UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

May 16, 1994

MEMORANDUM FOR: Edward L. Jordan, Director, AEOD
Robert M. Bernero, Director, NMSS

FROM: Hugh L. Thompson, Jr.
Deputy Executive Director for
Nuclear Materials Safety, Safeguards,
and Operations Support

SUBJECT: LESSONS-LEARNED REVIEW OF THE SEQUOYAH FUELS CORPORATION EVENT OF NOVEMBER 17, 1992

In the EDO's memo dated March 14, 1994, you were requested to review the circumstances surrounding the November 17, 1992 event at Sequoyah Fuels Corporation (SFC) facility near Gore, Oklahoma to identify generic implications in the area of emergency preparedness/response to other fuel cycle facilities to determine whether any changes are needed in how the NRC responds to fuel facility events, and develop an evaluation plan and schedule to address those issues. Your joint April 11, 1994 memo enclosed a plan and schedule for performing the review and targeted October 15, 1994 for issuance of your final report.

Enclosed is a May 4, 1994 letter from Diane Curran that identified a number of issues which appeared to be of a generic nature and should be covered in your lessons-learned review described in your April 11, memorandum.

Hugh L. Thompson, Jr.
Deputy Executive Director for
Nuclear Materials Safety, Safeguards,
and Operations Support

Enclosure:
As stated

cc: J. Taylor

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May 4, 1994

BY FEDERAL EXPRESS
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U.S. Nuclear Regulatory Commission
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Dear Mr. Thompson:

On March 7, 1994, you called to inform me that you had been assigned by the Chairman of the Commission to look into the NRC Office of Investigation's ("OI's") handling of Native Americans for a Clean Environment's ("NACE's") Silent Sirens Report and related correspondence.[1] In that report, NACE requested that OI investigate apparent misconduct by Sequoyah Fuels Corporation ("SFC") during and following the November 17, 1992, accident at the SFC plant.[2] You also asked for my views on the adequacy of the NRC Staff's response to our request for an investigation.

As I told you then, neither I nor my client had ever been notified of any action by OI on our request for an investigation, let alone that OI had delegated its own investigatory

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1 The full title of the report is "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" (September 29, 1993). Related correspondence consists of letters from Diane Curran to David C. Williams (NRC Inspector General), Ben Hayes (NRC Office of Investigations), and John C. Martin (EPA's Inspector General) (September 28, 1993, October 4, 1993, and December 21, 1993); and a letter from Diane Curran to Ben Hayes (November 4, 1993).

2 NACE also asked the Inspectors General of the NRC and EPA to investigate their own agency responses to the accident. These requests are not subject to your review.

responsibilities to the NRC Staff. Nor was I aware that the NRC Staff had reached what it considered to be a resolution of most of the issues raised by NACE as long ago as December; and I had never seen either of the two key documents that you referred to, Dwight D. Chamberlain's December 17, 1993, memorandum to Len Williamson, containing the NRC Staff's "Analysis" of NACE's concerns, or NRC Chairman Selin's January 31, 1994, letter to Rep. Mike Synar. Thus, even though NACE was the party which raised these serious issues for investigation, neither OI nor the Staff contacted us regarding the apparent resolution of our concerns. Not surprisingly, therefore, it was impossible for me to provide you with NACE's views on OI's or the NRC Staff's handling of the investigation during our telephone conversation.

NACE has since obtained and reviewed copies of the documents that you referred to in our conversation, which convey the Staff's conclusion that there is no need for further investigation into NACE's allegations. We have also received a belated formal response to our investigation request from Senior Allegations Coordinator Russell Wise. Letter from Russell Wise to Diane Curran (March 24, 1994) (hereinafter "Wise letter"). We are writing now to provide you with the views you requested. We note that Mr. Wise's letter addresses some issues that Mr. Chamberlain's memorandum does not, and vice versa. Moreover, these documents are inconsistent in some respects. Since Mr. Wise's letter makes no statement about the validity or relevance of Mr. Chamberlain's memorandum, we will address them both.

As set forth below, we are appalled and outraged by OI's failure to conduct an independent review of our concerns. Instead, OI turned the inquiry over to the NRC Staff, which had failed to conduct an adequate investigation into the November 17th accident in the first place. Moreover, the Wise letter and the "Analysis of Issues Identified in Diane Curran Letter dated November 4, 1993," (hereinafter "Analysis") which is attached to Mr. Chamberlain's December 17, 1993, memorandum, are fraught with gaps, inconsistencies, misstatements, and unprincipled excuses for SFC's misconduct. For the most part, the concerns we raised have been shunted aside or obscured, rather than resolved. Therefore, we are asking OI to reconsider our request, and conduct the independent and thorough investigation that NACE originally requested.[3] We also request that you support an independent investigation by OI.

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[3] See letter from Diane Curran to Ben B. Hayes (May 4, 1994) (enclosed).

I. OI Should Have Conducted an Independent Inquiry.

NACE sought a review of SFC and the November 17th accident by OI, because OI has independent authority to investigate licensee wrongdoing. Indeed, as prescribed in the NRC Investigative Procedure Manual, § 3.2.1.2 (January 31, 1989), OI "is responsible for an independent evaluation" of whether a requested investigation is warranted.[4] However, OI completely abdicated its independent authority and responsibility to evaluate the need for an investigation, by turning the matter right back to the NRC Staff.

NACE sought an independent investigation by OI instead of the NRC Staff for a number of reasons. First, the NRC's Region IV Staff had failed to thoroughly investigate or take enforcement action against SFC in the first instance. Obviously, regional inspectors and other Staff members involved in the 1992 enforcement action would have a vested interest in defending the adequacy of their own previous actions and conclusions. In addition, the NRC Staff had failed to take any action in response to the concerns raised by NACE in its meeting with the NRC Staff following the March 2, 1993, enforcement conference regarding the accident, already demonstrating its unwillingness to pursue this matter further. Further NACE had requested the NRC Inspector General to investigate the Staff's grossly inadequate response to the accident.[5] It would have been improper for the Staff to conduct an inquiry into the circumstances of a previous enforcement action, at the same time that an IG investigation of the Staff's own conduct during that enforcement action was pending.

Not surprisingly, by disregarding these factors and refusing to institute an independent inquiry into SFC's conduct, OI achieved the exact result NACE sought to avoid by submitting its investigation request to OI: the Staff predictably rehashed the conclusions of its inadequate 1992 inspection and enforcement action.

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4 See also NRC Manual, § 0517-034 (April 3, 1990), (OI Director may investigate allegations of wrongdoing "on own initiative"); NRC Appendix 0517, Part III, § A.2.d (where there is a difference of opinion among or between OI and staff members as to whether to investigate, OI "will reserve the authority to self-initiate investigations.)

5 See letter from Diane Curran to David C. Williams (NRC IG), Ben B. Hayes (NRC OI), and John C. Martin (EPA IG) (September 28, 1993).

II. Process for Staff Inquiry Tainted

It also appears that even within the Staff's own inquiry, no effort was made to ensure independence of supervisory headquarters Staff from the regional Staff members who were responsible for the botched enforcement action. The Wise letter indicates that the Region IV Augmented Inspection Team ("AIT") which carried out the 1992 inspection also conducted the "initial review" of whether an OI investigation was warranted. Wise letter at 1. Moreover, one of the inspectors who took a large part in the NRC's enforcement action against SFC, G. Michael Vasquez, was on detail to you for the last three months, and, as he told me, informally provided information during your own review of NACE's report. Given the total lack of independence in the NRC Staff's inquiry regarding NACE's allegations, there is no basis for confidence in any of the NRC's conclusions.

III. OI Failed to Communicate with NACE or Inform NACE of Its Actions

As discussed above, NACE never learned anything about OI's or the NRC Staff's handling of our concerns until you called me in early March. This violated OI's procedures, which require OI to "notify the requester within 30 days whether the matter has been accepted for investigation, and, if so, the priority of the investigation and the estimated schedule."[6] Investigative Procedure Manual, Office of Investigations (January 31, 1989). Moreover, despite the fact that NACE had directed its request for an investigation to OI, OI itself has never responded formally to NACE's request; instead, we have received a letter from Russell Wise, a member of the NRC Region IV Staff.

Furthermore, despite the array and complexity of the issues raised by the Silent Sirens Report, neither OI nor the NRC Staff ever posed a single question to NACE about it. In addition, neither OI nor the Staff informed NACE when NACE's allegations were referred to SFC, as required by the NRC Manual, § 0517-0510; nor did they inquire whether NACE wished to reply to SFC President John Ellis' December 3, 1993, letter to Mr. Hayes and the NRC IG and EPA IG, in which he responded to the allegations of the Silent Sirens Report. Instead, two weeks after receiving Mr.

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6 The only contact we have had from OI was a telephone call to me from Ben Hayes in early November 1993, in which Mr. Hayes told me that OI's inquiry had been delayed by the fact that he had inadvertently failed to send the entire Silent Sirens report to the regional office.

Ellis' letter, the Staff sent a memorandum to OI which concluded that all but two of the issues raised by NACE had been "satisfactorily closed out" during the NRC's original enforcement action. Memorandum from Dwight D. Chamberlain, Acting Director of the Division of Radiation Safety and Safeguards, to Len Williamson, OI (December 17, 1993), as characterized in a letter from Ivan Selin to Hon. Mike Synar (January 31, 1994). NACE submitted a letter to Mr. Hayes, the NRC IG, and the EPA IG on December 21, 1993, rebutting Mr. Ellis' claims.[7] However, we can find no evidence that the information in our December 21 letter was ever considered.[8]

IV. Scope and Subject of NRC Inquiry Inadequate

According to Mr. Wise's letter, the AIT conducted an "initial review" to determine whether NACE had "provided any new technical information" related to the accident. Wise letter at 1. Mr. Wise does not state whether or why the presentation of new information was a dispositive consideration in determining whether or not to pursue an investigation.[9] It should not have been. Although the Silent Sirens report presented some new information that may not have been known to the AIT, most of the information presented by NACE was already available to the NRC. The problem was that the NRC had not pursued the information, either by failing to address its legal significance, or by failing to inquire further into obvious deficiencies in SFC's emergency response. Thus, to frame the inquiry in terms of whether NACE had raised "new technical information" virtually guaranteed that the NRC would take no independent or fresh look at the facts that it had previously ignored.

Likewise, in numerous instances throughout the December 17th Analysis, the NRC refuses to pursue an issue raised by NACE on the ground that it was not within the scope of the AIT's original

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7 A copy of that letter is enclosed. NACE notes that it responded to Mr. Ellis expeditiously, within three weeks of his letter. This was a reasonable time frame, given that it took Mr. Ellis over two months to respond to the Silent Sirens Report, and his letter raised many factual issues.

8 Neither Mr. Ellis' letter nor our December 21 letter are mentioned in the Wise letter.

9 It should also be noted that nowhere does Mr. Wise explain the result of this evaluation, or how it affected the decision not to pursue an investigation.

inquiry. Thus, the NRC Staff's inquiry appears to have been governed by the unstated and unsupportable general rule that NACE's concerns would not be addressed if they went beyond the scope of the AIT's original investigation. This is an absurd result, given that NACE brought its concerns to OI precisely because the scope and depth of the AIT's original investigation was seriously inadequate.

Mr. Wise's letter indicates that his review involved some further inquiries were made beyond the scope of the AIT's original inspection.[10] However, these inquiries were not consistent. For instance, with respect to the issue of whether SFC notified the Sequoyah County dispatcher of the accident, the Analysis states that because it did not interview the dispatcher during the inspection, it was "unable to confirm" that they copy of the dispatcher's log attached to the Silent Sirens Report showed that no contact by SFC was made on the morning of November 17, 1992. Analysis at 6. Thus, the NRC was unwilling to conduct any further inquiries other than what the AIT had made during the inspection shortly following the accident.

Although Mr. Wise's inquiries regarding notification of the dispatcher went somewhat beyond the inquiries described in the Analysis, he also failed to contact the dispatcher in person, raising the question of whether he was also limiting his inquiries to the scope of the AIT's previous inquiries. If so, then the Staff has ignored the fundamental reason for the preparation of the Silent Sirens report, which was to seek resolution of the many issues that the AIT had failed to address because the scope and depth of its inspection were so inadequate.

V. NRC Staff's Response to NACE's Specific Concerns Inadequate

In the Wise letter, in Mr. Chamberlain's memorandum, and in Inspection Report 93-13 (February 2, 1994), the NRC claims to set forth the basis for its conclusion that the concerns raised by NACE were adequately closed out in 1993, and that therefore there is no need to revisit the matter. However, the NRC's purported justification for this conclusion, as given for each of the twelve individual allegations identified in my November 4, 1993, letter to Mr. Hayes, is rife with inconsistencies, illogic, and misstatements.

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10 As stated above, Mr. Wise never makes clear the relationship between the inquiry documented in his letter, and the inquiry documented in the December 17th Analysis.

In addition, the NRC failed to analyze or even discuss whether OI's criteria for opening an investigation were satisfied. Clearly, SFC's conduct in this case had the "indications of wrongdoing such as careless disregard, deception, and other indications of willful violations" that demonstrate the need for an investigation by OI. See OI Investigative Procedures Manual, § 3.3.[11] Section 3.3.5 lists "several factors to consider in attempting to identify whether an alleged or suspected violation was willful." The list, which is "not meant to be all-inclusive due to the varying nature of the violations surfaced in OI investigations," includes:

> a. Prior knowledge of the requirements by responsible personnel; this may be established circumstantially by demonstrating an individual's expertise in the nuclear industry, their position, and level of responsibility within their organization;
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> b. Documentation showing prior knowledge of wrongdoing and failing to report;
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> c. Being placed on notice of noncompliance from some source and failing to take corrective action;
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> d. A record of some past similar experience indicating that the licensee, entity, or individual knew the act was wrongdoing, yet proceeded regardless;
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> e. Documentary or testimonial evidence mitigating the possibility that the violation resulted from accident, worker carelessness, ignorance, or confusion;

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11 Section 0517-0413 of the NRC Manual also defines "wrongdoing" as consisting of:

> either (a) intentional violations of regulatory requirements or (b) violations resulting from careless disregard of or reckless indifference to regulatory requirements, or both (a) and (b). A reasonable basis for belief of wrongdoing exists when, from the circumstances surrounding it, a violation of a regulatory requirement appears more likely to have been intentional or to have resulted from careless disregard or reckless indifference than from error or oversight.

f. Attempts at deception by a licensee or contractor, such as

-- selective reporting of relevant information to the NRC,

-- failure to record/document reports of noncompliance,

-- efforts to contain, divert, or stop information from reaching NRC,

-- efforts to segregate, isolate, transfer, fire, intimidate, or otherwise retaliate or discriminate against allegers surfacing or attempting to surface information of interest to the NRC, or for providing safety-related information to employers, and

-- manipulation of documentation to confuse or hinder investigation/inspection efforts by NRC;

g. Documentation or testimony directly demonstrating that license management knew an act was wrong and against NRC requirements, but proceeded regardless;

h. Evidence of acts committed in the name of expediency, with later claims that the commission was a result of confusion on the part of the licensee; and

i. Falsification of documents.

As discussed below, the entire record is replete with evidence that SFC engaged in a pattern of conduct in which it took the course of "expediency" rather than lawfulness and prudence in responding to the accident -- in failing to timely sound the sirens to warn the public of the impending toxic plume, in quietly sending two Vice Presidents to the Mayor's Office in Gore rather than initiating formal notification of a General Emergency through the Sequoyah County Sheriff's office, and in publicly insisting that the accident had no harmful effects when it knew full well that its own employees, as well as members of the public, had been injured. The NRC's failure to open an investigation of SFC's conduct under these circumstances cavalierly ignores OI procedures, guidelines and responsibilities, and thus the Staff's response to NACE's concerns is completely unacceptable.

The Staff's inadequate responses to the individual allegations are discussed below:

A. Offsite Notification In the Silent Sirens Report, NACE faulted SFC for failing to sound any offsite sirens during the accident, even though SFC officials knew that toxic nitrogen dioxide (NO2) gas was leaving the plant. In failing to sound the sirens, SFC not only violated the emergency classification scheme which is a part of its license, but it also knowingly violated its strong and unequivocal commitment to the U.S. Congress and the NRC, following the 1986 accident, that the sirens would be sounded during any emergency that could affect the offsite public.

Mr. Wise's letter says nothing about whether SFC's failure to sound the offsite sirens constituted willful misconduct warranting an investigation. Instead, he avoids this serious issue, vaguely stating that, as a result of NACE's and the NRC's reviews of the accident, "NRC plans to re-evaluate certain elements of its emergency plan requirements for fuel cycle licensees." Wise letter, Attachment at 1. The suggestion of some future generic evaluation of NRC emergency planning rules is a completely nonresponsive and unacceptable answer to NACE's grave and specific concerns regarding individual licensee misconduct.

While the December 17th "Analysis" addresses SFC's failure to sound the off-site sirens, that response is self-contradictory, unclear, and muddled, and ignores the relevant criteria and facts in its repeated efforts to excuse SFC's actions. According to the Analysis, classification of an accident is based on the following considerations:

> The event classification scheme outlined in SFC's Contingency Plan was developed with consideration of the status of (process) systems (<u>whether containment was available</u> or whether the release could be controlled or terminated), the potential for or actual levels of radiological or hazardous materials released to the facility, effluents, and the relative risk or potential consequences of exposure to the particular materials involved."

<u>Id</u>. at 2. In this case, it is clear that early in the accident, SFC knew that containment was not available, and that the substance released was potentially harmful.[12] Therefore, under the

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12 As discussed in the Silent Sirens Report at 10, SFC had ample indications that the NO2 fumes would represent a threat to public health and safety, and that therefore a General Emergency should be declared. The fumes that had escaped the digester into the Main Process Building were voluminous and concentrated enough to require the evacuation of the west side of the building; and SFC had no reason to presume that the Main Process Building would contain these fumes. In

rationale articulated by the NRC Staff, the situation indisputably met the criteria for declaring a General Emergency: i.e.,

> Events are in process or have occurred which involve an actual or imminent major release of hazardous materials. Release can be reasonably expected to represent a threat to the public health and safety for areas beyond the site boundary.

Contingency Plan, § 3.2.4. The Staff concedes as much: "it could [] be argued the release of NO2 could have reasonably been expected to have represented a threat to public health and safety for areas beyond the site boundary or, in other words, that the event may have satisfied the definition of a General Emergency." Analysis at 3. Indeed, as admitted by Mr. Chamberlain, the accident did in fact cause offsite injuries. Analysis at 13.

However, ignoring these facts, the Staff goes on to excuse SFC's conduct, stating that "Nonetheless, when the licensee escalated the event classification, the release was essentially controlled (although not contained) due to the nature of the event," i.e., it was "self-terminating." Analysis at 3. In one breath the Staff asserts that the licensee's ability to contain a potentially dangerous plume is a factor in classifying an accident, and in the next breath it appears to take the contrary position that even if a release is not contained, it does not qualify as a General Emergency if it is terminated quickly. This position is not only illogical, but it contradicts the direct experience of the 1986 accident, in which a very short-lived release of UF6 gas caused significant offsite health damage.

The Staff also asserts that SFC determined that the accident did not "rise to a General Emergency" because the plume was "dissipating quickly." Id. Notably, the Staff does not state whether it agrees with SFC's characterization of the plume's behavior, but merely recites it as if it is a given. In actuality, SFC had no cause to believe that the plume was dissipating quickly. SFC officials had observed that the plume was

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fact, as early as 9:00 a.m., SFC's environmental manager realized that the plume was "travelling off-site," and between 9:00 and 9:10 three individuals -- an environmental engineer and two Vice Presidents -- left the plant "to determine the plume characteristics and the threat to the general public." Inspection Report 92-30, Appendix at 9-13 (December 18, 1992).

intact when it left the site, and [illegible] followed it for some distance, attempting to measure it. Indeed, the plume did not dissipate quickly, and injured tree farm workers and several people who were in the Gore elementary school yard in its path.[13] Indeed, the Analysis itself also faults SFC for failing to "recognize the potential for offsite travel of the plume in a more timely manner." Analysis at 8. It is unacceptable for the Staff to merely parrot SFC's assertions, without any evaluation or even acknowledgment of the facts which clearly contradict SFC's position.

The Staff also wrongly discounts the prior commitments made by SFC to sound the offsite sirens for emergencies affecting the offsite public. Analysis at 2. The Staff dismisses SFC's promises as "general" statements not intended to be "verbatim commitments." Id. According to the Staff, the fact that these commitments were made to the Commissioners themselves carries no weight because SFC knew that the commitments would later be reviewed by the NRC Staff. Id.

With such excuses, the Staff ignores the fact that SFC was brought before the Commission precisely because during the 1986 accident SFC had ignored its responsibilities under its Contingency Plan and failed to warn the offsite public. The extraction of these commitments was intended to ensure that if SFC were allowed to resume operation, SFC would live up to the commitments in its Contingency Plan to warn the public in the event of an accident with potentially significant offsite effects. It is also notable that the Staff fails entirely to acknowledge that SFC's commitments were not only made to the Commissioners, but to the United States Congress, and to the members of the community surrounding the facility. To suggest that SFC's commitments -- made before Congress, the Commissioners, and the public -- were without meaning or enforceable content is to negate the entire process by which the NRC and Congress sought to address the gravity of the 1986 accident and ensure that SFC would not endanger the public in such a reckless way again.

The NRC also attempts to excuse SFC from its 1986 commitments to sound the sirens in an emergency affecting the offsite public, by

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13 Neither Mr. Wise's letter nor the Analysis even mention, let alone respond to, the evidence provided by NACE that three people in the Webbers Falls school yard were injured by the plume, including a child. See letters from Diane Curran to David C. Williams, John C. Martin, and Ben B. Hayes, (October 4, 1993, and December 21, 1993). This is an extremely serious matter that should have been addressed.

stating that those commitments were made by Kerr-McGee, the then-owner of Sequoyah Fuels Corporation. However, the commitments were made by the president of Sequoyah Fuels Corporation, not by Kerr-McGee. These commitments cannot be allowed to evaporate merely as a result of SFC's purchase by another corporation. If indeed SFC under General Atomics' ownership can be excused from commitments made by SFC under Kerr-McGee's ownership, then the NRC defrauded the public when it allowed the plant to continue operating under the same name.

B. Control Room Evacuation. NACE also asked OI to investigate the apparent evacuation of the control room during the accident. Although NRC inspection reports state that the control room was occupied during the accident, NACE obtained documents through the Freedom of Information Act which indicate that in fact the control room was evacuated. Silent Sirens report at 12-13. In making its investigation request, NACE noted that if indeed the control room was evacuated, this has great safety significance, because it automatically would have required the classification of the accident as a General Emergency, for which the offsite sirens must be sounded. Instead, SFC classified the accident as a Site Area Emergency, for which sounding of the sirens is not required. As a result, members of the offsite public were exposed to toxic nitrogen dioxide gas without any warning from SFC. Thus, NACE questioned whether SFC had lied to the NRC about the evacuation of the control room in order to gain NRC approval of SFC's classification of the accident as a Site Area Emergency.

Mr. Wise's letter does not dispute the fact that the Contingency Plan requires declaration of a General Emergency when the control room is evacuated. He also concedes that the control room was evacuated. Wise letter, Attachment at 2. However, Mr. Wise attempts to excuse SFC for having failed to declare a General Emergency and sound the offsite sirens, on the ground that the evacuation of the control room was not complete, i.e., only "non-essential" control room personnel were evacuated. Id. However, the Contingency Plan does not state that declaration of a General Emergency is required only for "complete evacuation" of the control room. If the control room is evacuated, a General Emergency must be declared.

In the Analysis, the Staff attempts to minimize the significance of the evacuation, claiming that the evacuation of the nonessential personnel was "deemed prudent" because "NO2 had entered the control room as a result of ventilation problems." However, it is clear that evacuation was not just "prudent," it was necessary, because the control room was uninhabitable without special

breathing equipment. See Silent Sirens Report at 12-13, and note 16. In fact, several control room operators were injured and required medical treatment as a result of NO2 exposure. Inspection Report 92-30, Appendix at 16. Thus, since the control room was evacuated, it triggered the requirement to declare a General Emergency and sound the offsite sirens. Whether it intentionally ignored the requirement to declare a General Emergency under these circumstances, or whether it acted with reckless disregard of the requirements of the Contingency Plan, SFC showed willful misconduct that should have been investigated by OI.

Moreover, the Staff's Analysis is not at all adequate to resolve the question of whether the control room was completely evacuated, at least for some time during the accident, as indicated by two documents obtained by NACE through the Freedom of Information Act. Silent Sirens Report at 12, Attachments 16 and 13. These documents were: (a) an apparently contemporaneous account of contacts between SFC and NRC during the accident, which explicitly states that an SFC employee reported to the NRC at 9:20 a.m. that "the control room and both the UF6 and DUF4 facilities had been evacuated;" and (b) a Draft Event Description, apparently an NRC document, indicating that the Onsite Emergency Response Organization was relocated from the control room to the lunch room during the accident (at 9:10 a.m., "L. Silverstein brought radios down from Control Room to Onsite Emergency Response Organization in the lunch room," and at 9:20, "Larry Silverstein brought additional radio's (sic) down from the Control Room.") Attachments 16 and 13 to the Silent Sirens Report, respectively.

Mr. Wise attempts to discount the contemporaneous account documented in the memorandum described in (a) above as an initial communication which was superseded by later interviews stating that there was only a partial evacuation. Wise letter, Attachment at 2. However, Mr. Wise, as well as the Staff's Analysis, utterly fail to address or account for the statement in the Draft Event Description that the Onsite Emergency Response organization was in the lunch room, although the Contingency Plan requires it to be in the control room.

Moreover, both Mr. Wise's letter and the Analysis completely ignore the fact that at least for some period of time, there was not enough breathing equipment in the control room for all four emergency response personnel who had to be there. During the accident, "only two SCBA units were located in the control room for the four individuals needed there during the event." Silent Sirens Report at 16, note 16, quoting Inspection Report 92-30, Appendix at 15. The nearby motor control center #3, where other

SCBA's were located, was "engulfed in the plume and could not be reached." Id. Thus, the operators had to retrieve the needed equipment from the DUF4 building and from the north guard house, resulting in "a delay in providing needed safety equipment to the control room staff." Id. The NRC provides no explanation as to how the operators were able to stay in the control room without breathing equipment while they waited for the SCBAs to be retrieved, or whether it was necessary for them to evacuate for some period of time.

Taken together, the contemporaneous account of the control room evacuation which was provided to Ms. Kasner by SFC over the telephone and recorded in her memorandum, the Draft Event Description's statement that the Onsite Emergency Response Center was in the lunch room, and the fact that there was not adequate breathing equipment in the control room, provided significant evidence warranting an independent investigation into whether the control room was evacuated by the operators during the accident.[14] Yet, rather than investigating the significance of this information, the Staff simply reiterated the contents of the inadequate inquiry that the AIT conducted just after the accident. OI should have opened an independent inquiry into whether the control room was evacuated.

C. Notification of Sequoyah County Sheriff's Office. As discussed in the Silent Sirens Report at page 16, SFC's Contingency Plan requires that SFC notify the Sequoyah County police dispatcher of an emergency. On receiving this notification, the dispatcher must contact other local offsite agencies. Thus, SFC's initial notification of the county dispatcher is the first key step in alerting offsite agencies to stand by and be prepared

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[14] Indeed, as noted in my letter to Mr. Hayes of December 21, 1993, SFC admitted in Mr. Ellis' December 3, 1993, response to the Silent Sirens Report, that the Onsite Emergency Response Organization was in the lunch room at some point, at least for purposes of assembling. However, Mr. Ellis did not 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, or at least picked up, was not habitable? SFC does not explain.

to take emergency action should it be required. In evaluating SFC's response to the November 17th accident, the NRC completely failed to discuss whether SFC complied with its offsite notification procedures; moreover, discrepancies in various documents raise the concern that SFC did not follow the procedures. For instance, the county dispatcher's log contains no record of any contacts with SFC on the morning of the accident -- even though the dispatcher's log was the only place that an incoming call to the dispatcher should have been recorded. See letter from Diane Curran to Ben B. Hayes (December 21, 1993). Handwritten notes on two documents provide conflicting information about possible notification: those on SFC's Contingency Plan Implementing Procedures "(CPIPs") indicate that the Sheriff's office was notified at 9:30; but notes on the Sequoyah County emergency plan indicate that notification was made at 9:20.

The NRC's response to NACE's concerns is completely inadequate to resolve them. First, the NRC fails entirely to address the question of whether SFC followed its Contingency Plan procedures, which required it to notify the Sequoyah County dispatcher of the accident. According to Mr. Wise's letter, during the AIT's 1992 review, a county health official told the AIT that "SFC had provided notification of the event to the sheriff's office." Wise letter, Attachment at 3. In addition, after receiving the Silent Sirens Report, the NRC contacted the individual who served as the Sheriff during the accident, who "confirmed that his office was notified." Id. However, SFC's Contingency Plan specifically required notification of the Sequoyah county dispatcher, so that he can promptly notify other offsite agencies.[15] During a Site Area Emergency, the Off-Site Emergency Management Plan requires the dispatcher to notify the county sheriff, the county health and civil defense agencies, and the state highway patrol. Off-

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[15] The precise language of the Contingency Plan is:

> Declaration of a Site Area Emergency is followed by execution of the Emergency Call List - Site Area Emergency and full activation of both the Onsite Contingency Response Organization and the Offsite Response Organization. The U.S. Nuclear Regulatory Commission, the Hazardous Materials Emergency Response Commission of Oklahoma, and the Sequoyah County Sheriff's Office dispatcher will be notified. The dispatcher in turn notifies other local offsite agencies.

Contingency Plan, § 5.1.3 (emphasis added).

Site Emergency Management Plan, SFC Conversion Facility, Gore, Oklahoma, Rev. # 1, Appendix B (June 1, 1989), Attachment 22 to Silent Sirens Report. The dispatcher must also "stand by," prepared to notify the full list of local governments if a General Emergency should be declared. If, as it appears, SFC notified only the sheriff's office, rather than following the plan's requirement to notify the dispatcher, SFC side-stepped this important notification procedure, upon which activation of the full communications network depended.

Despite the obvious importance of this issue, it does not appear from Mr. Wise's letter that the Staff made any attempt to contact Rick Crutchfield, the county dispatcher, to inquire whether he was contacted by SFC during the accident, and why there is no record of a contact by SFC in his dispatcher's log. According to the December 17, 1992, Analysis, the AIT reviewed the copy of the dispatcher's log which was attached to the Silent Sirens Report, but concluded that "since the copy quality is poor[16], and since the AIT did not interview the Sheriff's Office dispatcher during the inspection, the AIT is unable to confirm that the document attached to the report represents a full record of calls received by the Sheriff's Office on November 17, 1992." Analysis at 6. However, there is no reason why the Staff could not review the original of the dispatcher's log at the County Sheriff's office, or interview Mr. Crutchfield regarding whether he was contacted on the morning of the accident. Thus, the question remains, did SFC avoid contacting the dispatcher during the accident and if so, why?

Moreover, Mr. Wise does not explain the discrepancy between the two documents which purport to show the time that the Sheriff's office received notification of the accident. According to Mr. Wise, the AIT reviewed the notations on the SFC CPIPs shortly after the accident, and "control room operators present during telephone notifications made from the control room independently verified the calls documented in SFC's records with the inspector." Wise letter, Attachment at 3. However, Mr. Wise's letter gives no indication that the AIT spoke with the actual SFC official who made the notification call or who made the notation in the CPIPs. Nor does Mr. Wise explain the discrepancy between the notations in the CPIPs, which indicate that the notification was made at 9:30 a.m., and the notations in the Off-Site Emergency Management Plan, which indicate that the dispatcher

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16 NACE obtained a certified copy of the dispatcher's log from the county sheriff's office, and attached copies of the certified copy to the Silent Sirens report.

received notification of the accident at 9:20 a.m. Therefore, the questions raised by NACE remain: Were the notes on the Sheriff's Plan made by SFC after the plan was removed by SFC from the Sheriff's office? If so, why? Did SFC make these notes in order to create the false appearance that the dispatcher was notified?

Mr. Wise's letter also fails to address the gross untimeliness of SFC's notification of the County. As discussed in my letter to Mr. Hayes of December 21, 1993, if SFC notified the County at 9:30, as indicated by the CPIP, and as the NRC claims to have "verified" through conversations with plant operators, the notification 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 -- so late as to be utterly ineffective to warn the offsite agencies of the potential danger posed by the accident. Even if the notification took place at 9:20, as indicated by notes on the the Off-Site Emergency Management Plan, it would have been too late for the offsite governments to take effective responsive action. The purpose of offsite notification of a Site Area Emergency is to warn offsite agencies so that they may prepare themselves if the accident worsens to a General Emergency -- not to provide post hoc information after the accident has passed. In this case, SFC should have declared a General Emergency and provided prompt notification to the dispatcher, who would have been required to notify all of the local governments in the area of the need to take protective actions. Even assuming for purposes of argument that SFC was correct in declaring only a Site Area Emergency, however, SFC was grossly negligent in waiting a half hour after the potential danger became apparent before it called the County Sheriff's office. Whether SFC's delay was intentional or recklessly negligent, it constituted the type of wrongful conduct which OI is required to investigate under its procedures.

D. SFC Non-response to Telephone Calls During Accident. In the Silent Sirens Report and my November 4 letter to Mr. Hayes, NACE raised the question of whether SFC stopped answering the telephone during the accident. See Silent Sirens report at page 17. This refusal to take calls would be particularly egregious, since SFC made no affirmative effort to communicate with the offsite public, other than to send the two vice presidents to the Gore mayor's office.

In response, Mr. Wise confirms that the Gore police department "had tried unsuccessfully to contact the Sequoyah facility by telephone shortly after the release." Wise letter, Attachment at 3. However, the Staff did not pursue this concern because "shortly after these initial attempts", the Senior Vice President

for SFC visited the Mayor of Gore's office "to explain what had occurred," and this information "was subsequently communicated to the police department to apprise them of the event." Wise letter, Attachment at 3. Mr. Wise does not discuss when the Mayor's office gave the information to the Gore police department, or whether the communication was timely. Mr. Wise does not acknowledge that the Gore police department had good reason to seek timely information regarding what was going on during the accident, because it would have been responsible for closing off access to highway 64 if the accident had been declared a General Emergency. Nor does he discuss the fact that if the county dispatcher had been notified, as required by the Contingency Plan and Off-Site Emergency Plan, the Gore police department could have learned the status of the accident from the dispatcher, and thus could have prepared to take emergency action if necessary.

E. Broken Communications and Notification Equipment. The Silent Sirens Report charged that SFC's communication and notification equipment was in such a state of disrepair during the accident as to show reckless disregard for the safety of SFC employees and the public. Silent Sirens Report at 21-22, letter from Diane Curran to Ben B. Hayes at 2 (November 4, 1993). The Staff's response to NACE's concern is completely inadequate.

1. Defective Communication Equipment The AIT attributed the onsite emergency director's unawareness that the plume was leaving the site to "problems encountered with radio communications." Inspection Report 92-30, Appendix at 8. Thus, rather than communicating the status of the plume by radio, the safety engineer who was outside the plant observing the plume had to come back into the control room to inform the onsite emergency director about the plume's movement. Id. Mr. Wise states that although this item required "correction" prior to restart, the NRC "did not identify any enforceable issues with regard to operability of communications equipment." Wise letter, Attachment at 3. However, although lacking in detail, Mr. Wise's letter provides even more factual information than the AIT which indicates that communication equipment at the SFC plant was in short supply and woeful condition, in violation of SFC's license.

SFC's Contingency Plan at § 6.3.1 provides for storage of an "ample" supply of portable radios in the control room. Mr. Wise never mentions this requirement or states whether the supply of radios in the control room was in fact ample. Instead, he states that the radios normally stored in the control room were "extra radios," thus implying that the control room supply was a limited surplus provided as an afterthought, rather than a significant quantity that was pre-determined to be "ample" for an emergency response. Wise letter, Attachment at 3.

Moreover, although the AIT report referred to only one inoperable radio, Mr. Wise's letter makes it clear that several radios had dead batteries, thus making it necessary for various individuals to share or borrow radios.[17] Id. The December 17 Analysis also states that "several" of the emergency radios were charged during the most recent audit of emergency equipment, thereby implying that not all of the emergency radios were charged. Analysis at 8. However, it gives not explanation as to why the other radios apparently were uncharged.

If, as it appears, SFC kept a small ad hoc supply of emergency communications and failed to maintain them all in good operating condition, this would have been a violation of SFC's license. Yet, neither Mr. Wise's letter nor the Staff's December 17 Analysis addresses any of the obvious outstanding questions regarding SFC's compliance with this requirement during the November 17 accident.

Moreover, Mr. Wise does not question the outrageous position taken in the Staff's December 17 Analysis that the broken radios raised no enforceable violations because the emergency radios did not have to be operable, but only had to survive their monthly operability test. Analysis at 7-8. It is unconscionable for the Staff to argue that the requirement in a Contingency Plan for a supply of emergency communications radios does not also convey the proviso that they must work. The purpose of routine surveillance testing is to confirm the operability of equipment which is relied on during an accident, and is not a substitute for the fundamental requirement that nuclear facility safety equipment must be safe and reliable. If this requirement is not enforceable, as the NRC Staff seems to argue here, then there is little basis for any confidence in the safety of nuclear facilities anywhere.

Even assuming for purposes of argument that the surveillance testing requirement was the only enforceable aspect of SFC's Contingency Plan with respect to operability of emergency communications equipment, there are many disturbing questions about the surveillance testing of the radios that remain unaddressed and unresolved by the Analysis. For instance, (1) was an "ample supply" of radios kept in the control room and tested during monthly audits, or were there just a few? (2) Why did some bat-

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17 While he provides no accounting of the actual number, Mr. Wise states that "a limited number" of radios had dead batteries. Id. at 7.

teries need recharging during the monthly surveillance -- weren't the radios charged continuously while they were stored in the control room, as would reasonably be expected? (3) The Analysis states that "several batteries were charged in the event that use of radios was required during an emergency." Id. at 8. Were there some radio batteries that were dead, but were not charged? If so, why not? (4) A battery that was checked or recharged during a monthly audit should not have been dead only a few weeks later if the radio was not used. Were some of the radios used and run down during normal operations, without checking them afterwards to make sure the, had enough power to be operable during an emergency, as required by Contingency Plan § 6.3.3? The Analysis provides no answers to any of these questions, and thus is a completely unsatisfying response to the concerns raised in the Silent Sirens Report.

As noted in the Analysis, NACE also "charged that NRC failed to make any attempt to evaluate the effect of radio communication failures on the adequacy and timeliness of SFC's emergency response." Analysis at 8. The Staff admits that the NRC's inspection report "did not provide a lengthy discussion of the AIT's review of this issue, but claims that "the impact of emergency communications was reviewed in detail by the AIT." Id. However, no further information is given about this review, other than the conclusory statement that:

> radio communications were not determined to be the root cause of timeliness concerns regarding upgrading the event from the initial classification. Of greater concern was the fact that SFC personnel did not recognize the potential for offsite travel of the plume in a more timely manner.

Id. at 8 (emphasis added). If the delay in being notified of the potential for offsite travel of the plume was not the cause for SFC personnel recognizing the potential for offsite travel of the plume in a timely manner, then what was? The Analysis provides no information.

2. Broken notification equipment. The Silent Sirens report also noted that the AIT had failed to discuss the full safety significance of SFC's failure to activate its onsite air horn warning system during the accident. According to the Contingency Plan, activation of the onsite air horn would have resulted in the automatic shutdown of the facility's ventilation system, which might have better protected occupants of the control room and the women's change room. Silent Sirens Report at 22.

In response, the Analysis states that at some unspecified time in the 1980's, SFC changed the plant design so that activation of the air horn system would not automatically shut down the ventilation system. However, although SFC modified the CPIPs to reflect this change, it never altered the Contingency Plan. Thus, it appears that for anywhere from two to twelve years, the design of the facility was not accurately depicted in the Contingency Plan. Whether or not, as NRC argues, the Contingency Plan could have been changed without the permission of the NRC, it should have been a matter of serious concern that it was allowed to remain inaccurate and uncorrected for such a long period of time. Such an inconsistency could raise serious confusion during an emergency, and shows careless disregard for the importance of maintaining accurate plans and procedures, especially where they must be relied on under accident conditions. The NRC's casual and dismissive attitude toward this issue is unacceptable.

F. **Inadequate Training of Onsite Emergency Response Director.** In the Silent Sirens Report, NACE noted that John Ellis, who was vice president of SFC at the time of the accident, was the principal onsite emergency response director designated by the Contingency Plan. Yet, according to an NRC inspector, one of the senior vice presidents (who NACE presumed was Mr. Ellis) had not received emergency response training. Silent Sirens Report at 25.

Mr. Wise responds that NRC official Linda Kasner discussed this issue with NACE director Lance Hughes, and that she "believes that her statements were mischaracterized in the Silent Sirens Report." Wise letter, Attachment at 5. According to Mr. Wise, Ms. Kasner explained to Mr. Hughes that at the time of the accident, "Mr. Ellis had not yet completed all required tasks specified in SFC's emergency response training program and that as a result, he had not yet been authorized to serve as the emergency director." Wise letter, Attachment at 5. Parenthetically Mr. Wise states that "Mr. Ellis had completed site-specific emergency response training prior to the November 1992 event but had not yet participated in a final training drill, a requirement for 'certification' in SFC's emergency response program." Id. Mr. Wise never states why Mr. Ellis was appointed to his post before this requirement was fulfilled, or whether that constituted a violation of SFC's license.

Mr. Hughes specifically recalls that at the March 2 enforcement conference, Ms. Kasner never mentioned Mr. Ellis by name or described the extent to which he was untrained, but merely stated that one of the SFC vice-presidents had not completed his emer-

gency response training.[18] Therefore, a conversation regarding Mr. Ellis and his specific qualifications never took place. NACE deduced that the individual referred to by Ms. Kasner must be Mr. Ellis, since the other vice president had been at SFC for a much longer time, and presumably should have been trained by then.

The NRC admits that although Mr. Ellis was listed in the Contingency Plan as the onsite emergency response director, he did not have the qualifications to carry out his responsibilities in that role. Yet, remarkably, neither Mr. Wise nor the Analysis says anything about why the Staff failed to cite SFC for this obvious and significant regulatory violation, let alone whether it showed willful wrongdoing on the part of SFC. Thus, once again, the Staff has regurgitated its earlier inadequate response to SFC's misconduct, without responding at all to the issues raised by NACE.

G. Failure to Seal Control Room. The NRC Staff also refused to investigate the fact that SFC knew before the November 1992 accident occurred that the control room was not sealed -- a violation of its license and prior commitments to Congress -- but it did nothing about it. See Silent Sirens Report at 14-15.

Mr. Wise does not explain why the NRC refused to investigate this issue. Instead, he makes a series of factual assertions which are apparently intended to support the Staff's determination that the problems which resulted in communication of process area and control room air at the Sequoyah facility were not recognized by the licensee or by NRC staff members prior to the November 1992 event." Wise letter, Attachment at 6. See also Analysis at 11.

However, Mr. Wise's factual assertions in support of this determination actually establish that an investigation of SFC by NRC is warranted under the applicable OI criteria. Mr. Wise acknowledges that following the June 1992 leak of fluorine gas into the control room, SFC "failed to conduct an investigation of sufficient depth to identify problems which allowed air from the process areas to communicate with the control room and other

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[18] Ms. Kasner also said that the fact that the vice president hadn't completed his training didn't mean that he wasn't qualified or couldn't carry out his duties under the Contingency Plan. Thus the Staff appeared to relax the emergency planning requirements for SFC on an ad hoc basis, ignoring SFC's violation of the written requirement.

occupied areas of the plant." Wise letter, Attachment at 6.[19] In addition, according to Mr. Wise, SFC did not provide the NRC with its investigation of the June 1992 leak until after the November 1992 accident, apparently because there was an internal dispute at SFC regarding the adequacy of the investigation and the proposed corrective actions. Id.

Admittedly, then, SFC had prior knowledge that the control room was not adequately sealed, in violation of its Contingency Plan and its commitments to Congress, but failed to take adequate corrective action; and for five months SFC failed to report the results of its investigation to the NRC.

The NRC Staff's conclusion, apparently endorsed by Mr. Wise, that both the licensee and the Staff lacked sufficient knowledge prior to the November 1992 accident to have taken preventive action to seal the control room, and therefore were not at fault, ignores the underlying problem: the apparent reason that SFC had no knowledge of the control room ventilation problem was that it had done an inadequate investigation of the June 1992 accident.[20] An investigation is required precisely because SFC willfully ignored clear indications, in June of 1992, that it was not in compliance with its Contingency Plan or its 1986 commitments to Congress to seal the control room.[21]

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19 The problems were "not discovered" until SFC conducted a "more thorough" investigation following the November 1992 accident. Id.

20 Mr. Wise also fails to address the significant fact that the Staff had found it a matter of "particular concern," following the June 1992 accident, that SFC had previously experienced other gaseous leaks to the control room. See Silent Sirens Report at 15, quoting EA-93-010.

21 In the Analysis, the Staff attempts to diminish the significance of SFC's 1986 commitment to seal the control room by arguing that it involved only the placement of windows, and that SFC's commitments or statements in the license were not necessarily intended to ensure that the control room was hermetically sealed." Analysis at 10. Nothing in the 1986 SER or SFC's Contingency Plan supports this crabbed and unworthy excuse for SFC's misconduct. These documents straightforwardly require SFC to "seal" the control room to protect it from the process area fumes.

H. Questions Regarding Use of Incorrect Off-Site Emergency Management Plan. NACE also asked OI to investigate actions by SFC in March of 1993 which raised questions about whether SFC had kept offsite officials up to date with current revisions of the Off-Site Emergency Management Plan, and, if not, whether SFC later tried to suppress evidence that the offsite officials did not have the correct revision to the plan when the accident happened. See Silent Sirens report at 8. Mr. Wise's response is inadequate to resolve the questions raised by NACE.[22]

In the Silent Sirens Report, NACE reported on its efforts to determine whether the Sequoyah County Sheriff's Office, which has a central role in offsite emergency communications under the Contingency Plan, was using a current version of the Off-Site Emergency Management Plan during the November 1992 accident. Silent Sirens Report at 8. NACE discovered that a short time after NACE had raised this concern with an NRC inspector, a SFC employee went to the Sequoyah County Sheriff's office, removed the Sheriff's copy of the Offsite Emergency Management Plan, and replaced it with a new one. Id.

Mr. Wise confirms the account given by NACE, but attempts to minimize it, stating that it was SFC policy to update the Offsite Emergency Management Plan by delivering revisions personally to the local government offices. However, Mr. Wise does not address such obvious questions as: Was the version of the Offsite Emergency Management Plan that was used by the Sheriff's office during the 1992 accident current? Why was SFC revising the Offsite Emergency Management Plan six months after the plant had ceased operation? Was the substitution timely, i.e., what was the date of the revision that SFC delivered in March of 1993? Thus, his letter completely fails to resolve NACE's concerns.

Mr. Wise also attempts to excuse SFC on the basis that SFC is not legally required to provide offsite emergency plans to the local governments around the plant. Wise letter, Attachment at 8. However, as he acknowledges, the Sequoyah County Local Emergency Planning Committee had adopted SFC's Off-Site Emergency Management Plan, and SFC made a regular practice of updating the plan for the county and for local agencies. Id. at 7-8. Thus, SFC had already established and committed itself to a procedure under which the county and local governments clearly had reason to expect and depend on regular updates of the plan from SFC. If

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22 The December 17th Analysis did not discuss this issue at all on the ground that it was outside the scope of the AIT's original investigation.

SFC failed to meet this commitment, and the safety of the public was thereby jeopardized, then SFC should have been held accountable to its commitment.

I. **False Statements to the Public.** As discussed in the Silent Sirens Report at 17-18, SFC repeatedly and knowingly made false public statements that there were no injuries as a result of the accident. These false statements could have influenced individuals who were exposed to the fumes not to seek necessary medical treatment. While essentially conceding that SFC's statements were inaccurate, Mr. Wise and the Staff once again go to great lengths to excuse SFC's misconduct. First, Mr. Wise vaguely states that "some of the statements highlighted in the Silent Sirens report and in NRC inspection reports may have been due to the timing of interviews following the event and the facts known by certain SFC employees at the time." Wise letter, Attachment at 9. However, as stated in the Silent Sirens Report, and as undisputed by Mr. Wise and the NRC, the "timing" was such that the SFC nurse had already examined a number of injured workers before SFC held its press conferences and provided false information to the public. Mr. Wise also seems to be arguing that before declaring to the affected community that there were "no injuries" caused by the accident, SFC, as the licensee, had no responsibility to consult with its own medical personnel who had treated injured employees and met with injured tree farm workers shortly after the accident. Such reasoning merely sanctions SFC's willful disregard for its responsibility to inform itself before giving out false information to the public, and makes a mockery of the fundamental regulatory principel that a licensee is responsible for knowing and accurately representing what is going on at its own facility.

Mr. Wise also excuses SFC's false statements on the basis of "disagreements in terminology (for example, SFC officials disagreed with NRC's characterization of the symptoms and effects experienced by members of the public and SFC workers)."[23] It is appalling to learn that the NRC thinks it is debatable whether breathing difficulty, nausea and vomiting, blistering of mouths, bleeding auditory canals, and severe headaches constitute "injuries," so that SFC could justifiably deny that any had occurred. Such an outlandish excuse raises serious questions about the NRC's understanding of and commitment to protection of public health and safety.

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23 This wording in Mr. Wise's letter implies that other "disagreements in terminology" exist, but Mr. Wise does not state what they are. If other disagreements exist in Mr. Wise's view, they must be explained.

Finally, the December 17th Analysis appears to excuse the NRC's failure to take action against SFC for its false statements on the ground that the NRC lacks authority to penalize a licensee for lying to the public and misleading them into believing that they should be unconcerned about any exposure they may have sustained during the accident. Analysis at 13 ("there were no enforceable issues identified regarding the licensee's characterization of the event to the press.") Such a narrow view of NRC enforcement powers is totally inconsistent with the fundamental regulatory concept, inherent in the Atomic Energy Act and the NRC's regulations, that licensees must truthfully represent the hazards posed by their facilities in order to ensure that public health and safety will be protected. The Staff's dereliction of its clear enforcement authority should either be corrected immediately or referred to the highest level of the Commission.

J. **Hospital Refused to Treat Injured Individual Based on False Information Supplied by SFC.** The Silent Sirens Report also charged that SFC instructed a local hospital not to treat Rick Williams, a tree farm worker who came to the emergency room complaining of burning eyes and itching skin after he had been exposed, even though SFC has a written agreement with this hospital to treat offsite injured individuals. Not only was SFC's instruction to the hospital wrong, but it appears to reflect undue influence on the conduct of a public health facility. Again, the NRC shunts the seriousness of this issue and cavalierly disregards the facts in an effort to exonerate SFC.

Mr. Wise confirms that the emergency room staff sent Mr. Williams home without treatment, but states that the NRC Staff could not confirm that SFC personnel influenced the hospital's action. Wise letter, Attachment at 10. According to Mr. Wise, the nurses present during Mr. Williams' visit to the hospital "were unavailable for interview." Id. Mr. Wise does not say why these nurses were unavailable, but unless they were dead or out of the country, we find it hard to believe that the NRC Staff was unable to contact them for the six months that NACE's request for an investigation has been pending.

Mr. Wise also states that, based on interviews with SFC staff, "it appeared that the nurses had only contacted SFC's public relations staff person rather than the company nurse." Id. However, Mr. Wise fails to recognize the inappropriateness of SFC public relations staff giving medical directions or advice to emergency room nurses, failing to connect the company nurse with the hospital staff, and directing, without adequate information, that care be denied.

Finally, Mr. Wise states that if an emergency room physician had been on duty when Mr. Williams came in, the physician "may" have sent Mr. Williams home anyway. Id. However, it is just as likely that the physican "may" have treated Mr. Williams, instead of sending him home.[24] At least Mr. Williams would have been evaluated by a physican and advised about the seriousness of his injuries, rather than being evaluated unseen by an SFC public affairs officer without medical training.

K. Apparent Lack of Training for Offsite Emergency Response Personnel. The Silent Sirens Report asserts that SFC has not fulfilled its commitment to Congress or the terms of its license with respect to training of offsite emergency response officials. The Report also asks the NRC to take action against SFC for submitting to the NRC, as part of its 1990 license renewal application, a letter of agreement which falsely indicates that SFC has conducted annual training at the Sparks Regional Medical Center, when in fact no training has been given since 1986, according to Sparks administrator Peter K. Leer and the head emergency room nurse. Silent Sirens Report at 27.

According to Mr. Wise, although the AIT did not review training provided by SFC to local medical personnel, the NRC subsequently "reviewed this issue with SFC personnel and with local hospital representatives," and concluded that the frequency of training was adequate, that "SFC emergency response training had been conducted as required and that training included a selected group of hospital personnel who might be expected to treat individuals in the hospital emergency rooms." Wise letter, Attachment at 10-11 (citing Inspection Report 93-13 (February 2, 1994).

There are a number of problems with this conclusion. First, the inspection of SFC's documentation of offsite hospital training does not consider whether SFC had conducted annual training between 1986 and 1991, as it had committed to Congress and the Commission. Second, the inspection report failed to consider the adequacy of the trainings that allegedly were conducted in 1992 and 1993, since "The content of the physician's reports varied in the level of detail used to describe the training." Inspection Report 93-13, Appendix at 11. Third, there is no indication that the NRC contacted Mr. Leer or the head emergency room nurse, even though it would be highly unlikely that real training could occur without her knowledge. Fourth, the type of "training" that

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[24] Mr. Williams was later treated by a physician, when his symptoms did not clear up after two days.

certain physicians claimed to have received appears, at best, to have been limited, informal, and ad hoc.[25] Thus, once again, the Staff has failed entirely to resolve NACE's concerns.

L. Poor Monitoring of Airborne Contaminants. As discussed in the Silent Sirens report at 19-21, the NRC's inspection report raises questions about the manner in which SFC attempted to monitor the concentration of the NO2 plume after it left the site. This causes concern as to whether SFC purposely avoided sampling the plume at its most concentrated locations.

For unexplained reasons, Mr. Wise's letter does not address this concern at all. Thus, it is completely unclear what the NRC's position is regarding this issue. Moreover, the December 17th Analysis is insufficient to answer the concerns raised in NACE's report.

First, with respect to offsite monitoring, the Analysis does not explain why the SFC technicians apparently did not measure the plume on the way to Gore, where it was visible to them and was concentrated enough to damage the health of tree farm workers. Silent Sirens Report at 20. Nor does the NRC attempt to explain why SFC sampled such disparate locations in Gore, especially the Gore High School, which is on the north side of town and not in the expected pathway of the plume. Id. Nor does the Staff discuss the effect of SFC's sloppy testing methods on the reliability of their results. Id.

With respect to onsite monitoring, the Analysis merely regurgitates the AIT's conclusory findings that SFC's measures were adequate, without responding to NACE's concerns. The Analysis ignores NACE's criticism that SFC failed to monitor the levels of uranium released from the stacks, a potentially important release pathway. Nor does the Staff state on what basis it concluded that SFC's fenceline monitors were "most likely" within the path of the plume. Analysis at 12.

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25 According to Mr. Wise, a physician from Sparks Regional Medical Center said that he sometimes met with SFC's physician "outside of the hospital, as a matter of convenience."

Conclusion

In conclusion, the Staff's response to the Silent Sirens Report and our request for an investigation of SFC's apparent misconduct constitutes an unacceptable rehash of the same incomplete and inconsistent analyses and poor excuses which prompted NACE to write the Silent Sirens Report in the first place. OI should not have abdicated its responsibility to conduct its own independent and disinterested inquiry into the concerns raised by NACE. Therefore, we insist on a new and independent inquiry by OI into this matter. Moreover, although we believe that the November 1992 accident does raise significant generic issues about the adequacy of the NRC's emergency planning regulations and oversight, in no way can a vague promise of further inquiry into unnamed generic issues substitute for a full accounting of SFC's liability for willful violations of NRC regulations, its license, and its prior commitments to take specific measures to protect the public health and safety from hazardous releases.

Sincerely,

Diane Curran
Counsel to NACE

cc: Ben B. Hayes, NRC OI
David C. Williams, NRC IG
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May 4, 1994

BY FEDERAL EXPRESS
Ben B. Hayes, Director
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U.S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, MD 20850

Dear Mr. Hayes:

I am enclosing a copy of Native Americans for a Clean Environment's ("NACE's") response to recent correspondence from the NRC Staff concerning NACE's Silent Sirens Report and NACE's request for an investigation into instances of apparent wrongdoing by Sequoyah Fuels Corporation ("SFC") in relation to the November 17, 1992, accident at its facility.[1] Although your office has never responded directly to NACE's request for an investigation, the correspondence from the NRC Staff apparently is intended to constitute the agency's official reply.

As discussed in detail in the attached letter to Hugh Thompson, the Staff's response does not remotely satisfy NACE's concerns. First, OI has entirely abdicated its responsibility to conduct an independent inquiry into the concerns raised by NACE, and instead simply referred our investigation request back to the same NRC Staff members who had failed to take appropriate action in the first place, and who clearly had a vested interest in defending their inadequate performance. Referral of the matter back to the NRC Staff was all the more inappropriate given the pendency of our separate request to the NRC Inspector General for an investi-

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1 NACE sent the Silent Sirens report to you under cover letter dated September 28, 1994. Followup correspondence was sent to you on October 4, November 4, and December 21, 1993. The NRC Staff's response is contained in a letter from Russell Wise to Diane Curran (March 24, 1994); and in a memorandum from Dwight D. Chamberlain to Len Williamson (December 17, 1993).

gation of the NRC Staff's actions in response to the accident. Second, rather than resolving NACE's concerns, the NRC Staff's response shunts them aside, making absurd and unacceptable excuses for SFC's misconduct. Moreover, to the extent that it substantiates NACE's factual allegations, and in some cases provides new information implicating SFC, the Staff's response confirms the need for an investigation -- yet the Staff refuses to acknowledge the clear implications of its findings. Thus, the Staff's response is completely inadequate.

SFC has not yet been brought to account for clear indications of wrongdoing, either through intentional misconduct or reckless disregard for regulatory requirements and public safety. Accordingly, NACE is renewing its request for an independent investigation by OI of SFC's apparent wrongdoing in relation to the November 17, 1992, accident.

Sincerely,

Diane Curran
Counsel to NACE

cc: Hugh L. Thompson, DEDF
David C. Williams, NRC IG
Hon. Mike Synar

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December 21, 1993

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John C. Martin, Inspector General
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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-

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

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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-

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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 other 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 repcrts, 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]

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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

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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