

ERRATA

S. Hrg. 106-570

**DEPARTMENT OF ENERGY'S MANAGEMENT OF
HEALTH AND SAFETY ISSUES AT ITS GASEOUS
DIFFUSION PLANTS IN OAK RIDGE, TENNESSEE,
AND PIKETON, OHIO**

HEARING

BEFORE THE

**COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE**

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

—————
MARCH 22, 2000
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ERRATA

The enclosed testimony submitted by Harry Williams, President of the Coalition for a Healthy Environment, is missing from this hearing or was not printed in error. This designation will print as pages 454 - 470.

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FAX LETTER

March 28, 2000

Senator Fred Thompson
Senate Governmental Affairs Committee
340 Dirksen Senate Office Building
Washington, DC 20510

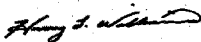
Testimony of Harry L. Williams to the Thompson/Voinovich Hearings K-25/Portsmouth Gaseous Diffusion Plants
hearings of March 22, 2000

Dear Honorable Senators:

Let me begin with thanking Senators Thompson and Voinovich for raising the
worker health problems to open senate committee process and receiving written
testimony in order to accurately address the extent of the problems and seek
more effective remedies.

I submit my testimony as a former Security Police Officer, Police Supervisor and police Training Commander with
knowledge of problems at the K-25 site and DOE sites in general.

Kindest Regards,



Harry Williams, President
Coalition for a Healthy Environment

HLW/file

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Attachment (1) Personal Testimony

Respondent Harry Lee Williams, Testimony

Introduction: Mr. Harry Lee Williams worked as a Security Police Officer (SPO) SPO Supervisor and Training Officer at the K-25 plant in Oak Ridge, Tennessee, 1976 to 96. He was negligently exposed by DOE on its inherently dangerous K-25 site to cyanide, hydrogen fluoride, nickel, mercury, other heavy metals, radiation, criticalities and other presently unknown toxic hazards at the chemically and radiologically contaminated K-25 Plant (K-25). The plant process and research programs also involved many classified compounds. The Department of Energy is guilty of negligence, including failure to enforce and apply DOE orders or proper oversight and management of its primary contractor, Lockheed Martin Energy Systems (LMES or LOCKHEED), which resulted in physical, mental and emotional damage by DOE and its agent and contractor, LOCKHEED. The respondent did not hire into a active national defense facility nor did he intend to. This was a job that on its face enriched uranium to 3 to 4% to power commercial reactors. Respondent asked frequently/periodically if he was being exposed to any substance that would cause him harm. His employer always insisted the workplace was safe in fact safer than at home. We now know better! I was told recently by former plant Shift Superintendents of the mid night purging releasing large volumes of UF6 etc. to atmosphere. The K-25 site has more ghosts and horrible stories than any other gaseous diffusion plant. We in Oak Ridge are also haunted by the operations and legacies of Y-12 and ORNL (X-10). The government has a duty to expose and correct these problems. **GOD HELP OAK RIDGE.**

1. **Describe the nature and extent of each injury:** Mr. Williams -- Depression; fatigue; suicidal ideation; short-term memory loss; loss of concentration; muscle and joint soreness throughout body; tingling and numbness of extremities; reduced abilities to work with his hands; chronic heart disease (two heart attacks, heart aneurysm, heart surgery (angioplasty) palpitations; shortness of breath, even with small exertions or sedentary activities; extreme and abnormal sensitivity to heat, painful at room temperatures comfortable for most people; extreme sweating and hot flashes for no apparent reason even, diffuse and extreme sweating on small exertions; night sweats; excretion of unexplained elevated levels of calcium from the urine; significant weight gain and loss, particularly in the abdomen and stomach; reduced desire for sex; eye and nose irritation; immune system disorders, such as Diabetes; heavy metal and toxic contamination of body found on laboratory tests and loss of marital consortium.
1. DOE and its contractor negligently failed to relocate Harry Lee Williams from the Oak Ridge K-25 Site from January 13, 1989 until November 27, 1993. On March 8, 1996, through July 23, 1996, Respondent became aware of toxic poisoning of his body and asked for removal from the toxic K-25 workplace. On March 28, 1996, Dr. Joel Perkerson, Primary Care Physician(PCP) removed Williams from this unhealthy environment DOE's negligence has resulted in significant compromise to Respondent's quality of life, ability to earn a living, mental health, and physical health to the extent of being permanent and irreparable. Mr Williams is now suffering on long term disability.
2. DOE is guilty of negligence by failure to inform Respondent and other workers of the toxins and contaminants present in his workplace and of

the dangers these substances posed to his health and well being.

3. DOE is guilty of negligence in allowing LMES to inadequately acknowledge and investigate his complaints of an unsafe workplace. Therefore DOE is guilty/responsible for various toxins entering his body.
4. By April 1995, DOE's contractor was on notice that workers at the K-25 plant were getting sick and wanted to be moved to other off site/reservation facilities. DOE negligently failed to enforce its contracts and federal law and failed to adequately monitor, audit, guide, manage and train its contractor in responding to these serious environmental health and safety concerns. As a result of this life-threatening DOE negligence, Respondent and other workers were met by a hostile employer with resistance, delays and rudeness from LOCKHEED, which sought to suppress health concerns about the K-25 uranium enrichment plant site. Respondent was not initially accepted by LMES as a participator in the so called cyanide working group. Respondent was further denied access to the National Institute of Safety and Health by LMES. Respondent had to locate Mrs Worthington through the Internet on his own initiative.
5. Since March 28, 1996, Respondent has been on short term and then on long term disability. He is unable to work at any occupation.
6. Respondent was diagnosed with Chemical encephalopathy and other impairments from toxic exposures by Dr. Kaye H. Kilburn, M.D., from the University of Southern California's Environmental Medicine Clinic. He submitted results from two hair samples submitted to his PCP. These hair analysis show heavy metal poisons and heavy metals, including arsenic, chromium, lead, tin, calcium, magnesium, Antimony, Arsenic, Beryllium, Bismuth, Cadmium, Mercury, Silver, Aluminum, Iron, Nickel, Thorium, Uranium, and Germanium, Rubidium, Titanium, Zirconium, magnesium, Cobalt, Vanadium, Molybdenum, Boron, Lithium, Phosphorus, Selenium are present in Respondent's body, due to his occupational exposures at DOE's negligently managed K-25 and Y-12 sites.
7. DOE's contractor resisted filing medical reports and discouraged Respondent from raising concerns about his health. DOE's negligent failure to enforce its contracts, orders and standards and other federal and international legal obligations caused damages to Respondent.
8. Respondent's future medical conditions from exposure to these toxins and the synergistic effects from the combination of these toxins within his body are not fully known at this time because of the long latency periods associated with these conditions.
9. Respondent's injuries occurred at DOE's K-25 and Y-12 sites in Oak

Ridge, Tennessee. Respondent's employment at the K-25 Site commenced on September 26, 1976 as a Security Policeman. Respondent was physically located at the K-25 Site until November 17, 1993 when he was transferred to the Y-12 Nuclear Weapons site which is another LMES managed site and it too is heavily contaminated similar to K-25. Then in October 1, 1994, Respondent was transferred back to the Central Training Facility a property of the K-25 site. Also at the CTF Respondent was exposed to the pollution from the SEG Incinerator, which also burns radioactive and other hazardous waste, releasing toxins and furans. Also the IT Corporation (Known to be a contaminated facility), these industrial facilities are located about 1/8 to 1/4 mile upwind from Respondent K-25 work site.

10. During his years at the polluted, contaminated K-25 site, he occupied office space at Buildings K-1020, K-1008 (old filter test facility), K-1652, K-303-8 (K-25 Building), Y-12 Security Police Headquarters, temporary Trailer and a Trailer at the CTF K-1654 located in the center of track. During his periods of employment at K-25 site Respondent while in performance of his duties was frequently in the 75 major buildings and infrequently in the lesser buildings and burial grounds.
11. Such work responsibilities often required him to work throughout the site; however, He often conducted job surveillance for other personnel to perform work at these facilities to report any known hazards such as radiation and radiological contaminants and report to management. DOE and its contractor LMES\Union Carbide did not make these hazards known for many years.
12. K-1420, recently listed as one of the top ten most dangerous DOE facilities in the nation, served as a facility for decontamination of equipment, processing of waste, and electroplating. K-1420 confined at the time were highly contaminated throughout with contamination often loose and un-contained. Its immediate premises were host to several hundred drums of waste and was used to store this waste as well as to package and reprocess the waste. Radiological contamination was extensive even throughout the surrounding asphalt parking lot, the change areas, and even in the lunchroom. The metal plating facility once was located in the K-1420 Building was a source of cyanide and other chemical toxins. As a Security Police Officer and Supervisor, Respondent was not aware of the radiological condition of the facility, and had no training or knowledge about the chemical hazards present. DOE's negligent failure to enforce contracts, orders and standards led to this lack of information. Mr. Williams was to be transferred to the K-1420 Building after his first heart attack in 1989. This attempt shows a chilled management structure that is grossly incompetent.
13. Respondent was concerned about airborne transmission of hazardous chemicals and radioactivity to his body and believes to this day that

air monitoring at the entire K-25 plant for such was severely inadequate. There was no continuous real time air monitoring, and he knew of no air monitoring for toxins. For several years in the early to late 80's the radiation monitors/alarms were disabled on the K-25 and K-27 buildings.

14. Work assignments at K-1037 were primarily in areas where atomic laser isotope separation (AVLIS) was taking place. This was an experimental process being developed for the enrichment of uranium to the isotope of U-235. Once again, Respondent is deeply concerned about the air that he breathed while working in these areas and realized that his knowledge of the past building application as the classified Gaseous Diffusion Barrier Plant. Respondent now has reason to believe that the legacy contamination of the classified compounds may still be present and that the uranium was substantially altered, but he was not instructed or informed with knowledge of the process to know about chemical components or the inherent legacy contamination as well as the AVLIS contributions to the buildings contaminations.
15. Other job duties were at K-1435, the Toxic Substances Control Act Incinerator (TSCAI). He routinely conducted supervisory patrols and/or surveillance and monitoring of Security Police personnel. These surveillance included walking in the close vicinity of empty drums that had stored waste. He was not informed by labels or by instruction of the prior contents. In 1987/88 Respondent performing duties as the shift Security Police Supervisor responded to several accidents and spills at the Westinghouse incineration demonstration pilot plant in the Portal eight parking lot. At no time was Respondent advised of the contamination or the health risk associated with this project.
16. On many occasions while working at the K-25 plant Respondent responded to releases relative to process system failures. Respondent conducted both patrols and supervisory patrols of the major process buildings, laboratories, machine shops, metal plating facilities, etc.. Respondent was never properly informed as to the extent of associated hazards and risk to his work place.
17. Very often while working in the proximity of the waste tanks, he would be aware of suspicious looking cylinders (later to be identified as Manhattan Project cylinders). He asked Vicki Tharp (plant spokesperson on health and safety issues) on more than one occasion about the health hazards at the K-25 plant to which she replied we were safer at the plant than at home. The yellow and sometimes green and grainy appearing substance was not only found on the Manhattan Project Cylinders but on various pipes, valves, all throughout the K-25 and K-27 buildings. He was not told or did not know then but realizes now that these compounds were in fact a product of the of the process and were thought to be enriched uranium ranging from a 5 to 90% depending where in the process one visited. Not only was this a carcinogen,

- heavy metal, and a radiation hazard. While Lockheed Martin stated in 1992 that DOE and its contractor were practicing principles of ALARA (As Low As Reasonably Achievable) for chemical exposures, DOE and LOCKHEED failed to keep that promise with respect to the exposures suffered by Respondent and other K-25 workers. Respondent had frequent occasion for many years to patrol in very close proximity to UF6 storage cylinders in various parts of the plant including the Hydrogen Fluoride tank farm and various waste containers.
18. DOE and its contractor negligently failed to impart any knowledge of the contents of these waste tanks and storage cylinders relative to hazards and volatility involved even though a routine part of his work was around them.
 19. DOE and its contractor negligently failed to provide adequate training and information for Respondent regarding chemical hazards, risks, or protective measures, including his right to have his medical records maintained and available at the facility responsible for Respondent day to day medical care; also available if there was an emergency response to provide treatment to Respondent due to his several chronic illnesses. Respondent, was actually denied the good medical practice of having his medical records maintained at the plant providing care. For a period of months in 1995 and 1996 Respondent was informed by both the nurses and doctors that his medical files were missing or maybe misplaced. Respondent, DOE and the contractor was negligent in there failure to respond to Respondent environmental, health and safety concerns, including imminent threats to human life such as he reported to LOCKHEED on several occasions. To provide an example Respondent was required participate in a fire training exercise at the fire training facility located in the main plant containment area on the north side of K-25. This facility burnt waste motor oil and transformer lube oil (contaminated with PCB's). The thick black smoke from this facility would be so thick at times it interfered with viability in a large area of the plant.
 20. Limited chemical training covered Material Safety Data sheets. K-25 plant pollutants continued to be concealed by frustrating employee efforts to get MSDS for the chemicals used in connection with the K-25 Insituform sewer line lining project.
 21. On May 30, 1996, DOE's contractor and subcontractor violated a 1996 "stop work order" by K-25 plant manager Harold Conner on the sewer lining process because of concerns regarding diisocyanate. Mrs. Sherry Farver, a friend and co-worker /peer of Respondent raised concerns with DOE and LOCKHEED about the violation of the stop work order but never received a response from either DOE or LOCKHEED. LOCKHEED managers lied about the violation of the stop-work order. The Material Safety Data Sheet for the diisocyanate compound showed that the compound had a Threshold Limit Value (TLV) of 5 parts per billion, a highly toxic chemical, and that it was not to be used

around hot water, to prevent "vigorous" and "violent" reactions. DOE's subcontractor used this diisocyanate compound in exactly this manner -- in conjunction with hot water for curing -- unreasonably risking Respondent's life and the lives of other employees due to DOE's failure to enforce OSHA, EPA and other standards that are mandatory. "Let's don't put anything in writing," Harold Conner, the LOCKHEED K-25 plant manager told a group of workers on May 22, 1996 in a meeting about the stop-work order. DOE's negligent management allowed this to happen.

22. On occasion, Respondent was required to respond to TSCA during the trail burns and original start up process where an accident or release had occurred and/or a failure of the TSCA waste processing systems. He was never told by DOE or its contractor of a mechanism called the Thermal Release Vent -- which opens and directly vents TSCA emissions to the atmosphere when the system malfunctions. He now wonders what combination of contaminants that he breathed as a result of this and subsequent releases.
23. TSCA has had thirteen known accidental releases for durations of two or more hours each and at least two very serious accident/incident at the incinerator pilot project located in the Portal Eight parking lot. DOE negligently failed to protect workers from the synergistic effects of hazardous waste incineration as well as the increased hazards associated with products of incomplete combustion from hazardous waste incineration such as cyanide, dioxins, and furans.
24. The later incidental K-25 Site toxic exposures did not consist of field work. His work assignments were administrative as an instructor, and training officer.
25. When he first realized that he was being poisoned, Respondent assumed the exposures were from his past assignments in the field. As he learned of more workers who experienced the same poisoning, he realizes that many of these workers had never worked in waste processing areas of the site. Some of the workers were cafeteria workers and solely administrative office workers. He and the others lived in different surrounding counties and performed a number of diversified jobs at the site, but it was quite apparent their one common link was the Oak Ridge K-25 or the Y-12 Site.
26. On September 27, 1976, Respondent began his career employment at Oak Ridge K-25 Site.
27. In 1989, preceding and specifically following his first heart attack his depression and fatigue became extreme. In 1993, Respondent began treatment with antidepressants.
28. During 1989-1995, Respondent's physical and mental health declined.

Fatigue and malaise were relentless and increasing. Angina pain became a frequent occurrence. Incontinence (both of the bowel and urinary tract) accidents occurred frequently. Other symptoms developed, including severe short-term memory loss, tingling and numbness of his extremities, muscle twitches and sleep apnea. heat intolerance, sweating, muscle/joint pain, eye and nose irritation develop and constant moderate level ringing in my ears, dizziness, extremity conduction and control, and a significant loss of old factory senses.

29. On March 8, 1996, Respondent was examined by his PCP (general practitioner) and asked for a urine thiocyanate test.
30. On March 8, 1996, Respondent learned that the urine thiocyanate test was 29 micrograms/milliliter with normal range for a non-smoker being only 1-4 micrograms/milliliter.
31. On or about March 16, 1996, Respondent met with his manager Michael Knazovich to discuss his concerns and to request an investigation of his work area as two employees who were tested had high thiocyanate levels. LOCKHEED refused Respondent's request to take biological samples from other workers in the CTF and specifically his peers in his trailer. The CTF is located approximately 1/4 mile down wind of the SEG incinerator. On the stated basis that Lockheed believed there was no concern to workers.
32. On April 26, 1981 or before To March 1983, Respondent was exposed to what now and then is characterized as an unsafe laser, that Respondent believes has damaged his eyes contributing to his poor vision.
33. Respondent did phone/file a medical incident report on April 25, 1996: on this date Respondent was sick at home. Acting upon instructions from Dr. Edelman of the Vanderbilt Medical Center, he stated that Respondent should file with Workman's Comp (Willis Caroon). To meet the requirements for filing Workman's Comp. Respondent had to file a medical incident report. Upon information and belief, other workers were deprived of the ability to file medical incident reports in the time period since K-25 was closed. This negligently deprived DOE of operations information that would have allowed it to devote sufficient resources to environmental, safety and health information at the K-25 plant.
34. Respondent was under his PCP's on going care on March 28, 1996, with visits at least every six weeks if not more often. Respondent PCP stated that he didn't know how to treat the various toxic issues I had raised concerns about. This led to my visits to Dr. Kilburn, USC and a request to see Dr. James Bond a Neuro-opthamologist that my Insurance would not approve.

35. During January 1996, ill workers petitioned NIOSH for a health hazard evaluation of the K-25 site.
36. DOE Oak Ridge Operations Employee Concerns and Diversity manager Rufus Smith did not even respond to a concerns filed by Respondent in August, September, October of 1997. Mr. Smith replied by certified mail (return receipt) September 29, 1997, and October 9, 1997, with Mr. Smith sending Respondent condescending letters stating Respondent being a disabled employee on disability cannot raise concerns around issues that he (Williams) did not witness. Mr. Smith made another statement that continued the chilled environment on reporting health, safety and security concerns by stating that the concern was also presented to DOE all most verbatim by another employee: indicating that this was somehow a violation of policy. DOE's actions in mishandling of the employee concern were negligent and indifferent to the value of human life.
37. Mr. Smith's registered letter requiring a return receipt closing out the Williams - Glenn concerns never set forth original concerns and complaints regarding mishandling of environmental and health concerns at LMES site(s). Any police report, let alone a nuclear safety concern report, must set out the concern or be a useless piece of paper. Without setting forth the Farver concern, the "report" lacked a yardstick and failed to show that it addressed all of the concerns, demeaning employees protected activity and negligently failing to respond to it properly placed Respondent health in jeopardy along with other ill employees. And close by residents. DOE's employee concerns program is a negligent failure and should be shut down under Court order or a settlement agreement.
38. Mr. Smith never met with or spoke with Williams, Glenn or Farver or other employees before closing out there concerns. Mr. Smith did speak with Mrs. Ann Oricks co-worker, and co-employee with Respondent. Commander Smith was rude to Mrs. Orick. Mr. Smith failed to keep his promises to Mrs. Orick. In two letters, Mr. Smith negligently or intentionally denied Respondent his first amendment rights by denying this disabled employee the right of filing legitimate concerns.
39. On March 28, 1996, Respondent was told by his PCP that his health required he be placed on short term disability. Respondent had to remove himself from the unhealthy work environment that exist at K-25 and Y-12 plants and for that matter the other ORO plant sites.
40. On February 8, 1996, NIOSH personnel arrived in Oak Ridge.
41. On or about February 9, 1996, Respondent was not scheduled to meet with NIOSH nurse Karen Worthington. Respondent had to locate Worthington via Internet and talk to her by phone; Worthington requested medical records and signed release forms Respondent complied. There has been no further contact with NIOSH.

42. On April 4, 1996, Respondent was seen by Dr. Phillip Edelman by directive of his PCP. Edelman report was inconclusive by design. Williams not knowing that Edelman was the contract DOC for LMES was subjected to the influence of LMES management involvement in his personal medical care.
43. Respondent worked very competently and diligently, earning several favorable written recommendations and the respect of managers and co-workers alike. DOE owed him a duty of care to protect him from harm from ultra-hazardous operations, including "legacy contamination" from such operations, which contamination was known to DOE.
44. This is a case of *res ipsa loquitor* negligence, by keeping Respondent in a harmful work environment first at K-25 for a decade or more and then at Y-12 for 11 months and some days and then back to K-25 for another year or more. Never once providing a safe work place; after he was found to have poisons in his body.
46. Respondent's Primary Care Physician Dr. Joel Berkerson wrote in his 1997 patient notes that Respondent medical problems could be attributed to possible environmental exposures.
47. DOE's negligence has again resulted in a worker's unusual illnesses and chemical sensitivities, due to DOE's indifference to the value of human life of Oak Ridge contractor employees. This can be confirmed by the March 1998 meeting at Pollard Auditorium with a team of doctors and contract Health Physics Technician. Where what appears to be at least several standard deviations above normal of beryllium in the topsoil in and around the K-25 site. Respondent also learned that the K-25 Powerhouse area was also contaminated with Beryllium legacy waste. As a security police training officer Williams participated in several tactical weapons exercises in and around the area and buildings. This powerhouse area was known to be highly contaminated by the DOE and its prime contractor Union Carbide/Lockheed Martin Energy Systems.
48. Respondent seeks not only compensation, but thorough reforms to halt Oak Ridge Operations' negligent conduct of its environmental, health, safety and nuclear criticality functions, in violation of federal law, DOE Orders and contractual responsibilities.
49. DOE negligently failed to enforce its own safety and whistle blower protection rules and contractual provisions, resulting

in personal injury to Respondent due to the presence of dangerous chemicals and radiation. DOE's negligence abused the trust of K-25 workers, to whom DOE owed a duty of care, protection and loyalty.

50. The radiation in K-25 was negligently termed by DOE as "historical" or "legacy" radiation (due to the time when it was deposited), as if that obviated the requirement to decontaminate and decommission a uranium enrichment plant with thousands of missing pipe segments, some removed due to criticalities or near-criticalities.
51. DOE now admits that K-25 presented significant life, safety and health risks to workers. The radiation and chemical exposure was ongoing for K-25 workers. DOE negligently failed to ever inform any workers that K-25 was a Superfund Site, or that workers were being exposed to chemicals and radiation on a daily basis.
52. DOE's negligently misleading "historical" or "legacy" radiation designation, DOE's yellow radiation ropes and DOE's vague assurances did **not** fulfill DOE's legal and moral duty to clean up the radiation and toxins, with K-25 shut down in 1985. These acts and facts have been documented in the Nashville Tennessean in 1997.
53. DOE's duty to follow its own safety, health, environmental and radiological standards at K-25 after the end of the Cold War is not a "discretionary duty" under the Federal Tort Claims Act (FTCA). DOE's breach of its duty is the proximate cause of Respondent's damages. DOE put K-25 workers in harm's way with a risk of nuclear criticality and chemical releases ever-present, radiation alarms not working, and strange smells, asbestos, cyanide, and other hazards permeating the buildings. The confinement of human beings in this K-25 site was tantamount to a warped, negligent "experiment" with some 3500 peoples' lives, without moral or legal justification or excuse, in violation of the Geneva Convention and the Nuremberg Principles.
54. When Respondent was moved in May of 1992 to K-303-8 DOE had been negligent in failing to perform its duties to protect worker and public health from the incompetence of DOE's contractor, Lockheed Martin, which had previously placed other workers in harm's way in unsuitable office space in unsafe locations, a fact that was known to DOE.
55. DOE/AEC signed in 1971 a memorandum of understanding (MOU) with the Department of Labor Occupational Safety and Health Administration, pledging to obey all OSHA standards. DOE

Orders require that safety be protected. Such agreement and orders were negligently not complied with, to the detriment of Respondent and K-25 workers.

56. DOE failed to supervise its contractor properly in performing annual, weekly and other required, necessary and proper maintenance chores at the uranium enrichment plant and the nearby incinerators, as well as storage of radioactive and toxic materials on the K-25 site, some in leaking containers.
57. DOE failed to give orders required by DOE Orders to clean up the K-25 plant. No proper deactivation, decontamination or decommissioning of the K-25 site was ever done, with uranium and other tonics left in the pipes of the plant, with thousands of missing pipes and visible uranium dust and other contaminants strewn about the K-25 plant.
58. Respondent now has a number of health conditions that are chronic and relate to chemical sensitivity, which health conditions were created by the unsafe conditions in DOE's dangerous workplace, the K-25 site. Those health conditions interfere with Respondent's ability to enjoy life with his family and a loss of consortium with his wife.
59. After the Cold War ended, DOE's negligent placement of workers in such hazardous areas as the K-25 plant -- and DOE's failure to see that training and safety information was given to workers in such hazardous areas -- was beyond the pale of any "discretionary function." There was no justification or excuse as asserted in the Cold War for failing to inform workers about the risks of K-25, which was closed in 1985 and negligently not decontaminated or decommissioned during the ensuing twelve (12) years.
60. Respondent expressed to the management of DOE and Lockheed Martin Energy Systems his serious concerns regarding his being moved to the K-303-8 (a more hazardous plant area) an office at the K-25 plant. LOCKHEED took approximately 18 months to move Respondent, furthering his chemical exposures. DOE's failure to enforce its contractual and DOE Order provisions regarding workplace safety put Respondent in harm's way and worsened his illnesses. DOE's failure to act on Respondent's employee concern kept him in harm's way.
61. For years, Respondent's concerns were largely ignored.

Negligent Acts By Department of Energy

62. Respondent DOE demonstrated negligence and unfitness to protect worker safety, which failure exacerbated the health

effects upon Respondent and other K-25 workers, needlessly exposed to a uranium enrichment plant that was negligently not decontaminated and decommissioned, sitting in dangerous condition twelve years after its abandonment, in close proximity to an improperly managed incinerator burning both radioactive and toxic wastes in a manner that assured a "blowback" of toxins onto the K-25 plant site. DOE negligently:

- a. Failed to perform or supervise or provide proper deactivation, decontamination and decommissioning;
- b. Failed to perform or supervise or provide proper oversight;
- c. Failed to perform or supervise or provide occurrence reporting;
- d. Failed to perform or supervise or provide maintenance;
- e. Failed to perform or supervise or provide proper biological monitoring of employees;
- f. Failed to perform or supervise or provide proper medical care for employees;
- g. Failed to perform or supervise proper workplace radiological, chemical or heavy metal monitoring;
- h. Failed to perform or supervise or provide medical services, negligently failing to adhere to the provisions of DOE Orders;
- i. Failed to perform or supervise or provide proper industrial hygiene or health physics protection;
- j. Failed to take care that DOE's contractual requirements and orders were executed by its contractor;
- k. Failed to investigate adequately in response to Respondent's safety complaints to DOE;
- l. Failed to provide a full and fair investigation and report in response to Respondent's employee concerns and other worker safety and health concerns;
- m. "Investigated" incompetently, e.g., letting LOCKHEED investigate itself pursuant to the custom, usage, practice and procedure of the DOE, ERDA and AEC in dealing with its contractors throughout the years;

- n. Chilled worker concerns about health threats with DOE's "scorched earth" and negligent policy of unjustly and indiscriminately fighting workers' concerns about workplace hazards, as demonstrated by former AEC Order 0521, as was documented by Clifford T. Honicker without rebuttal by DOE -- in the New York Times Magazine. DOE managers and minions negligently continued to conceal information on DOE plant hazards even after the end of the Cold War in 1991. This policy of fighting the just claims of contractor workers with federal tax dollars involves a scheme or plan whereby DOE and LOCKHEED contract and combine to spend millions of dollars, in order to have a chilling effect on workers who reveal safety, health and environmental problems involving DOE and LOCKHEED negligence. This negligent policy insulates negligent managers from criticisms, negligently furthering the environment in which DOE's negligence persists.
- o. Massively resisted any change that would end its negligence in an inherently dangerous facility, while in deep denial that any problems exist at the facility, to the extent that DOE Oak Ridge Operations Manager Jim Hall refused to meet with three reporters from the Nashville Tennessean newspaper regarding environmental, safety and health problems at the K-25, X-10 and Y-12 plants in Oak Ridge. As Leonard Schroeter writes:
- Much like the tobacco industry, the nuclear industry, which was wholly indemnified by the United States government, has a policy of full-scale war against any person with the temerity to suggest that radiation might be bad for their health. Thus, despite the new O'Leary policy of disclosing what a half century of nuclear secrecy, questions still remained as to whether the United States government continued to be committed to no accountability, no responsibility, and no compensation for the powerless victims.¹
- p. Committed other negligent acts of commission and omission, acts presently concealed by negligent use of classification, including acts related to the use of heavy metals including but not limited to mercury,

¹ Leonard W. Schroeter, "Human Experimentation, The Hanford Nuclear Site and Judgment at Nuremberg," 31 Gonzaga Law Review 147,161.

arsenic, copper, chromium, molybdenum, lithium, lead, tin, strontium and magnesium at the K-25 site. Respondent requests discovery through Ms. Jacqueline O. Kittrell, who has a "Q" clearance and is authorized by DOE and Justice to engage in classified discovery.

- q. Continues to subject Respondent and other workers, residents and citizens to negligence, including the "re-industrialization" taking place without proper protections for workers, with DOE employee concerns personnel telling LOCKHEED workers expressing concerns about K-25 to stop calling their offices, e.g., about new personnel working for new employers who have located at K-25 as part of "re-industrialization," without adequate training, information or radiation and chemical protection, including workers observed eating and smoking in radiological areas in contaminated buildings;
 - r. Continues to ignore reports of safety and health and environmental concerns regarding, including its failure to resolve the concerns about violations of OSHA depleted uranium standards, conflict of interest in investigating safety concerns, as set forth in Mr. Farver's May 29, 1997 letter to the Secretary of Energy;
 - s. Continues to ignore concerns about retaliation, including the incredible, request by PCP to remove Respondent from an unhealthy work environment. Respondent raised concerns about his work place from October 1993 to April 28, 1994. Respondent was moved out of harms way until Colonel Willis Leon Clement (Retired) was presented with the April 28, letter from Respondent' PCP. Colonel Clements failed to Forward this letter to medical. Respondent had Dr. Zannoli put this letter into his medical file. Respondent was repeatedly retaliated for protected activity by LTC Lorry Ruth (Retired) a direct report to Colonel Clements.
63. DOE and contractor management has announced policies to "celebrate whistle blowers." DOE did not make its contractors change their behavior in the wake of the revelations of the Varnadore case.
64. In fact, negligent DOE managers in Oak Ridge, like DOE ORO Diversity and Employee Concerns Director Rufus Smith, have themselves been retaliator against DOE employees. These facts are known to DOE, which kept Mr. Smith in a position of trust and responsibility, where his omissions kept Respondent in harm's way, without action by DOE.

65. Instead of fulfilling their legal duty to protect all employees and to protect employee whistle blowers, top DOE management allowed negligent DOE and contractor managers to create and maintain the "old culture" -- the culture hostile to safety, in the form of a very hostile working environment to raising safety, health, environmental and other concerns. This hostile working environment exists on DOE property in violation of DOE orders. Respondent's K-25 colleague and fellow CHE member, Ms. Ann Walzer, was harassed, intimidated and discriminated against and fired by LOCKHEED for asking to be moved away from the K-25 site, the Department of Labor Occupational Safety and Health Administration found in December 1996. LOCKHEED fired the only toxicologist on site involved with the Coalition for a Healthy Environment.
66. This hostile K-25 working environment was utterly intolerant toward worker concerns about K-25. DOE officials were "frozen in the ice of their own indifference." As a result of DOE's negligence in allowing it to persist, Respondent and numerous K-25 workers already in harm's way were kept in unhealthy work environments longer.

Relief Requested

67. Respondent requests that health care be provided and DOE pay loss wages and compensatory damages.
68. Respondent further requests that DOE provide for lifetime medical monitoring and treatment by independent physicians of the his choosing, and for all employees so exposed.
69. Respondent requests that DOE agree to:
- B. Immediate and unconditional declassification, pursuant to the Freedom of Information Act, the Privacy Act, the community "right to know" laws, the publicly announced declassification orders of Secretary of Energy Hazel O'Leary, and the recommendations of the Report of the President's Commission on Protecting and Reducing Government Secrecy, of all documents on toxic hazards on the Oak Ridge reservation, including the use and abuse of chemicals and compounds, including but not limited to cyanide, mercury, arsenic, copper, chromium, molybdenum, lithium, lead, tin, strontium, magnesium and nickel. at K-25, other K-25 hazards and the nearly 100 still-classified compounds to which workers were exposed in Oak Ridge, and the contents of the Records Holding Task Group (RHTG) in Oak Ridge, Tennessee. Rather than forcing plaintiffs to seek this necessary and proper

declassification *ad hoc*, piecemeal, one case at a time, and risk missing relevant information, Respondent hereby makes this urgent, generic request for all information on such hazards should be declassified at last. The Cold War ended six years ago. Inasmuch as a Q-cleared attorney is ready to conduct the review, the declassification should not be delayed by one more day.

CONCLUSION

70. Respondent requests that the DOE Headquarters seriously consider criminal referrals to EPA and the Justice Department of DOE and LOCKHEED managers responsible for the negligent failure to decontaminate and decommission the K-25 plant for 12 years after its closure, for the chemical, heavy metal, radiation and criticality problems there, and for the negligent operation of the TSCAI and other incinerators in this highly polluted environment. This request cannot adequately be considered by DOE attorneys in Oak Ridge, who are associates of the persons who might be so charged.
71. We are ready, willing and able to assist you and your office in its work. Please call upon us when we can help you understand what DOE ORO did to Respondent and other workers similarly situated.