MRS S C GOULTY
FINANCE & SECRETARIAT (NUCLEAR)1

D/DGSM/CSSE/Sec(Nuc) 5/143

DPA

Defence Procurement Agency
DGSM/CSSE
Defence Procurement Agency,
Ministry of Defence
Rowan 1a, #164
MOD Abbey Wood
Bristol, BS34 8JH

Switchboard: 0117 91 3000

Mr R Evans
6 Birtwhistle House
150 Parnell Road
LONDON
E3 2JY

16 June 1999

Dear Mr Evans

REQUEST FOR DOCUMENTS - PQ 84348

The documents you requested in your letter of 30 May are enclosed. I have had to use two boxes, and have enclosed a copy of this letter in each box. This is Box One of Two.

If you wish to make a complaint that your request for information has not been properly dealt with, you should appeal to The Ministry of Defence, OMD 14, Rm 617, Northumberland House, Northumberland Avenue, London WC2N 5BP. You may at any time register a complaint with the Parliamentary Commissioner for Administration (the Ombudsman) through your Member of Parliament, but the Ombudsman will expect you to have exhausted the internal Ministry of Defence complaints procedure first.

Yours sincerely
Sarah Goulty

S C GOULTY

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Yours sincerely
Sarah Goulty

S C GOULTY

Protective Marking

AWE Bid Control Note
MOD Question/ AWE Answer

Tender Number:	Unique ID Ref: 1 MOD 1 Q 123	Date: 17-Mar-99

MOD Question:

Tech Spec 194

Can we request a copy of NII feedback after last site emergency exercise to assess their performance.

MOD Originator:	MOD Release Authority:

AWE Response Time Category:

Enter **A** (5 days), **B** (10 days), **C** (15 days) or **D** (specified days) B

The response time required for Category D, if selected, shall be: 0 working days

AWE Answer:

1. AWE(A) Level 1 Exercise - SITEX98
   Confirmation of HSE observations is contained in their letter ref ALD 70249R dated 27/5/98 attached.

2. AWE(B) Level 1 Exercise - SITEXB98
   Confirmation of HSE observations are contained in the attached letters ref BUR 77061R dated 9/10/98 and BUR 77066R dated 3/2/99.

AWE Source/ Document Reference(s):

AWE Owner Name:	Date:
AWE Peer Review Approval:	Date:
AWE Bid Support Office Authorisation for Release:	Date: 31/03/99

MOD Authorisation:		
The AWE Answer is Delivered	Signature:	
Reference (if applicable):	Print Name:	Date:

Protective Marking

Form BSO-BCN Issue 1

RICC FILE: HSE 175/43

HSE

Health & Safety Executive
Nuclear Safety Directorate
HM Nuclear Installations Inspectorate
Director and HM Chief Inspector, Laurence Williams

Hunting-BRAE Ltd
Regulatory Interface Control Centre (RICC)
A85 14/10/98
Atomic Weapons Establishment
Aldermaston
Reading
RG7 4PR

Direct Dial: 0151 951 4794

File Ref. No.: NUC700/52/11 P2 E4
Unique Number: BUR77061R

For the attention of Mr R Tinsley, Licensed Site Manager, Burghfield

9 October 1998

Dear Mr Tinsley,

NUCLEAR INSTALLATIONS ACT 1965
BURGHFIELD EMERGENCY EXERCISE - 22 SEPTEMBER 1998

In accordance with the normal requirements for licensed nuclear sites' HSE inspectors witnessed the rehearsal of the Burghfield site emergency arrangements on 22 September 1998 and provided you with feedback on the key points at the debriefing on the same day. The purpose of this letter is to provide formal confirmation of our observations and to highlight areas where we consider further improvements are required. The primary comments are contained in the body of the letter with other more detailed comments listed in the attached Appendix.

It was noted that several areas of good practice were observed during the exercise and it was clear that great effort has been made to successfully rectify previously identified deficiencies in the arrangements. However, the different nature of the accident scenario revealed significant deficiencies in the preparedness and response of facility staff, fire fighters and health physics support in dealing with this type of radioactive release. It is therefore considered that urgent action is required to review the arrangements for dealing with releases of this nature which should include consideration of training, provision and use of protective equipment, emergency instructions monitoring equipment and preparedness for dealing with potentially active waste and effluent. This demonstration also showed an unacceptable delay in providing adequate health physics support to deal with this event. The strong reliance on health physics staff deployed from Aldermaston to assist Burghfield staff is not regarded as satisfactory and it is strongly recommended that an alternative strategy is adopted.

In view of the significant deficiencies identified in the arrangements, we require the Company to carry out an exercise before the end of January 1999 to demonstrate that improvements have been made to rectify the observed weaknesses.

The HSE acknowledge the action taken by the Company to embargo work activities involving the use of this type radioactive material, excepting storage in transport containers, and would not wish operations involving this material to recommence until the above exercise has been successfully conducted to our satisfaction.

Head of Division 3, General Sites: Dr R P Pape, HM Deputy Chief Inspector
St Peter's House, Stanley Precinct, Bootle, Merseyside L20 3LZ
Tel: 0151 951 4000 Fax: 0151 951 3942

If you wish to discuss the above requirements or any of the specific matters identified in the attachments please contact me.

Would please provide a response to this letter by 12 November 1998 and arrange for a copy to be supplied to the relevant safety representatives.

Yours sincerely,

HM Principal Inspector
(Nuclear Installations)

Appendix to letter reference UN BUR77061 dated 9 October 1998

COMMENTS BY HSE OBSERVERS ON EXERCISE HELD AT BURGHFIELD ON 22 SEPTEMBER 1998

1. Scene of Incident and Transfer Barrier

a. The initial evacuation of the assembly area went smoothly.

b. The use of a smoke generator to simulate the fire revealed a significant deficiency in the ventilation system. Smoke extracted from the inner room was quickly picked up by the air intake system and distributed into the outer room area. This would appear to offer a similar route for contamination to be spread within the facility.

c. The operation of the rapid extract system seemed to be delayed several seconds following the initiation of the activation alarm, and then cut out a number of seconds later.

d. Fire fighters, health physics staff and re-entry team were inappropriately dressed for this type of event. Consideration should be given to fitting intercoms to BA equipment.

e. Emergency extract system failed on demand.

f. Change procedures and protective equipment at Transfer Barrier were inadequate for the hazard.

g. Re-entry team were inadequately equipped to make entry - no tools or torch were carried. There was an excessive delay in making a re-entry. Although the team were dressed at 1120, they did not make the entry until 1215.

h. The BA board appeared to be well managed though its location resulted in a significant BA air usage for the rescue teams in getting to and back from the incident. The contamination of clothing also required additional continued air usage during undressing.

i. Whilst portable activity in air monitoring was used its efficiency was uncertain in this scenario. Also there appeared to be no on-site capability for smear or sample analysis.

2. Forward Control Point

a. Appeared to function well and evidence of good briefings being given. Refurbishment of area together with provision of installed equipment for dealing with emergencies needs to be progressed.

3. Zone Control

a. The control point was set up quickly and the initial response in the area appeared to work well. However, personnel remained in the facilities within the Assembly Area as per their instructions. It is unclear why this thought appropriate as there are no welfare facilities available in this area. Furthermore, there is a canteen at the entrance to the Assembly Area, which would

appear to be suitable to accommodate all personnel within the area, and would enable them to be removed from the hazard.

b. The Zone Control appeared to function well with good evidence of team working within the Zone Control personnel. However, the permanently stationed personnel at the entrance to the Assembly Area (police & supervisor) were not part of this team. This resulted in the Zone Controller not knowing that the Rapid Extract system had only run for 16 seconds. Furthermore, little use of the installed video cameras was made to monitor the plant or personnel within the area.

c. There was a lot of distracting background noise in the area which was made worse by a radiotelephone being used by a team member with the volume turned up close to the zone control desk .

4. Burghfield Command Post (BCP)

a. There was a significant lack of appreciation early in the incident of the possible dose implications. This resulted from there not being an health physicist as part of the team until fairly late on into the incident. When an RPA did arrive from Aldermaston he was swamped with immediate questions.

b. There was conflict between strategic and tactical control, with a tendency for the BCP team to direct the tactical group to achieve activities in a way they considered inappropriate. The particular example is the direction to attend to the sewage plant problem without protective equipment.

c. There was a lack of preplanning of actions and associated resources to deal with generic problems. For example, the need to contain potentially contaminated water/liquors on site had not been thought through as part of their preparedness for emergencies. Similarly, the ability to monitor the Burghfield site evacuees.

d. On the positive side the BCP was set up quickly and efficiently, and briefing and control of personnel in the BCP was good.

e. When setting new focus points at each "time-out" the Emergency Controller did not review, until late on in the exercise, the previous ones.

f. The attendance of a security advisor for a substantial part of the exercise at the command table did not appear to be warranted for this type of incident. His advice did not appear to be sought and given the lack of seats at the command table it may have been better to allocate his seat to another advisor. (In fact when it became obvious that the RPA was having to make calls standing up he volunteered his seat and went to the back of the room).

g. The log keeping amongst some players appeared a little hap-hazard at times with not all calls being logged.

h. It should be ensured that all members of the BCP team know how to operate equipment such as fax machines etc.

5. Medical Aspects

a. The fire and rescue personnel arrived at (09.17) 10 minutes after the fire started. As there were only 4 casualties formal triage was not performed by the fire/rescue team. The initial group of injured were shepherded along the corridor to the forward control point where they were met by the first-aiders and the site nurse.

b. There was a problem with the deployment of additional first-aiders who were not allowed access to the complex by the police on the security gate - they were directed to the medical centre instead. In this scenario there were enough first-aiders at the scene but there would not have been enough if more casualties had been involved. Appropriate first-aid was administered to the casualties at the forward control post.

c The Aldermaston medical support team (a doctor and a nurse) arrived at forward control at 9.40 (37 minutes after the incident start) and they then took charge of the casualty treatment. Correct precedence was given to serious injury over possible contamination - The P1 fireman with the chest injury was transferred directly to the Royal Berkshire Hospital at 09.40 (23 minutes after his rescue). A Health Physicist was not available to accompany the casualty from the scene to hospital.

d. Generally there was effective liaison between the medical personnel, first aiders and the health physics personnel. Casualty reporting procedures were instigated correctly although initially there was some confusion of casualty numbers in the BCP - this was discovered to be due to double counting.

e. The casualties were given comprehensive reassurance briefing on the hazards and management of any potential radiation exposure by the medical officer.

f. Overall the medical aspects of the response were considered to be satisfactory.

6. Other Zones & Control Of Site

a The role call in zone 3 was claimed to have been completed within 10 minutes. However, this was limited to confirming number of personnel within the facility and was not a true roll call.