unusual Event
- B. Alert
- C. Site Area Emergency
- D. General Emergency

Id. at pp.3,4.

Protective Action Recommendations (PARs) are made by State Officials for each Emergency Response Planning Area (ERPA). There are seven (7) ERPAs within the Emergency Planning Zone (EPZ), which is an area of approximately 10 mile radius surrounding the Seabrook Station. Some portions of the EPZ go out to almost 14 miles from the Station. Seabrook Station Evacuation Time Study, Rev 2. (ETE Study), Figure 1-3, pp. 1-17. Exeter Hospital is located in ERPA F approximately 6 to 7 miles from Seabrook. Portsmouth is 11 to 12 miles away and is located in ERPA G. Id. Table 10-3 1 at pp. 10-19.

The PAR for all transit dependent populations including ALS patients at the Portsmouth and Exeter Hospitals will be the same PAR proposed for the general population. Seabrook

Station Evacuation Time Study Handbook (ETE Handbook), Section 3.1.2, p. 3-1. If the State recommendation is to evacuate the general population, the Hospital officials will decide on a patient to patient basis whether to evacuate. At this stage it is a medical decision and the ETE will not play a role in that decision. While the general population ETE may have had a role in the State's recommendation, the medical personnel must decide if the ALS patient can handle the trip, a trip not only to the edge of the EPZ but past that to the receiving hospital. Once the decision as to medical feasibility of safe transport is made, Hospital officials must decide whether to transport the patients as soon as ambulances are available or to wait for the general population to exit prior to transporting the patients.

A review of the NHRERP documents indicates that unless conditions at special facilities warrant individual attention by State and local emergency personnel, any PARs to the general population would apply to the special facilities. Based upon this, it is anticipated that ALS patients medically capable of safe transport will be transported when the PAR for the general population is to evacuate. In the case of special facilities such as hospitals, the PAR may be revisited based upon input received from facility managers. At the initiative of the manager of the Hospital, a more detailed evaluation of the PAR for the specific facility can be undertaken based upon facility-specific sheltering pro-

tective factors. The sheltering factors for the Exeter and Portsmouth hospitals are 0.20 and 0.25, respectively. NHRERP v. 8, Section 6.2, p. 6.2.1. As guidance, New Hampshire Emergency Response personnel can use a Form B "Special Facility Protective Action Worksheet" and Table 6.9 "Special Facility Protective Action Guidance Chart" to assess the options of shelter, evacuation and/or KI issuance. NHRERP, v.8/Rev.3, Section 6, pp. 6.2-1, 6.9-1. The resulting protective action recommendation would be a facility specific recommendation which takes into account accident specific data and sheltering factors. Id.

The EMS vehicles are expected to be able to mobilize quickly (about 20 minutes) because of the emergency nature of their daily tasks. Then, assuming a 2 1/2 hour transit time to an evacuating facility (via a staging area) and 40 minutes to load passengers, the vehicle would begin traveling out of the EPZ within about 3 1/2 hours. Id. section 3.2.2, p.3-2; NHRERP, vol. 6 at p. 11-26. Outbound travel would be controlled by the speed of other evacuating vehicles or would take about 15 minutes if the roads were clear. As can be seen from Table 2-1, the shortest ETE is 3:35 (3 hours, 35 minutes) so any outbound EMS vehicles would commingle with the general population and their ETE would be considered the same. ETE Handbook, pp. 2-7, p. 3-2; NHRERP, vol. 6, pp. 11-26. The shortest ETE listed in Table 2-1 does not include ERPAs F and G. For those Regions



including Exeter or Portsmouth Hospital, and midweek daytime Scenarios (Regions 11, 12, 16, 17 and Scenarios 3 through 7), the minimum ETEs are even longer. (4:40 for Exeter and 5:35 for Portsmouth, respectively). ETE Handbook, Table 2-1, p. 2-7; ETE Study, Table 10-8, pp. 10-24.

The envelope times for evacuation of ERPAs F and G for the different accident scenarios range from 0 -4:40 to 0-9:10. For each of the accident scenarios, the time required to prepare and load ALS patients is within the general population ETE for the ERPA. ETEs specific to a generic ALS patient population are of limited utility in deciding to evacuate or shelter an ALS patient due to variation in patient preparation times.

As we have read and analyzed the papers with respect to this issue, we have concluded that there is no one who would use ETEs for the 35 New Hampshire ALS patients for any constructive purpose. These patients represent a very special sub-population. Their ETEs appear to be shorter than that calculated for the general population. Furthermore, these patients -- who include patients in the Intensive Care Unit, the Operating Room/Recovery Room and those in active labor -- are under extensive medical supervision and these professional care-givers are the only people in a position to evaluate the condition of the patient, the risks of moving the patient, the nature of required life-support equipment and whether the patient can be prepared for evacuation

before the arrival of an ambulance, and the availability of properly trained staff to effect the move. The medical staff also will be generally informed about the risk to their patients of a release from Seabrook Station and will be able to make a rough comparison of the possible effects of a release and the health effects of moving them.

Licensees' uncontradicted Statement says:

8. The emergency plans of both of the hospitals provide for the decision on ALS patients protective actions (e.g., evacuation) to be made by the medical staff on a case-by-case basis and without reference to the ETE for that individual.

Since ETEs, strictly speaking, are averages and are not computed for individuals, we understand Licensees to be alleging that the medical staff will make its choices without reference to the ETE for that class of individuals.

Although Intervenors say they contest this Statement of Licensees (Intervenors Statement #6), they do not allege any specifics. In particular, they do not state who would use the ETE for a class of individuals or for what purpose they would use it.<sup>20</sup>

We conclude that the choice of the correct strategy must be made by the medical staff on an individual basis,

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<sup>20</sup>See, e.g., Affidavit of Robert L. Goble, at iv, which states:

Although uncertainties are always present in developing ETE's, reasonable and attainable accuracy in the estimates will produce results which can make a difference in the choice of PAR across a broad spectrum of accident situations.

given all the facts at hand, and that they would not (and should not) use a pre-calculated average value such as an ETE to make a decision for any particular patient. Hence, there is no genuine issue of fact here, either.

V. Summary of Conclusions

We grant summary disposition because there is no genuine issue of material fact as to any of these findings:

1. A prudent planning basis for the ALS patient census at the time of an emergency would be a total of 35 patients in the entire New Hampshire portion of the EPZ (22 at Exeter Hospital and 13 at Portsmouth Regional Hospital).

2. A prudent planning basis for the time required to prepare ALS patients to be moved by an ambulance is 45 minutes after the arrival of the ambulance.

3. The ETE for ALS patients is similar to that for the general population during daytime hours.

4. Decisions about whether to evacuate ALS patients will be made by medical staff on a case by case basis and without reference to the ETE for that class of patient.

We therefore conclude that there is no genuine issue of fact with respect to the remanded issue. Consequently, the issue will be summarily dismissed.


ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 18th day of December 1990, ORDERED, that:

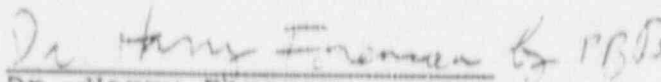
Summary Disposition is granted with respect to the remanded question of whether evacuation time estimates (ETEs) in the New Hampshire Radiological Emergency Response Plan (NHRERP) had been adequately derived with respect to consideration of the time necessary to prepare advanced life support patients for transportation. ALAB 924, 30 NRC 331 (1989) at 351.

This is a final disposition of the portion of this case that is pending before us.

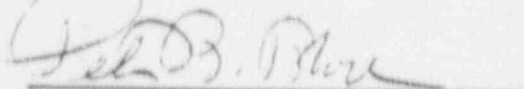
THE ATOMIC SAFETY AND LICENSING BOARD,



Dr. Richard F. Cole



Dr. Harry Foreman



Peter B. Bloch, Chair

Bethesda, Maryland

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

In the Matter of

PUBLIC SERVICE COMPANY OF NEW  
HAMPSHIRE, ET AL.  
(Seabrook Station, Units 1 and 2)

Docket No. (s) 50-443/444-DL-R

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing LB M&D (LBP-90-44) DTD 12/18 have been served upon the following persons by U.S. mail, first class, except as otherwise noted and in accordance with the requirements of 10 CFR Sec. 2.712.

Atomic Safety and Licensing Appeal  
Board  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Peter B. Bloch, Chairman  
Atomic Safety and Licensing Board  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Richard F. Cole  
Atomic Safety and Licensing Board  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Law Judge  
Ivan W. Smith  
Atomic Safety and Licensing Board  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Harry Foreman  
ASLB  
1564 Burton Avenue  
St. Paul, MN 55108

Edwin J. Reis, Esq.  
Office of the General Counsel  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Diane Curran, Esq.  
Harmon, Curran & Tousley  
2001 S Street, N.W., Suite 430  
Washington, DC 20009

Thomas G. Dionan, Jr., Esq.  
Ropes & Gray  
One International Place  
Boston, MA 02110

Robert A. Backus, Esq.  
Backus, Meyer & Solomon  
116 Lowell Street  
Manchester, NH 03106

Paul McEachern, Esq.  
Shaines & McEachern  
25 Maplewood Avenue, P.O. Box 360  
Portsmouth, NH 03801

Docket No. (s) 50-443/444-DL-R  
LS M&D (LBP-90-44) DTD 12/18

Gary W. Holmes, Esq.  
Holmes & Ellis  
47 Winnacunnet Road  
Hampton, NH 03842

Barton Z. Cowan, Esq.  
Eckert, Seamans, Cherin & Mellott  
600 Grant Street, 42 Floor  
Pittsburgh, PA 15219

Jane Doughty  
Seacoast Anti-Pollution League  
5 Market Street  
Portsmouth, NH 03801

George W. Watson, Esq.  
Federal Emergency Management Agency  
500 C Street, S.W.  
Washington, DC 20472

Edward A. Thomas  
Federal Emergency Management Agency  
442 J.W. McCormack (POCH)  
Boston, MA 02109

George D. Bisbee, Esq.  
Assistant Attorney General  
Office of the Attorney General  
25 Capitol Street  
Concord, NH 03301

Suzanne Breiseth  
Board of Selectmen  
Town of Hampton Falls  
Drinkwater Road  
Hampton Falls, NH 03844

Leslie Greer, Esq.  
Nuclear Safety Unit  
Office of the Attorney General  
One Ashburton Place  
Boston, MA 02108

Matthew T. Brock, Esq.  
Assistant Attorney General  
Office of the Attorney General  
One Ashburton Place  
Boston, MA 02108

Philip Ahrens, Esq.  
Assistant Attorney General  
Office of the Attorney General  
State House Station, #6  
Augusta, ME 04333

Allen Lambert  
Civil Defense Director  
Town of Exeter  
20 Franklin Street  
Exeter, NH 03833

William Armstrong  
Civil Defense Director  
Town of Exeter  
10 Front Street  
Exeter, NH 03833

Anne Goodman, Chairman  
Board of Selectmen  
13-15 Newmarket Road  
Durham, NH 03824

Peter J. Matthews  
Mayor of Newburyport  
City Hall  
Newburyport, MA 01950

Docket No. (s) 50-443/444-DL-R  
LB M&O (LBP-90-44) DTD 12/18

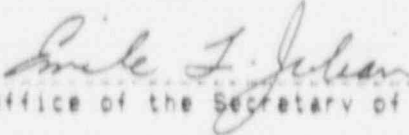
Michael Santosuosso, Chairman  
Board of Selectmen  
South Hampton, NH 03827

Stanley W. Knowles, Chairman  
Board of Selectmen  
P.O. Box 710  
North Hampton, NH 03862

R. Scott Hill-Whilton, Esquire  
Laquolis, Hill-Whilton & Rotondi  
79 State Street  
Newburyport, MA 01950

The Honorable  
Gordon J. Humphrey  
ATTN: Janet Coit  
United States Senate  
Washington, DC 20510

Dated at Rockville, Md. this  
19 day of December 1990

  
Office of the Secretary of the Commission