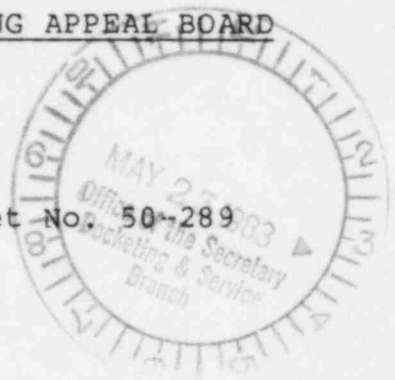
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING APPEAL BOARD



In the Matter of	)	
	)	
METROPOLITAN EDISON COMPANY	)	Docket No. 50-289
	)	
(Three Mile Island Nuclear Station, Unit 1)	)	

THREE MILE ISLAND ALERT
MOTION TO REOPEN THE RECORD

Three Mile Island Alert (TMIA) hereby moves the Atomic Safety and Licensing Appeal Board to reopen the record on the issue of Licensee management's competence and integrity. This motion is made in view of the voluminous amount of new information which recently materialized regarding management competence and integrity issues, which raises so many significant questions that the NRC staff has chosen to withdraw its prior long-standing endorsement of Licensee management's competence and integrity. (See Attachment). This staff action is particularly significant in light of the heavy reliance placed by the Licensing Board on the staff's former unwaivering support of Licensee management's competence and integrity, resulting in a decision favorable to restart. (To the extent this motion corresponds to the Aamodts outstanding motion to reopen the record, TMIA supports the Aamodts motion). In suppport of this motion, TMIA states as follows:

1. On July 2, 1979, the Commission issued an Order directing that TMI-1 be maintained in a shutdown condition

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pending further order of the Commission, further determining it to be in the public interest that a hearing precede any possible restart of TMI-1. The Commission based its action on a conclusion that,

> In view of the variety of issues raised by the accident at the Three Mile Island Unit No. 2 facility, the Commission presently lacks the requisite reasonable assurance that the same licensee's Three Mile Island Unit No. 1 facility, a nuclear power reactor of similar design, can be operated without endangering the health and safety of the public.

2. By its Order and Notice of Hearing dated August 9, 1979, Metropolitan Edison Company (Three Mile Island Nuclear Station, Unit No. 1), CLI-79-8, 10 NRC 141 (1979), the Commission established a Licensing Board (ASLB) to conduct the hearing, and further specified the basis for its concerns about operation of TMI-1. In this order, the Commission particularized, on the NRC staff's recommendations, the minimum "short-term" actions which would be required of the Licensee to resolve the Commission's concerns. Among those actions was the requirement that,

> The licensee shall demonstrate his managerial capability and resources to operate Unit 1 while maintaining Unit 2 in a safe configuration and carrying out planned decontamination and/or restoration activities. Issues to be addressed include the adequacy of groups providing safety review and operational advice, the management and technical capability and training of operations staff, the adequacy of the operational Quality Assurance program and the facility procedures, and the capability of important support organizations such as Health Physics and Plant Maintenance.

10 NRC 141 at 144-145.

3. In addition, because of acute concern regarding this Licensee's management stemming from the TMI-2 accident, the Commission directed the Licensing Board to examine 13 specific management issues, each of which the Commission determined must be resolved before there could be any assurance that TMI-1 could be operated safely. See, Order of March 6, 1980, CLI-80-5, 11 NRC 408. Those specific issues included: Licensee's management structure (1); the quality of the operations and technical staff (2); the Health Physics program (4); the Radiation Waste system (5); financial/technical interface (6); safety reviews and operational advise (7); management actions during the TMI-2 accident (10); sufficiency of in-house technical capability (11). TMIA was admitted as an intervenor in these proceedings primarily to pursue TMIA Contention 5, which alleged that Licensee has engaged in dangerously poor maintenance practices, thus rendering it unqualified to operate TMI-1 without endangering the health and safety of the public.

4. The ASLB issued a Partial Initial Decision on August 27, 1981, resolving these issues in favor of restart, as well as those dealing with training which were pursued by other intervenors, the Aamodts. See, LBP-81-32, 14 NRC 381. TMIA appealed this decision to this Appeal Board, and is currently awaiting oral argument in the case.

5. In addition, after allegations of operator exam cheating were made public in the summer of 1981, the

Licensing Board reopened the record of these proceedings by Order dated October 2, 1981, to examine:

> ...the effect of the information on cheating in the NRC April examination on the management issues considered or left open in the Partial Initial Decision, recognizing that, depending on the facts, the possible nexus of the cheating by two particular individuals and may involve the issues of the Licensee's management integrity, the quality of this operating personnel, its ability to staff the facility adequately, its training and testing program, and the NRC process by which the operators would be tested and licensed.

Both TMIA and the Aamodts intervened in these proceedings. The ASLB's Partial Initial Decision on the reopened proceedings was issued July 27, 1982, again resolving the issues in favor of restart. TMIA appealed this decison as well to this Appeal Board, and is currently awaiting oral argument in the case.

6. In oral and written comments to the Commission, the NRC staff has steadfastly maintained that management competence and integrity issues were correctly resolved by the Licensing Board in favor of restart. However, in comments submitted to the Commission on April 18, 1983 regarding its analysis of the GPU v. B&W trial record, the staff indicated for the first time that its previously held support was in need of "revalidation." It explained in an April 26, 1983 memo from William J. Dirks, Executive Director for Operations, that the basis for the need to "revalidate" was the "open issue of the Hartman allegations concerning the falsification of leak rate data," which could "possibly affect the staff's position on management

integrity." These allegetions were developed on the record of the GPU v. B&W trial, and are also the subject of a federal grand jury investigation.

7. By memo to the Commission dated May 19, 1982, (See Attachment), the staff concluded that "the issues raised by the Hartman allegations should not by themselves be a bar to restart." However, when considered together with several other "open issues," the staff determined that if can no longer draw a conclusion regarding management integrity. This suggests a major reversal in the staff's previously unwaivering support for Licensee's management and its view that the PIDs "removed the management concerns which formed the part of the basis for the Commission's immediately effective shutdown order for TMI-1."

8. The staff lists five separate matters which it defines as "open." (Attachment, p. 2). TMIA requests a reopening of the record to examine the management implications of each issue mentioned, but in addition requests that the following be examined:

1. The credibility of Region I's Inspection Report No. 50-289/83-10, particularly with regard to the Hartman allegations and the BETA and RHR management audits.
2. The credibility of Victor Stello's report(s) on the impact of the GPU v. B&W trial record on restart issues.
3. The management implications regarding allegations made by other "whistleblowers" besides Parks and King, and the significance of the Department of Labor finding that Parks was retaliated against by management for reporting safety violations.

Each of these matters is highly relevant and material to a full and complete resolution of management and integrity issues.

9. The BETA and RHR management audits have already been provided to this Appeal Board, although they are not now on the record of this proceeding. The Licensee has also provided copies of "clarification" letters from both RHR and BETA, each of which downplays the significance of some of the most damaging findings in each report. Information in each letter seems to contradict findings in the reports in certain respects. Clearly, without access to the raw data, and examination of it in context of an adjudicatory hearing, it is impossible to determine the credibility of either the reports or the explanatory letters.

10. It appears that the Washington staff is likely to provide the Board with comments or investigative reports on each of the five "open" items. To leave the task of evaluating any one of these matters solely to the staff, which is a party to these proceedings, without providing the other parties an opportunity to place material evidence on the record in the context of a full adjudicatory hearing, would be an plain violation of the well-established rules against ex parte communications, as well as the principle that any evidence presented in a case before an administrative agency be received only during a public hearing, on the record. Seacoast Anti-Pollution League v. Costle, 572 F.2d 872 cert. den. 99 S.Ct. 92 (1978).

Further, it would violate the express intent of the Commission in establishing this hearing process for the purpose of evaluating those issues which it believed necessary before finding that TMI-1 could be safely operated. Failure to reopen these proceedings to examine this evidence would be extremely prejudicial to the other parties, and would continue to place the integrity of this hearing process in doubt.

11. Moreover, under the NRC's own standards for reopening a record, defined in Kansas Gas and Electric Company (Wolf Creek Generating Station, Unit No. 1), ALAB-462, 7 NRC 320, 328 (1978), it is clear that the record must be reopened in this case. First, the motion is timely because the subject incidents and documents just recently came to light, including the Hartman allegations the details of which were not generally known by the intervenors until the B&W trial depositions were made available last month. Second, the motion is directed to a significant safety issue -- i.e. management competence and integrity. In fact, the staff's withdrawl of its prior endorsement of Licensee's management, based on these "open" issues, demonstrates just how significant they are. Third, as will be demonstrated, infra, a different result would have been reached initially had this material originally been considered by the Licensing Board.

12. With regard to the B&W trial record, TMIA is now scrambling to review this enormous amount of material. The

June 1 deadline set by the Commission for the parties' review of the entire record will certainly not be met by TMIA. In light of the fact that the trial exhibits were not placed in the public document room in Harrisburg until late April, and that the exhibits were virtually impossible to use until someone arrived from the NRC to help organize them on May 13, it will be literally impossible to meet the Commission's deadline. (We should note that the staffs in the public document rooms in both Harrisburg and Washington have been enormously helpful and cooperative in assisting us and should be recognized for their efforts in trying to organize such an inordinate number of documents in such a short timeperiod). Although TMIA's review is far from complete, TMIA has already found information which is quite material to many of the issues litigated before the Licensing Board. In addition, according to Board Notification 83-71, there apparently exists some highly relevant and material information which the staff has discovered in the record concerning evidence of falsification of operator test records. This deserves a full investigation by this Board.

13. In addition, the B&W record reveals a number of serious management problems existing before and after the accident which relate to Commission concerns addressed in the August 9 and March 6 Orders, supra, and which Licensee and staff witnesses guarantees had been corrected. These assurances were relied upon heavily by the Licensing Board

in resolving management issues in favor of restart. But upon examining the BETA and RHR management audits, completed only months ago, it is readily apparent that many of the management problems existing before the accident continue to the present day despite hearing testimony to the contrary. In addition to independently demonstrating a pattern by the Licensee of failing to correct recognized problems, this reflects very poorly upon the credibility of the hearing witnesses, many of whom gave virtually unqualified endorsements of the present organization. And because the ASLB Board relied almost exclusively upon Licensee and staff witnesses in formulating its decision on management issues, the PIDs' findings and conclusions are directly in question.

14. Moreover, a number of management related problems revealed in the B&W record as well as the management audits, some of which are also relevant to the "whistleblowers'" experiences, were entirely shielded from Licensing Board consideration. For example, inaccuracies in warehouse inventory records, (BETA at 28), feelings that the TMI Human Resouces group is unresponsive to site needs (BETA at 31), the insensitivity of top management to an individual's personal well-being (BETA at 94), (the last two tying in directly to the "whistleblowers'" allegations), and the practice of writing procedures as an easy but ineffective way to solve a problem, were all mentioned in Licensee's 1978 management audit. B&W Exhibit 843. Also, the 1978 audit reveals that supervisors feel that upper management do

not give them enough authority to make decisions, and are involved in too much detail. BETA finds the same situation today. P. 112-113. The 1978 auditors found that some supervisors are not sure what their responsibilities are, never having seen a job description and never having had the job explained to them. Similarly, BETA found in 1983 that the [five "engineers" presently reporting to the TMI-1 Manager, Plant Operations] are not performing functions which could be truly called engineering. P. 22. RHR makes a specific finding that action from prior audits, or temporary action which was taken quickly petered out. There was expressed pessimism that the RHR audit would lead to any lasting improvements in areas of the operators' concerns. Similarly, in the 1978 management audit, B&W Exhibit 843, statements were made to the auditors to the effect that an audit like this is performed to have the personnel at TMI feeling that "management is concerned" only to eventually "whitewash" the report in the end. (Significantly, in the memo accompanying the 1978 audit, the auditors state that almost all findings and recommendations contained in the 1978 audit can be found in a 1975 audit).

15. Ironically, with regard to a number of issues, the BETA study stands as a virtual retraction of its once glowing report on management presented during testimony before the Licensing Board by Messrs. Wegner and Miles in February 1981. For example, in testimony addressing Board Issue 4 and 5 on Health Physics and radiation waste problems

BETA testified, "[t]he commitment to excellence in radiological controls is apparent in the management of GPU," and goes on to hail Licensee's program. (Wegner ff. Tr. 13,284 at 19 et seq.) Further, BETA gives full support to the radiological waste program, and concluding that TMI-1 is appropriately staffed with personnel qualified to process radiological waste safely. Id. at 29. Indeed, the ASLB concluded that the radiological control program was adequate and that "based on the findings of the Staff and on the BETA assessment, the Board is satisfied with licensee's radioactive waste program." PID at ¶376, 386. Yet BETA's 1983 audit finds that "[t]here are too many instances where radiological controls are not as good as they should be.. The work force has not accepted enough of the responsibility for high quality radiological work performance. Excessive generation of radioactive waste is part of these problems." Moreover, "there are far too many deficiencies, there are too many cases of loose control of radioactive contamination, there is too much radioactive waste, and the performance of radiological control personnel and of radiation workers is often poor." Also, "[t]he old negative attitude of operations and maintenance personnel being against radiological controls has been stamped out, but has not yet been replaced with the needed positive attitude. PP. 26-28. BETA now makes a number of recommendations to attempt to correct the situtation. But based on BETA's 1981 testimony, one would have reasonably assumed that such

blatant problems had already been corrected. And the question remains why BETA presented such misleading 1981 testimony on which the ASLB directly relied. Clearly, these questions need to be explored thoroughly by this Board.

16. There are a number of other examples where BETA's 1981 testimony seems to conflict with its current views. For example, regarding technical capability (Board Issue 11), BETA enthusiastically endorsed the situation at TMI-1 in 1981, concluding "[b]ecause of its combined size and consolidated technical strength it can provide GPU corporate management with a much more professional assessment of matters which might affect reactor safety," and, "[b]y combining the technical resources of the various GPU utilities, a larger pool of talent has been assembled which can be put at the disposal on the nuclear plants in order to resolve problems and to insure a better flow of information between the plants." (Wegner, supra, at 10, 11). Yet in 1983, BETA reveals that in its review of technical functions, "it found an orgnization struggling to get its work done with a lot of new people still trying to figure out what their jobs were. It found top management within T/F having to spend an inordinate amount of time solving day-to-day problems... It found T/F management still attempting to put in place methods of operation..." P. 64. Further, "the overall effectiveness of T/F... is lacking." P. 65. And, "the organization has not learned how to discipline itself to meet commitments with a quality

product... [I]t is BETA's opinion that very few people should be added to T/F until the present organization can demonstrate it can manage what is already there." P. 66. Also, BETA states that "[t]he training of project engineers is weak." P. 75. With regard to the T/F Chemistry programs, BETA found that "until recently, ...TMI-1 lacked competent management of their chemistry programs," and "[s]igns of jealousies, finger-ponting, turf battles, and expressions of 'that is not my job' have been all too evident...[The Chemical Engineering and System Laboratory personnel] has not provided what has been needed to solve the major chemistry problems at TMI-1... in a reasonable time."

17. Additionally, both BETA and RHR make a number of findings which, on their face, raise serious questions as to the managerial and technical capability of Licensee to safely operate a nuclear reactor. Some of these issues were considered but improperly dismissed by the ASLB. For example, the BETA report finds the following:

> -- problems such as the steam generator leak problem, the psychological stress issue, the cheating scandal, and restart requirements prevented key GPUN people from devoting their full attention to the task of making the new organization work. P.7.
>
> -- while it could be argued that now, after three years, [the accident] should not still have an unsettling effect on the organization, its people, and how work is performed, this is not the case. P. 8.
>
> -- the Office of the President [should evidence] a greater sensitivity of instances where the functional orgnization breaks down. P. 21.

-- weaknesses still exist which tend to degrade the quality, quantity, and efficiency of maintenance work. P. 23.

-- the BETA interviews of site people concerning maintenance at TMI-1 had a repeating theme that: "Problems do not get solved." Engineering has not been brought into the solution of the problem. This failure to obtain engineering support is a problem in proper supervision, both in the Maintenance Department and Plant Engineering. P. 24.

-- maintenance deficiencies in the chemistry program at TMI-1 were identified two years ago. Corrections have been slow. P. 25.

-- there are at least 21 different section level groups having engineers at the TMI-1 site reporting to five different Division Directors. This leads to confusion in some cases as to which group will handle a given problem. P. 25. (These types of concerns were also raised by "whistleblower" King).

-- we frequently encountered senior people in GPUN who felt that the QA Department was not responsive to the absolute need for QA support. The opinion was expressed that the QA Department was not urgently concerned with resolving problems and clearing deficiencies...Some felt that QA was unnecessarily interfering with the accomplishment of work...[I]t was disconcerting to encounter these feelings and opinions in important people... It is important... that such feelings do exist, and they must be overcome. P. 63.

-- having 36 people to perform ["communications"] tasks is excessive... [they] are sometimes performing questionable tasks. P. 105.

-- too many senior managers want to create the impression that they are "good guys," and that their people "love" them. P. 107.

-- there is a reluctance for GPUN managers/supervisors to flag poor supervision on the part of contractors. P. 108. (This has been most recently evident in GPU's dealings with Bechtel on TMI-2 clean up operations.)

--supervisors are not sensitive to, and are not reacting to, poor working conditions at the work site. P. 108.

> -- [paper generation is not only] a constant source of complaint, but our observations indicate that it is real. (Interestingly, paperwork confusion was an issue in the 1978 audit, and one of TMIA's strongest criticisms regarding the new maintenance work request system at TMI). P. 110.
>
> -- writing a procedure seems to be the easy way to solve a problem. Then once a procedure is written, supposedly the problem is solved and the burden shifts to the person at the bottom who is supposed to follow it. P. 111.
>
> -- BETA repeatedly heard the complaint that too many decisions are made at too high a level...It was felt by those interviewed that this phenomenen originated at the level of the Office of the President. P. 112.
>
> --there appears to be a reluctance within the GPUN system to take action either to improve the performance of poor performers or to terminate their employment. P. 114. (This was also a problem recognized in the 1978 audit, particularly with regard to ineffective foremen).

18. Similarly, the RHR report, which conveys the current perception and attitude of operators on a number of safety-related issues, evidences serious management problems. Some of these problems were recognized in the BETA study, and many concern issues which were the subject of the ASLB hearing. For example, the report notes the following:

> -- regarding the GPU structure, there are multiple problems of coordination between the newly created departments.
>
> -- only 6 out of 10 consider the objective of GPU's "safety" mission to be valid.
>
> -- a slight relative majority agree that top management is more concerned about public safety than about generating electricity (including a substantial majority of Trainees). "Since this ties in with the primary objective of the corporation, there should be more concensus than there is," and "[w]hile precisely articulated by

top management, [these safety goals] are only vaguely recollectible by operators.

-- a slight majority agree that the constructive benefits made since the accident are more than offset by the cumbersome procedures and organizational structure. Most agree that they are required to do too many things on the job which are not productive.

-- a majority of operators would not put efficiency second to safety.

-- many operators feel that detailed procedural instructions are a hinderance in day-to-day operations. There is also considerable feeling that emergency procedures need to be simplified.

-- they complain of working in a paperwork jungle.

-- there is a perception among operators that their uniform was imposed by management without consulting with operators, and without sufficiently researching radiation safety aspects of the material.

-- a majority... agree that when it comes to disciplinary practices there are two standards: a tough set for operators and an easier set for top management.

-- there is strong disagreement that the concept of support departments is working out in practice. The source of the problem was credited by a majority of responding operators to both structure and management, with a little more weight to the later.... The consultants see the present structure as requiring exceptionally strong management talent to make it work. As a result, the structure may need modification.

--2/3 of the operators felt other departments didn't have the same sense of urgency as they did... the majority of operators concur that they do not get action fast enough on their problems. In the perception of 2 out of 3 operators, other departments do not have the good of the organization in mind when they go about their daily work.

-- at TMI, there was greatest dissatisfaction with Rad-Con policies and after that, equally with Training and Material Management.

-- only one in five believe that GPU Nuclear management is as concerned about its employees and organizational issues as it is about public relations and technical issues....Two out of three deny that management has committed to an accountable organization which resolves problems at the correct level. (This was a recognized problem in the 1978 audit also. The auditors suggested that weak supervisors developed from lack of accountability.) Even more disagree that management sees to it that there is cooperation between departments.

-- operators, more so at TMI, disapprove of top management's handling both of regulatory agencies and of the attacks of anti-nuclear activists.

-- they are concerned about management's design of an organizational structure which creates multiple problems of coordination and lack of management effort in bringing about coordination within this structure. They keep saying "there is no one in charge"...Some are scandalized by what they consider waste of money and wrong priorities on spending. (These are some identical issues raised by "whistleblower" King in particular). They cite dead wood in the management ranks and reward of managers for significant failures for which they would have been severely censured. They see a lack of a formal program of training to improve the skills of supervisors and managers.

-- 55% agreed to having adequate support (facilities, procedures, equipment, etc.) for doing their job. However, 45% disagreed and some of these strongly.

19. Perhaps the most important revelations in these two audits concern the training and testing program which was intensely scrutinized both in the main and reopened proceedings, criticized consistently by the intervenors, and fully supported by the ASLB. The RHR report, which found that training is of exceptionl importance to licensed operators, makes the following observations:

-- only 60% of those who responded agreed that the content of the last exams was job relevant and only 1/3 agreed that the oral portion of the exam tested how one would act in an emergency.

> -- most considered the training department is not oriented to the needs of the operators.
>
> -- there is strong agreement that there is not enough training on plant conditions.
>
> -- operators complained of a lack of convergence between training, testing, and ability to operate the plant. 3 out of 4 denied that training prepared individuals to pass exams and is successful at this but it doesn't prepare them sufficiently to operate. To compound this, what is taught in training is different from what they experience in the plant.

BETA makes the following observation:

> -- inefficiencies in the TMI training program are brought about due to the lack of a realistic schedule. P. 56.
>
> -- too much emphasis is being placed on proving to the world that the training program is good and not enough on doing what should be done to produce a competent operator. P. 57.
>
> -- there exists a lack of supervision of instructors in the TMI Training Department. It would seem that this finding should be unnecessary considering the seniority and experience level of the training staff...[B]ased on the observations made, there should be concern over classroom performance. P. 58.
>
> -- more attention is being paid to the "trappings" of training rather than to a concerted effort on obtaining an effective end product. P. 59.

These findings conflict directly with the conclusions of the managment PIDs, and warrant full examination by this Board.

For all of the foregoing reasons, TMIA hereby demands that the record of these proceedings be reopened to remedy deficiencies in the current record on management

incompetence and integrity issues, and to provide the parties with the right to examine highly relevant material evidence in the context of a full adjudicatory hearing.

Respectfully submitted,

By: Joanne Doroshow

Louise Bradford
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May 23, 1983

Three Mile Island Alert