

SHAW, PITTMAN, POTTS & TROWBRIDGE

A PARTNERSHIP OF PROFESSIONAL CORPORATIONS

1800 M STREET, N. W.
WASHINGTON, D. C. 20036

(202) 822-1000

TELECOPIER

(202) 822-1099 & 822-1199

RAPIFAX 100

(202) 822-1072

TELEX

89-2693 (SHAWLAW WSH)

CABLE "SHAWLAW"

JOHN F. DEALY*

COUNSEL

RAMSAY D. POTTS, P.C.
STUART L. PITTMAN, P.C.
GEORGE F. TROWBRIDGE, P.C.
STEPHEN D. POTTS, P.C.
GERALD CHARNOFF, P.C.
PHILLIP D. BOSTWICK, P.C.
R. TIMOTHY HANLON, P.C.
GEORGE M. ROGERS, JR., P.C.
FRED A. LITTLE, P.C.
JOHN B. RHINELANDER, P.C.
BRUCE W. CHURCHILL, P.C.
LESLIE A. NICHOLSON, JR., P.C.
MARTIN D. KRALL, P.C.
RICHARD J. KENDALL, P.C.
JAY E. SILBERG, P.C.
BARBARA M. ROSSOTTI, P.C.
GEORGE V. ALLEN, JR., P.C.
FRED DRASNER, P.C.
R. KENLY WEBSTER, P.C.
NATHANIEL P. BREED, JR., P.C.
MARK AUGENBLICK, P.C.
ERNEST L. BLAKE, JR., P.C.
CARLETON S. JONES, P.C.
THOMAS A. BAXTER, P.C.
JAMES M. BURGER, P.C.

SHELDON J. WEISEL, P.C.
JOHN A. McCULLOUGH, P.C.
J. PATRICK HICKEY, P.C.
J. THOMAS LENHART, P.C.
STEVEN L. MELTZER, P.C.
DEAN D. AULICK, P.C.
JOHN ENGEL, P.C.
CHARLES B. TEMKIN, P.C.
STEPHEN B. MUTTLER, P.C.
WINTHROP N. BROWN, P.C.
JAMES B. HAMLIN, P.C.
RANDAL B. KELL, P.C.
ROBERT E. ZAHLER, P.C.
ROBERT S. ROBBINS, P.C.
STEVEN M. LUCAS, P.C.
DAVID M. RUBENSTEIN, P.C.
RICHARD E. GALEN
LYNN WHITTLESEY WILSON
MATIAS F. TRAVIESO DIAZ
VICTORIA J. PERKINS
JOHN H. O'NEILL, JR.
JAY A. EPSTEIN
RAND L. ALLEN
ELISABETH M. PENDLETON
HARRY H. GLASSPIEGEL

JEFFERY L. YABLON
JACK MCKAY
THOMAS H. MCCORMICK
JOHN L. CARR, JR.
PHILIP J. HARVEY
ROBERT M. GORDON
BARBARA J. MORGAN
BONNIE S. GOTTLIES
HOWARD H. SHAFFERMAN
DEBORAH B. SAUSER
SCOTT A. ANENBERG
CAMPBELL KILLEFER
PAUL M. THOMAS
SETH H. HOGASIAN
SHEILA MCC. HARVEY
DELISSA A. RIDGWAY
KENNETH J. HAUTMAN
DAVID LAWRENCE MILLER
FREDERICK L. KLEIN
STEVEN P. PITLER*
RICHARD J. PARRINO
ELLEN A. FREDEL*
HANNAH E. M. LIEBERMAN
SANDRA E. FOLSOM
JUDITH A. SANDLER

EDWARD D. YOUNG, III
ANDREW D. ELLIS
RICHARD A. SAMP
THOMAS E. CROCKER, JR.
WENDELIN A. WHITE
STANLEY M. BARG
LESLIE K. SMITH
VIRGINIA S. RUTLEDGE
KATHERINE P. CHEEK
JANICE LEHRER-STEIN
TRAVIS T. BROWN, JR.
RICHARD H. KRONTHAL
STEPHEN B. HEIMANN
SANDRA E. BRUSCA*
EILEEN L. BROWNELL
PAMELA H. ANDERSON
ALEXANDER D. TOMASZCZUK
PHILIP D. PORTER
MICHAEL A. SWIGER
ELLEN SHERIFF
ANITA J. FINKELSTEIN
EILEEN M. GLEIMER
DAVID R. SAHR
C. BOWDOIN TRAIN
* NOT ADMITTED IN D.C.

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WRITER'S DIRECT DIAL NUMBER

(202) 822-1084

Administrative Judges
Gary J. Edles, Chairman
John H. Buck
Christine N. Kohl
Atomic Safety and Licensing
Appeal Board
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

IN THE MATTER OF
METROPOLITAN EDISON COMPANY
(Three Mile Island Nuclear Station, Unit 2)
Docket No. 50-320 259 Restart

Dear Chairman Edles and Judges Buck and Kohl:

Please find enclosed a copy of a recent GPU Nuclear Corporation News Release and accompanying letter report to GPU Nuclear from an independent investigator, concerning a report recently issued by the NRC's Office of Investigations, entitled "Three Mile Island Nuclear Generating Station, Unit 2 Allegations Regarding Modifications, Quality Assurance Procedures and Use of Polar Crane."

Respectfully submitted,

Ernest L. Blake, Jr.

Ernest L. Blake, Jr.
Counsel for Licensee

8310030403 830929
PDR ADDCK 05000289
G PDR

cc: Attached Service List

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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 SP
)	
(Three Mile Island Nuclear)	(Restart)
Station, Unit No. 1))	

SERVICE LIST

Administrative Judge
Gary J. Edles, Chairman
Atomic Safety & Licensing
Appeal Board
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Administrative Judge
John H. Buck
Atomic Safety & Licensing
Appeal Board
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Administrative Judge
Christine N. Kohl
Atomic Safety & Licensing
Appeal Board
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Jack R. Goldberg, Esquire (4)
Office of the Executive
Legal Director
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Docketing & Service Section (3)
Office of the Secretary
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Administrative Judge
Ivan W. Smith, Chairman
Atomic Safety & Licensing Board
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Administrative Judge
Walter H. Jordan
Atomic Safety & Licensing Board
881 West Outer Drive
Oak Ridge, TN 37830

Administrative Judge
Linda W. Little
Atomic Safety & Licensing Board
5000 Hermitage Drive
Raleigh, NC 27612

Atomic Safety & Licensing
Board Panel
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Atomic Safety & Licensing
Appeal Board Panel
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Douglas R. Blazey, Esquire
Chief Counsel
Department of Environmental
Resources
514 Executive House
P. O. Box 2357
Harrisburg, PA 17120

John A. Levin, Esquire
Assistant Counsel
Pennsylvania Public Utility
Commission
Post Office Box 3265
Harrisburg, PA 17120

Mr. Henry D. Hukill
Vice President
GPU Nuclear Corporation
Post Office Box 480
Middletown, PA 17057

Michael F. McBride, Esquire
LeBouef, Lamb, Leiby & MacRae
1333 New Hampshire Avenue, N.W.
Suite 1100
Washington, D.C. 20036

Ms. Louise Bradford
TMI ALERT
1011 Green Street
Harrisburg, PA 17102

Mr. Norman Aamodt
R. D. 5
Coatesville, PA 19320

John Clewett, Esquire
The Christic Institute
1324 North Capitol Street
Washington, D.C. 20002

Michael W. Maupin, Esquire
Hunton & Williams
707 East Main Street
Post Office Box 1535
Richmond, VA 23212

Ms. Gail Phelps
ANGRY/TMI PIRC
1037 Maclay Street
Harrisburg, PA 17103

Jordan D. Cunningham, Esquire
Fox, Farr & Cunningham
2320 North Second Street
Harrisburg, PA 17110

Ellyn R. Weiss, Esquire (1)
William S. Jordan, III, Esquire (1)
Harmon & Weiss
1725 Eye Street, N.W., Suite 506
Washington, D.C. 20006

Mr. Steven C. Sholly
Union of Concerned Scientists
1346 Connecticut Avenue, N.W.
Dupont Circle Bldg., Suite 1101
Washington, D.C. 20036

Chauncey Kepford
Judith H. Johnsrud
Environmental Coalition on
Nuclear Power
433 Orlando Avenue
State College, PA 16801

David E. Cole, Esquire
Smith & Smith, P.C.
2931 Front Street
Harrisburg, PA 17110

Administrative Judge
Gary L. Milhollin
Atomic Safety & Licensing Board
1815 Jefferson Street
Madison, Wisconsin 53711

**Three Mile Island
Nuclear Station**

Post Office Box 480
Middletown, PA 17057
717 948-8197

For Further Information

Contact: Douglas Bedell
Gordon Tomb

For Release: Immediately

News Release

GPU Nuclear

Public Information Services

Date: September 23, 1983
#126-83N

GPU NUCLEAR RESPONSE ON TMI-2 CLEANUP ALLEGATIONS

Middletown, PA -- The report by the Nuclear Regulatory Commission's Office of Investigations relating to allegations that safety requirements were ignored at Three Mile Island's Unit 2 is "misleading to the public and lacks any perspective as to what the adequacy of controls for the TMI-2 cleanup is all about," GPU Nuclear Corporation President Robert C. Arnold said today.

"We are convinced that the NRC's Office of Investigations report, which deals principally with procedural issues, fails to identify the extent to which procedural deviations were related to the changes being instituted in the organization so that it could better cope with unprecedented problems. Further, the report does not make clear that these deviations were, in fact, of no direct safety consequence," Arnold said.

"The investigators took a very narrow approach in their interpretation of the regulatory requirements. They arrived at judgments and conclusions which, we believe, are not supportable by the technical facts or reasonable interpretations of regulatory requirements and guidance," he said.

"From our own investigation and from analysis of the NRC report, we are convinced that:

- The physical work has been done safely. There have been no allegations to the contrary.
- A small fraction of the refurbishment activities on the polar crane that were carried out under Bechtel administrative procedures

did not conform in some respects with the GPUNC administrative controls. These were controlled adequately to assure safety. Corrective action to prevent recurrence of such deviations has been taken.

- There was no effort to 'circumvent' quality assurance. Indeed, the quality assurance program was effective in identifying problems that did exist and led to corrective action initiated by the company.
- There was an honest effort to proceed in a safe, efficient and timely fashion with high regard for the need to protect the public health and safety.
- There was no collusion between the Company and the NRC.

"We believe," Arnold stated, "that none of the public allegations about lack of safety at TMI-2 or harassment of people who voiced concerns about safety have any merit. Further, while it is not directly addressed in the NRC report, there was no 'mystery man' who secretly turned off high pressure injection pumps the morning of the accident. This issue was raised in the original allegations.

"The manner in which the report overlooks the very deliberate and effective procedural improvements that were achieved in conjunction with an extensive and fundamental restructuring of the organization in 1982 and 1983 detracts from the merit of the report and unfairly mischaracterizes the Company commitment to a safe and early cleanup," Arnold said.

"Several of the findings set forth in the report represent differences in judgment between the investigators and the Company as to what the requirements were," Arnold said. "In those instances where the report asserts the Company did not correct identified shortcomings, the Company's interpretations of the requirements disagree with the investigators' underlying interpretations.

(more)

"The TMI-2 cleanup is a totally unprecedented task undertaken by competent and dedicated individuals who regard their work with a high sense of responsibility. As the NRC staff reviews this document, we hope they will provide a more balanced interpretation of the NRC requirements and guidelines. To fail in that regard is to cause further confusion for the public about a report which is already misleading."

Enclosed with this statement is a letter to Arnold from Edwin H. Stier, an outside investigator who GPU Nuclear asked to investigate the original allegations last March of safety violations in the TMI-2 cleanup by Lawrence P. King, Richard D. Parks and Edwin H. Gischel. Stier, who has spent 17 years as a state and federal prosecutor, most recently was Director of the New Jersey Division of Criminal Justice. He is now in private practice.

Stier's investigation began March 28, 1983. Since then, he and his nine-member staff have received statements from 80 individuals and reviewed more than 1,000 documents. He is preparing a full report that will be submitted to GPU Nuclear and the Nuclear Regulatory Commission.

Arnold said the Company will be describing the refurbishment of the polar crane at an NRC meeting to be held Tuesday, September 27, in Middletown, and at a meeting of the Advisory Panel for the Decontamination of Three Mile Island, Unit 2, to be held Wednesday, September 28, in Harrisburg, and urged the public to attend.

"I ask all who have a concern about these matters to attend one of these meetings to hear the facts firsthand," Arnold said.

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KIRSTEN, FRIEDMAN & CHERIN

A PROFESSIONAL CORPORATION
COUNSELLORS AT LAW

17 ACADEMY STREET

NEWARK, N. J. 07102

(201) 623-3600

JOSEPH HARRISON (1930-1976)
OF COUNSEL

September 23, 1983

MILTON LOWENSTEIN
OF COUNSEL

RICHARD E. CHERIN*
HAROLD FRIEDMAN
JACK B. KIRSTEN*
PHILLIP LEWIS PALEY*
EDWIN H. STIER
DENNIS C. LINKEN

EDWARD S. LEVY
MARGARET E. ZALESKI
GERARD K. FRECH*
STEVEN PASTERNAK*
JOHN K. ENRIGHT

*MEMBER N.J. & N.Y. BARS

Mr. Robert C. Arnold, President
GPU Nuclear Corporation
100 Interpace Parkway
Parsippany, New Jersey 07054

Subject: Allegations by TMI-2 Employees

Dear Mr. Arnold:

You have requested my comments on a report issued by the NRC, Office of Investigations (OI), entitled "Three Mile Island Nuclear Generating Station, Unit 2 Allegations Regarding Safety Related Modifications, Quality Assurance Procedures and Use of Polar Crane." The following comments are based upon the evidence we have gathered in the course of our investigation which included substantially the same subject matter covered by the OI report.

We have reached a stage in our investigation where I have sufficient information to respond to your request for comment. Our investigation began on March 28, 1983 and has continued, full-time, through the present. During the course of the investigation we will have reviewed in excess of 1,000 documents and have obtained sworn, transcribed, question-and-answer statements from approximately 80 witnesses. We have now concluded the fact-gathering phase of our work and are preparing our final report. In that report, we intend to cover the full range of issues raised by Lawrence King, Richard Parks and Edwin Gischel, the TMI-2 employees whose public allegations precipitated the investigation by the NRC as well as our own. Although we have not yet completed writing the final report, we have reached conclusions concerning the validity and implications of the allegations that have been made. These conclusions have been reached by an analytical process independent of GPU Nuclear Corporation (GPUN) management.

The NRC investigation described in the OI report is far narrower in scope than the investigation that we have conducted. OI focused heavily on one set of issues relating to compliance with administrative procedures. It is unclear why they did not address issues, such as whether activities at TMI-2

have in any way endangered public health or safety. They did not evaluate the effectiveness of the safety review system, and the extent of management's concern for the protection of public safety. In my view, it is not possible to assess the seriousness of procedural errors unless these related safety issues are analyzed as well.

From the limited scope and depth of the OI report, very sweeping conclusions have been drawn by the investigators which were probably not intended to be as categorical as the language of the report suggests. In his cover memorandum to NRC Chairman Palladino, Mr. Hayes, Director of the Office of Investigations, states without qualification "the allegations were not only substantiated, but we found them to be illustrative rather than exhaustive." Presumably this statement intended to cover only a narrow category of allegations.

It is clear from our investigation (and should have been evident to OI) that many of the allegations made by Parks, King and Gischel are contradicted by the overwhelming weight of the evidence. For example, all three allege that TMI-2 management intentionally withheld information from the Site Operations Department about the polar crane load test Safety Evaluation Report (SER) to minimize the time available for them to review and criticize the SER. The testimony and documentation clearly demonstrate that Site Operations had received the necessary information and had the opportunity to comment sufficiently in advance of their review of the final revision of the SER. Parks suggests that a critical document had not been reviewed or approved by Site Operations or the NRC. In fact the document had been reviewed and approved by both and bears the signatures of Site Operations and NRC personnel. Numerous other examples have been found where witnesses who allegedly possessed evidence supporting the allegations have contradicted them.

The obvious danger in overgeneralizing about the validity of the allegations is the confusion it engenders. As important as administrative procedural compliance may be, it would be unfortunate if one were to infer solely from the verification of an allegation of procedural noncompliance, that a related safety allegation might also be true. We have found that the allegations must be very carefully sorted and separately investigated and analyzed to account for the half-truths and distortions inherent in many of them.

Even within the narrow framework of procedural compliance, the OI report provides no means of assessing the significance of its findings. A procedural violation may be serious or inconsequential depending upon its cause and its public health and safety consequences. In measuring the significance of a

procedural violation some reasonable criteria must be applied beyond word for word compliance. For example, the OI report does not apply the following criteria:

- Has the physical safety of the general public or site personnel been jeopardized to any degree?
- Has the work activity been subjected to the scrutiny of the safety review groups which constitute the checks and balances system designed by GPUN management to identify and correct potential safety problems?
- Has the GPUN Quality Assurance Department (QA) identified and resolved procedural deficiencies in the ordinary course of its work?

Additionally, during the time period covered in the OI report, TMI-2 was undergoing a fundamental restructuring of its management. The objectives and the effectiveness of that reorganization must be examined in depth and understood in order to judge whether procedural noncompliance was endemic to TMI-2 or transitory. The OI report makes only passing reference to the fact that the reorganization has been taking place. It does not analyze the actions taken by the Director of TMI-2 to resolve the very problems that the report describes.

Without discussing each issue considered in the OI report, I will offer some comments based upon the above criteria. Our investigation has found no evidence that any work performed on the polar crane created a safety hazard for the public or for site personnel. None of the information contained in the OI report or in any other source leads to a contrary conclusion. As our investigation report will describe, the engineering judgments made in the course of refurbishing the polar crane, and, in connection with other activities which were the subject of allegations, met reasonable standards and were based upon appropriate consideration for public health and safety. For example, it was alleged that, in addition to procedural violations relating to the proposed load testing of the polar crane, calculations were not performed to determine the consequences of dropping the test load. We have confirmed that, in fact, such calculations had been done. Similarly, we have investigated many other safety allegations that have been found to be without merit.

The OI report fails to consider the extent to which alleged procedurally deficient activities were nevertheless subjected to the GPUN safety review system. This deficiency may leave an uninformed reader with the mistaken

impression that a procedure may have been intentionally violated to circumvent the safety review system. One example is the OI report's discussion of the polar crane No Load Test. The OI report concludes that the test violated site test procedures because it was not reviewed by the Test Working Group (TWG). Seven other specific violations of the test procedures are set forth in the report, including such findings as "failure to include the RBPC (Reactor Building Polar Crane) No Load Test in the Master Test Index."

What the OI report neglects to mention is that prior to the No Load Test being conducted, it was categorized as "Important to Safety" thereby subjecting it to the highest level of safety review. The test procedure was reviewed by the Plant Operations Review Committee, QA, NRC and the Site Operations Department, where it was approved by King. The performance of the test was witnessed by representatives of Quality Control. The chairman of TWG was satisfied with the test plan prior to its performance, and reviewed the test results, determining that they were satisfactory. Finally, notwithstanding its prior approval of the test, QA subsequently issued a quality deficiency report noting "the administrative program controls for testing were not followed." However, QA went on to find, "the test results were technically adequate." Unless the reader of the OI report has all of the information concerning the performance of the No Load Test including the details of the review process to which it was subjected, the procedural violation may take on exaggerated proportions.

In addition to procedural violations that had been identified, investigated and resolved by QA, OI investigators assert several other violations based upon their interpretation of GPUN procedures. Varying interpretations of procedures are understandable. Site administrative procedures are highly complex and often ambiguous. Their construction must be tempered with logic and recognition of their intended function. Procedural uncertainties should not be resolved simply on a literal interpretation of the procedures themselves. The OI report does not identify such ambiguities nor does it fully explain the reasoning process which led to the GPUN interpretation which the report criticizes.

An illustration of this problem is the discussion in the OI report of the use of the GPUN maintenance procedure to authorize the refurbishment of the polar crane. The conclusion of the OI report is that it "was the incorrect procedure to use. . ." This conclusion is significant. It calls into question the procedural validity of all of the refurbishment work on the polar crane.

Our investigation has carefully traced the process by which the refurbishment work was initiated. By reviewing the maintenance procedure with the individual who wrote its relevant provisions, we have determined the basis for its use for the refurbishment of the polar crane. He identified specific language in the procedure which authorizes its use for such purposes. However, even if the OI investigators are ultimately correct in their interpretation of the maintenance procedure, the absence of a clear articulation of GPUN's rationale suggests that the procedure might have been used in bad faith. In fact, there was a reasonable, logical basis for the procedural approach taken by GPUN, but the reader of the OI report has no way of knowing that.

It is highly significant that the procedural deficiencies that constitute the primary subject matter of the OI report occurred at a time when TMI-2 was undergoing a major reorganization. Its objectives included the establishment of uniform, practical procedures and measures to assure procedural compliance. Shortly after the reorganization became effective, a new procedural system was initiated. Training has taken place and the effort is ongoing.

When the issue of procedural compliance was raised internally, the new TMI-2 Director took immediate action to investigate the matter and assure that future activities complied strictly with site procedures. Through his effort, uncertainty about the applicability of Bechtel administrative procedures to recovery work has been resolved.

To evaluate the response of TMI-2 management to procedural deficiencies, it is necessary to understand that completion of the reorganization has taken many months. Reorganization has progressed slowly, with apparent inconsistencies between the organizational structure and Technical Specifications. The OI report comments upon this. However, it does not consider that new Technical Specifications intended to complete the reorganization process have been awaiting NRC approval for 10 months.

In analyzing the issue of misclassification of activities, the OI report makes no reference to the Quality Classification List (QCL). The QCL should identify the proper safety classification for all plant systems. It was correctly alleged by King that misclassification of activities had resulted in large measure from an outdated QCL. Neither this nor any other underlying cause for misclassification was explored by the OI report. The impression created is that the safety classification system was intentionally circumvented.

On the basis of numerous interviews, we have identified fundamental differences in engineering judgment which have existed for some time in different parts of the TMI-2 organization. Certain groups tend to rely totally on the literal contents of the QCL. If a system is listed as "Important to Safety," any related activity is so classified despite the absence of any safety implications. Other groups in determining safety classification emphasize the safety implications of the activity to be performed. These differences in approach have caused disagreements in determining safety classifications. What may appear on the surface to be an intentional misclassification may, in fact, be legitimate difference of opinion by responsible engineers.

The TMI-2 Director has attempted to solve this problem by updating the QCL so that obsolete systems are reclassified "Not Important to Safety" and new recovery systems are properly classified according to their current functions. The OI report makes no assessment of the potential impact of this effort on the safety classification process.

Therefore, the conclusions reached in the OI report concerning the response of management to procedural deficiencies are based upon events which occurred during the most difficult period of the reorganization. The report fails to take into account either the objectives or accomplishments of the new TMI-2 management.

A further finding of the OI report deserves some comment since it suggests an improper relationship exists between GPUN and NRC representatives at the site. The OI report, however, does not consider the stated objectives of the NRC in establishing a unique regulatory relationship with TMI-2 after the accident. Our investigation has found that practices exist whereby NRC personnel attend GPUN meetings, GPUN transmits draft documents to the NRC for information purposes and the NRC staff informally communicates its concerns to GPUN. However, this communication is apparently based upon an expressed NRC policy to "oversee day-to-day licensee activities."

The OI report states that the investigation of allegations of harassment and intimidation of TMI-2 employees and the so-called "mystery man" remain open and will be the subject of future reports. Our investigation has been concluded in those areas and will be documented in our final report.

In previous communications to you we have indicated that the sworn statements of witnesses identified by Parks have refuted his "mystery man" allegations. Additionally, a recent Babcock and Wilcox analysis of system responses indicates that there could have been no "mystery man" at the time of the accident as suggested in the Parks affidavit.

Mr. Robert C. Arnold, President
September 23, 1983
Page 7

Our investigation of the harassment and intimidation allegations was extensive. However, it did not encompass allegations that Parks had been subjected to harassment by Bechtel which was the subject matter of litigation between Parks and Bechtel. With respect to King, Gischel and Joyce Wenger, King's secretary, we have determined that none of them had been subjected to harassment as they alleged.

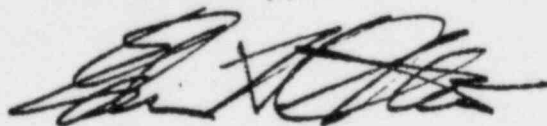
King's employment was terminated based on a conflict of interest. While employed as the Site Operations Director, he was an owner of and operated a consulting firm which recruited GPUN employees. Our investigation traced the origin of the information which led to King's termination as well as the internal GPUN investigation of that information. The judgment to terminate King's employment was based upon factors independent of any safety or management concerns raised by him.

Gischel claimed that as a result of expressing concerns about the testing of the polar crane, GPUN pressured him to take a neuro-psychological examination. Our investigation has determined that the decision to urge Gischel to take the examination was made independent of and without the knowledge of GPUN management by a psychological counselling service under contract to GPUN from which Gischel voluntarily sought help. Approximately a month after Gischel had expressed his concerns about testing the polar crane to management, a psychologist from that service requested GPUN to assist it in convincing Gischel to be examined. The psychologist felt that the test was necessary to diagnose fully the after-effects of a stroke which Gischel had suffered. Failure to take the test would leave a serious question about Gischel's ability to perform in his employment. There was no connection between efforts to convince him to be examined and his expressed views on the testing of the polar crane.

Joyce Wenger's allegations of fabricated evidence to justify her termination have been thoroughly examined and found to be without basis. All of the individuals involved in the incidents which led to her termination have been interviewed and refute her claims.

Unfortunately, the allegations which have been made, and the work being performed at TMI-2, are so complex and highly technical that it is difficult to summarize them in a way which is not over-generalized. The OI report seems to suffer from a quite natural desire on the part of the investigators to cut through a great deal of detail and reach the heart of the matter. In attempting to do so, however, balance and perspective have been jeopardized.

Sincerely,



Edwin H. Stier

EHS:lhv

KIRSTEN, FRIEDMAN & CHERIN