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July 26, 1984

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

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

LICENSEE'S COMMENTS IN RESPONSE TO COMMISSION ORDER OF JUNE 1, 1984

By Order, dated June 1, 1984, the Commission requested the parties to comment on whether, in view of ALAB-772 and all other relevant information, including investigation reports by the Office of Investigations, the management concerns which led to making the 1979 TMI-I shutdown orders immediately effective have been sufficiently resolved so that the Commission should lift the immediate effectiveness of those orders prior to completion of review of any appeals from ALAB-772.1/ Licensee herewith provides its comments which address: (1) the question

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1/ The June 1 Order set June 15, 1984, as the deadline for comments from the parties other than the Staff. By Order of June 12, 1984, that deadline was extended to July 6, 1984; by order of July 5, 1984, the deadline was further extended to July 26, 1984.

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whether to proceed with an immediate effectiveness decision without awaiting the results of the merits review; (2) the results of recent OI investigative reports; and (3) other relevant information recently available to the Commission which may bear on a decision to restart TMI-1.

Immediate Effectiveness

The legal question whether the Commission should proceed with its immediate effectiveness decision without awaiting the outcome of the merits review2/ is not a new question. The standards governing the Commission's decision of immediate effectiveness were established by the Commission in its Order and Notice of Hearing which started this proceeding five years ago. In pertinent part that Order provided:

> The Commission shall issue an order lifting immediate effectiveness if it determines that the public health, safety or interest no longer require immediate effectiveness. The Commission's decision on that question shall not affect its direct appellate review of the merits of the Board's decision.

CLI-79-8, 10 N.R.C. 141, 149 (1979); see also CLI-81-19, 14 N.R.C. 304, 305-6, (1981).

2/ Timing of completion of the merits review is in doubt. The Licensing Board decisions related to management are favorable to restart. The Appeal Board in ALAB-772 has ordered the hearing reopened and remanded to the Licensing Board to consider three subjects. Licensee has sought a stay of the remand and has petitioned for review of ALAB-772. Meanwhile, the Licensing Board has set a hearing schedule which would lead to a decision on the remanded issues no earlier than the spring of 1985.

To alter that approach now and decide to await the completion of the merits review before acting on immediate effectiveness would be totally contrary to the Commission's initial commitment to decide restart within 35 days after the Licensing Board's decisions. It also would be inconsistent with the Commission's recognition of its responsibility and obligation to lift the immediately effective suspension of TMI-1's operating authority once the bases for suspension have been removed or rectified. Licensee and the Staff in pleadings over the past five years, including most recently Licensee's Comments on ALAB-772 filed with the Commission on May 29, 1984, have maintained that the Commission is legally obligated under those circumstances promptly to lift the extraordinary suspension it imposed without prior hearing in 1979. Licensee has pointed out several times that the Commission had sufficient information available to it to lift the immediate effectiveness of the shutdown orders. Further, Licensee has argued that the Commission is not confined to the adjudicatory hearing record in making this decision -- again, most recently in its May 29, 1984 Comments.3/

3/ As early as October of 1981, in addressing immediate effectiveness the Commission opted to hear directly from Licensee management rather than relying exclusively on the adjudicatory record. See Transcript of Oral Argument on Immediate Effectiveness, October 14, 1981. There are many examples since then of the Commission considering relevant information outside the formal adjudicatory record.

We will not repeat here the legal bases previously cited for our position (see, e.g., Licensee's Comments on ALAB-772 (Management Phase), May 29, 1984, n. 1, 2), except to observe that the distinction in this restart proceeding between the merits review and lifting the suspension has been recognized explicitly by the Court of Appeals for the District of Columbia Circuit in the recent so-called Philadelphia Inquirer case.4/

In short the Commission has both the right and the responsibility to promptly lift the suspension of Licensee's authority to operate TMI-1. To await the results of the merits review5/ of this proceeding before deciding immediate

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4/ The court in Philadelphia Newspapers, Inc. v. Nuclear Regulatory Commission, 727 F.2d 1195 (D.C. Cir. 1984) thoroughly examined the procedural posture of the proceedings relating to TMI-1. The court found that that the TMI-1 proceedings in fact involve four different proceedings which "the Commission has been careful to conduct separately," 727 F.2d at 1197. Among these different proceedings recognized by the court are the formal adjudicatory hearings before the Licensing Board (the "On-the-Record Proceeding") and the separate and distinct informal adjudication before the Commission concerning when to lift the TMI-1 suspension assuming a favorable Licensing Board decision (the "interim restart proceeding"). 727 F.2d at 1197-99.

5/ Similarly, to await the results of the Staff's certification of every item, or a final physical readiness report, or the results of the steam generator amendment proceeding, or the myriad of other factors which potentially could affect TMI-1's actual operation, would be unjust. The Commission's obligation is to decide immediate effectiveness promptly, i.e., just as soon as it has information sufficient to address the concerns which led to the 1979 shutdown. The Commission is not obligated -- indeed, it is not legally entitled -- to await the elimination of every potential roadblock to actual startup, be

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effectiveness would be inconsistent with a course the Commission has set for five years. It also would be patently unjust and violative of Licensee's rights to an expeditious proceeding to consider the extraordinary action taken by the Commission in 1979.

Recent OI Reports

The Office of Investigations (OI) has released over the past few months a number of investigative reports related to TMI. These reports address: (1) possible harassment of individuals at TMI-2 for raising safety concerns (H-83-002); (2) timeliness of Licensee's provision of BETA and RHR consultant reports (1-83-013); (3) possible falsification of TMI-1 leak rate tests (1-83-028); (4) possible pre-TMI-2-accident training irregularities (Q-1-84-004); (5) possible improper influence on contractor to change report (Lucien Report) (Q-1-84-006); (6) possible improper changes in Licensee's TMI-2 accident investigation report (Keaten Report) and basis for Licensee's response to 1979 Notice of Violation (1-83-012); (7) four allegations by

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it physical problems with a steam generator or some other instant hurdle; it is rather obligated expeditiously to make an immediate effectiveness decision on restart, even if actual restart is conditioned or prohibited for some other reason. The Commission's failure to act promptly builds into actual restart what could be very time consuming and costly delays as a result of promised judicial appellate attempts to further block restart.

Harold Hartman other than his allegations involving TMI-2 leak rate testing practices;6/ (8) alleged falsification of radiation monitoring reports at TMI-2 (1-83-015); and (9) potential improper management influence on plant operators to change testimony (1-84-005).

None of these reports provides grounds for delaying further a decision to lift the suspension of TMI-1's operation. We address each of these reports seriatim. 7/

In early 1983, allegations were made by three Licensee employees and one Bechtel employee at TMI-2 that they were harassed or discriminated against for raising safety concerns. There have been two major investigations of these allegations, one by OI and one commissioned by Licensee and performed by Edwin Stier, former Director of the New Jersey Division of Criminal Justice.

After reviewing in excess of 1000 documents and obtaining sworn statements from approximately 80 witnesses, Mr. Stier

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6/ No completed OI report on Hartman's allegations regarding leak rate testing at Unit 2 has been released and possibly none has been completed. See discussion pages 16-18 infra.

7/ In addition, attached to these comments are copies of three letters from Licensee to Mr. Denton, Director, NRR, in connection with his evaluation of some of the OI reports. (Attachments 1-3.) In these letters, Licensee discusses in some detail a number of significant elements in the recent OI investigative reports, principally Report No. H-83-002. Licensee is still evaluating the remainder of the recently released OI reports and intends to provide further input to the Staff.

found that none of Licensee's employees had harassed these individuals as they alleged:

> The allegations that accuse management of following a policy of ignoring problems brought to its attention and of punishing employees who raised the issues are untrue.

Stier Report, ("TMI-2 Report: Management and Safety Allegations"), dated November 16, 1983, Volume I at 13.

The corresponding OI Report did not give Licensee management the same clean bill of health. However, it raises no question regarding any Licensee management personnel who are involved with restart and operation of TMI-1 and thus provides no bar to a restart decision.8/

The second matter investigated by OI concerns the timeliness of Licensee's provision of two consultant reports (by BETA and RHR) to NRC. OI determined:

> The investigation did not disclose any evidence of a deliberate attempt or conscious management decision by GPUN to withhold the information in the BETA and RHR reports from the NRC.

8/ The one individual whose actions were questioned by OI and who had any responsibilities for TMI-1 was the then President of GPUN, Robert Arnold. Mr. Arnold has provided his views on the OI Report to Chairman Palladino in a letter dated June 8, 1984. Since Mr. Arnold has removed himself from the management of GPU Nuclear Operations, resolution of his role, if any, in the alleged harassment -- or in any of the other issues in this proceeding -- is no longer necessary to resolution of the management integrity issues connected with the restart decision.

OI Report 1-83-013, at 4 (emphasis added). Moreover, the NRC Staff evaluated the two reports and found: "no information which raised significant safety or regulatory concern." NUREG-0680, Supp. No. 4 at 2-1 to 2-2 (Oct. 1983).

Additionally, the Appeal Board very recently had occasion to address the reportability of these two consultant reports in deciding a motion to reopen the restart proceeding to take evidence on the question. The Appeal Board stated:

> We therefore find no improper action by licensee with regard to the reporting of the BETA and RHR studies and, accordingly, no basis for reopening the record on that count.

ALAB-774 (June 19, 1984), slip op. at 15. Thus, there is no reason to further withhold authorization to restart TMI-1 based on the BETA and RHR reports.

The third area covered by recent OI reports concerns leak rate test practices at TMI-1 during a one-year period in 1978-1979. The overall conclusion of this OI investigation is favorable to Licensee, finding neither a systematic pattern of falsification9/ nor a motive to falsify the leak rate

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9/ The OI conclusion on this issue was:

> "Based on the testimony received and the documents and analysis reviewed, we have concluded that there was no systematic pattern of falsification of leak rate surveillance tests at TMI-1 during the time period

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data.10/ Leak rate test practices at TMI-1 have also been

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> in question nor can we prove that any individual operator knowingly and willfully attempted to manipulate leak rate surveillance test results. At the same time, we cannot exclude the possibility that individual operators may have attempted to manipulate test results for unknown reasons. The explanations given by the operators and licensee management, as to why the hydrogen and particularly the water additions are present during the test periods, are plausible given the numerically small number of tests actually involved and the magnitude of the responsibilities assigned to the shift operators.

Memorandum from the Director, OI, to Regional Administrator, NRC Region I, dated April 16, 1984, forwarding Investigation Report 1-83-028, page 2.

10/ OI concluded as to any motive to falsify leak rate tests:

> "Technical analysis has demonstrated that TMI-1 was an inherently 'tight' plant in terms of RCS leakage and that there was minimal difficulty experienced in obtaining acceptable leak rate test results. Additionally, the surveillance tests were performed in a conservative fashion in that while the surveillance tests were required by technical specifications to be performed every twenty-four hours, the operators routinely performed the tests every shift. As such, we have not been able to identify any motive which would cause the operators to feel they had a reason to attempt to alter leak rate test results by making unaccounted for hydrogen or water additions."

Id.

investigated by Edwin Stier at Licensee's request. In a report ("TMI-1 Reactor Coolant Inventory Balance Testing") dated June 13, 1984, which covers leak rate practices at TMI-1 since 1974, Mr. Stier concluded (at pages 9-10; footnote not in original text):

> The overwhelming weight of evidence demonstrates that TMI-1 personnel did not manipulate or otherwise improperly influence the outcome of reactor coolant inventory balance tests.
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> The leak rate test calculation at TMI-1 was essentially accurate within the limitations of available plant instrumentation. Its most significant calculation errors did not affect the accuracy of reported test results.
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> - When averaged over time, test results reflected actual reactor coolant system leakage.
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> - Individual test results varied significantly from one another and a single test could not be relied upon to give a precise measurement of unidentified leakage.
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> In September 1974, a practice of discarding and not otherwise documenting test results determined by plant personnel to be invalid was established at TMI-1.
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> - This practice was not intended to conceal actual reactor coolant system leakage.
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> - The failure to document the invalidation of test results was contrary to the intent of TMI-1 Technical Specifications and procedures.
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> The company did not create or permit a defect in makeup tank level instrumentation that provided a means to manipulate leak

rate tests.11/

- The makeup tank level transmitter was installed according to manufacturer's specifications, which called for the installation of a condensation collection point and drain valve on the low pressure line below the level of the transmitter.

- No discernible inaccuracy existed in the makeup tank level transmitter until September 1977, when water collection in the low pressure line became excessive.

- The Maintenance Department took steps to remove water from the low pressure line, but was not successful in preventing excessive accumulation.

- It is not likely that water accumulation in the low pressure line of the level transmitter had a significant effect on the evaluation of reactor coolant system leakage during any period of TMI-1 operation.

Thus, the subject of TMI-1 leak rate testing does not provide a basis for delaying a decision on restart of TMI-1.

11/ The "defect" is the absence of a drain valve which would have allowed for the removal of water that could accumulate in the low pressure line of the makeup tank transmitter. Existence of water buildup in this region ("a loop seal") could allow hydrogen additives to affect leakrate measurement. This problem was first identified by Faegre and Benson in their 1980 review of leakrate testing at TMI-2. OI stated that even after Faegre and Benson identified the problem at Unit 2, Licensee took no affirmative actions to determine whether a potential for the same problem existed at Unit 1 -- until an NRC related inspection in September 1983. OI's observation is simply wrong. As Mr. Stier's investigation bears out (pages 32-34), Licensee took steps to apply the learnings of the Faegre and Benson report to TMI-1 years before the September 1983 NRC inspection.

The fourth area which is the subject of recent OI reports relates to possible training irregularities at TMI in the period prior to the March, 1979 accident at TMI-2. The OI investigation was prompted by a 1976 memorandum written by a former supervisor of training at TMI, Mr. Tsaggaris. OI concluded:

> This investigation has not produced any information to indicate that the TSAGGARIS memorandum was in reference to actual conditions of noncompliance with any requirements of the requalification program, nor was there any testimony to indicate that the licensee willfully concealed information concerning noncompliances from the NRC. Additionally, an NRC Region I inspection performed within several months of the TSAGGARIS memorandum did not identify any instances of noncompliance which should have been reported.

OI Report No. Q-1-84-004 at 6.

The Appeal Board recently was asked to reopen the restart hearing record on the basis of this same OI report. In denying the motion to reopen, the Appeal Board found:

> It follows that [the information in the OI report] would not have likely affected the Licensing Board's decision on training -- or, for that matter, ours in ALAB-772 -- in any significant respect.

ALAB-774, slip op. at 8 (footnote omitted). Thus, pre-accident training practices discussed in this OI report do not provide a basis for withholding a restart decision.

The fifth subject of recently released OI reports relating to TMI explored whether improper influence by management or by individuals from Licensee's startup and test organization had

been exerted on a contractor whose 1980 report on pre-accident practices at TMI-2 was critical of Licensee. OI's findings were evaluated by NRR. NRR concluded that the information developed by OI concerning the contractor report did not raise questions concerning the integrity of management or the Licensee employees involved, and further determined that the individual employees have been contributors to important changes in the present startup and test program at TMI-1 which Region I characterized as exceptional. Memorandum from the Deputy Director, Division of Human Factors Safety to the Director, Office of Investigations, Region I, Field Office, dated April 24, 1984, at 4-5 (Exhibit 6 to OI Investigation Report Q-1-84-006). Thus, there is no reason to delay restart on the basis of this report.

Another recently released OI investigation report explores management involvement in changes to drafts of the Keaten Report and the basis for Licensee's 1979 response to a Notice of Violation. This OI report finds no fault with any member of Licensee's management who would be involved with restart or operation of TMI-1.12/ The OI report raises questions

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12/ Specifically, the investigation did not produce any information which would implicate Messrs. Kuhns, Clark, Hukill and Ross in any conduct which had the effect of influencing changes in the Keaten Report. While OI finds Mr. Dieckamp did influence the addition of information on the Davis-Besse precursor event, OI found the added information did not appear to be ei-

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concerning two individuals with respect to a change in the Keaten Report and with respect to the accuracy of Licensee's response in 1979 to an NRC Notice of Violation. Neither of these individuals is involved with restart of TMI-1, and there is thus no reason to withhold restart authorization on the basis of this report, even if OI's questions regarding the two GPU individuals are valid.

The seventh area addressed in recent OI submittals to the Commission is not a conventional OI report but an OI evaluation of allegations by Harold Hartman other than his allegations concerning pre-accident leak rate testing at TMI-2. The OI evaluation provided to the Commission in June, 1984, reflects no recent investigative effort by OI. Rather, it consists largely of a collection of investigative reports based on work in 1979 and 1980, with OI's "Observations" included. OI reports no conclusions.

There are four different subjects addressed by these Hartman allegations. One relates to his recollection of whether procedures for estimating critical rod position were followed appropriately during an April 1978 plant startup at

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ther inaccurate or contrary to the Keaten Task Force's conclusions. None of these individuals were found to have contributed to alleged inaccuracies in Licensee's response to the 1979 Notice of Violation.

TMI-2. OI observes that "some of the information...provides some indication that the incident occurred." Others who were involved in that startup flatly deny any knowledge of impropriety and the records alone are not sufficient to resolve the issue. We see no relationship to TMI-1 restart in any event. A second allegation concerns difficulties with surveillance tests for the emergency feedwater pumps at TMI-2. 1980 information reviewed by OI indicates there were problems with surveillance tests conducted on these pumps in 1978-1979. This issue wasn't characterized even by Hartman as involving deliberate violation or falsification of procedures. Clearly, there is no link to TMI-1 restart in any event. The third issue involved the circumstances of Hartman's resignation. OI observed that while information concerning the details of his resignation was inconsistent, if not contradictory, Hartman did not indicate that he was the subject of any intimidation or harassment. Any connection with restart is totally lacking. The fourth Hartman allegation concerns the recollection of a licensed operator that shortly before the accident at TMI-2 a shift supervisor called the system dispatcher about taking TMI-2 off-line to check out plant leakage. The shift supervisor in question (who no longer works for Licensee) denies any such call and there is no record of such a call. As in the case of the other three Hartman allegations, we see no link to restart. It is instructive particularly to note OI's view that

none of these Hartman allegations warrant any further investigative effort.

The eighth and ninth areas addressed in recent OI investigative reports concern the falsification of radiological monitoring reports by a TMI-2 employee and the potential that management improperly influenced operators to change their testimony in the GPU litigation with B&W. Neither of these reports reflects negatively on Licensee's management. The falsification of three radiological monitoring reports by the TMI-2 employee was uncovered by Licensee management, investigated and reported to the NRC. The employee was terminated as a result of Licensee's investigation and OI simply confirms Licensee's work. OI reports no evidence that Licensee management influenced or made any attempt to influence the testimony of the operators in the B&W litigation. The operators' testimony was based on their recollection of events during the accident and their review of technical data compiled and provided to the operators during the course of the litigation.

There remains just one area to Licensee's knowledge which is the subject of an OI investigative effort and is not available now to the parties. That one area concerns TMI-2 leak rate testing practices prior to the accident. Licensee took steps more than a year ago to remove any cloud over restart which might obtain due to the pendency of this issue. Thus, in Licensee's letter to Chairman Palladino of June 10, 1983, we

pointed out that no member of Met Ed's/TMI senior management is now involved with TMI. Four levels of management, the Met Ed president, vice-president, station manager, and both unit managers responsible for TMI at the time of the accident are not with the present operator, GPU Nuclear. Moreover, Licensee committed to reassign personnel such that no TMI-2 licensed operator (who therefore could have been involved in leak rate testing at TMI-2) would operate TMI-1;13/ that commitment has been fully carried out. To provide added assurance that any inappropriate attitudes or practices of the past are not carried forward to GPU Nuclear's operations, Licensee further committed to remove from any role in overview assessment, analysis or audit of TMI-1 plant activities all personnel with pre-accident involvement as Met Ed exempt employees at either TMI-1 or TMI-2; this commitment, too, has been fully implemented. Thus, today at TMI-1 there is no licensed operator, nor member of the plant's operating management all the way up to and including the president of GPU Nuclear, nor member of any overseeing or auditing group of plant activities, who is reasonably suspected to have played a role in TMI-2 pre-accident leak rate test practices. In short, as the NRC staff and the Commission itself have noted, the lack of a final

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13/ The sole potential exception is the current Supervisor of Operations at TMI-1, Mr. Ross. He has uniformly been cleared of potential involvement in any wrongdoing.

closeout of this subject by OI ought to play no role in a decision to allow restart.

ALAB-772 And Other Relevant Information

As the Commission observed in its Order of June 12, 1984, the parties previously have provided their views on immediate effectiveness "on numerous occasions." Thus, the Commission asked the parties in their instant comments to address only the effect, if any, of newly available information and ALAB-772.

Licensee has already provided its views on the effect of ALAB-772 on an immediate effectiveness decision. See Licensee's Comments on ALAB-772 (Management Phase), dated May 29, 1984. Licensee maintained in those views that ALAB-772, including its remand for additional evidence in three areas, does not justify further delay in the Commission's restart decision.14/

One important new piece of information regarding ALAB-772 does warrant particular emphasis. Clearly, the Appeal Board's concern with training, particularly the perceived need for additional input from Licensee's OARP Review Committee (training experts) since the discovery of cheating and ensuing reopened hearing, is the most significant issue the Appeal Board remanded. Shortly after ALAB-772 was issued, Licensee

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14/ In fact, Licensee disputes that a remand is justified. See note 2 supra.

reconstituted the OARP Review Committee. The Reconstituted OARP Review Committee has reviewed pertinent documents, conducted personnel interviews and made first-hand observations of training at TMI. By notice of July 3, 1984, Licensee provided to the Commission, Boards and parties a report of the findings of Licensee's Reconstitued OARP Review Committee on the concerns expressed by the Appeal Board in ALAB-772.15/ That Committee's conclusions are:

(1) The Committee is pleased at the response of GPU Nuclear Training and Education Department to the recommendations contained in the 1980 OARP Review Report. It feels that progress has been outstanding and that the GPU Nuclear Training and Education Department now ranks among the top utility programs in the United States.

(2) The commitment of resources and dedication of the training personnel is indicative of the interest and commitment of top management in the development of the training program. The confidence in the GPU Nuclear management expressed by the Committee in 1980 has been justified.

(3) The management of the training program is well qualified and the specific management hierarchy is appropriate. The diversity of background and the extensive practical

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15/ The Reconstituted OARP Review Committee Report title page bears the date June 12, 1984. Counsel is informed the title page was signed on that date by the Committee members in anticipation of filing the document by June 15. When the Commission extended the comment period on ALAB-772 by its Order of June 12, the Committee decided to take more time to complete its report. The report as finalized was provided by letter dated June 28, 1984, and received by Mr. Clark, President of GPUN, on July 2, 1984. Additional copies were made and delivered by messenger to counsel on July 3 for prompt service on the Commission, Boards and parties.

operational experience of the training personnel are commendable.

(4) The instructor development program is appropriate and should prove to be effective.

(5) The examination development, control, and security procedures are more extensive than any that the Committee has seen in industry or academia.

(6) The commitment to the use of task analysis as a basis for the establishment of learning objectives in the development of course and examination content is an example of the extra effort being committed to relate training to on the job performance and to increase the safety of plant operations.

(7) The management of the training program recognizes its responsibility associated with the cheating incident. They have taken specific steps to correct this situation and are dedicated to assuring that it never happens again.

(8) The redesign of the Control Room shows that GPU Nuclear management is determined to provide a well-human engineered control room to complement the training program.

(9) The development and procurement of the Basic Principles Trainer Simulator and the securing of a replica simulator are further evidence of GPU Nuclear management's commitment to excellence in the training program.

(10) The "bottom line" as far as the Committee is concerned is that the GPU Nuclear training program produces qualified operators and is adequate to support the restart of TMI-1.

Special report of the OARP Reconstituted Review Committee (June 12, 1984), at 82-83.

In addition to ALAB-772, there are several other recent developments that may warrant Commission attention. Included in Licensee's discussion below are the indictment of a former employee, the current status of plant readiness for operations, including the area of emergency preparedness, and the Commonwealth of Pennsylvania's interim comments on the June 1 Commission Order. In Licensee's view, none of these developments constitutes any basis for delaying a restart decision.

On June 19, 1984, Licensee gave notice that a federal grand jury had indicted a former Supervisor of Operations at TMI-2. In our Notice to the Commission, we pointed out that this individual is not employed by GPU or any of its subsidiaries and, even when he was employed in the GPU System, he played no role in TMI-1 restart activities.

On July 5, 1984, we responded to a Licensing Board request for a status report on the physical readiness of TMI-1 to operate. We informed the Board that TMI-1 was ready then to operate and could be restarted any time shortly after receiving authorization, allowing about ten days for final operational readiness activities. On July 18, 1984, we updated that report to say that TMI-1 would be ready to operate in August.

On June 25, 1984, the Executive Director for Operations, Mr. William J. Dircks, forwarded to the Commissioners a memorandum on "Emergency Preparedness Deficiencies for TMI-1." At pages 7 and 8 of the Dircks Memorandum the Staff summarizes its

views on the handling of remaining emergency preparedness issues in the TMI-1 Restart proceeding. As Licensee understands the Staff position, it is:

(1) The communication aspects of the FEMA Category A deficiencies need to be resolved prior to restart;

(2) The remaining FEMA Category A deficiencies should be handled separate from the restart proceeding;

(3) The recent D.C. Circuit decision on emergency planning (UCS v. NRC) does not affect the restart of TMI-1; and

(4) But for Staff certification relating to the communication aspects of the FEMA Category A deficiencies, the emergency preparedness part of the TMI-1 Restart proceeding has been concluded.

Licensee generally agrees with these conclusions. In particular, the last three Staff conclusions correctly analyze the relevant TMI-1 restart concerns. As to the first Staff conclusion, Licensee believes that, since TMI-1 is by Commission order to be treated like any other operating plant, the noted communications deficiencies also should be resolved outside the restart proceeding. However, the Commissioners need not reach that issue, since drill activities at TMI during June and July, 1984 adequately responded to the communication issues identified in the FEMA Category A deficiencies.

Attached (Attachment 4) is a July 25, 1984 letter from Licensee (H.D. Hukill) to the Staff (J.F. Stolz) describing those emergency preparedness drill activities. As indicated in

the letter, on June 18 and July 17, 1984, communications drills were run with the counties surrounding TMI. Those drills successfully demonstrated the ability of the counties to receive, record and transmit emergency declaration notices and protective action recommendations under simulated emergency conditions. This is sufficient for the Commission to favorably resolve all outstanding restart-related emergency preparedness issues.

Finally, we take this opportunity to react to the Commonwealth of Pennsylvania's initial comments of June 15 in response to the Commission's June 1 Order. Those comments relate to the impacts of Unit 2 decontamination efforts on the safe operation of Unit 1. The Commonwealth identifies two specific issues which it asserts need to be resolved prior to restart (at p. 4):

> (1) the safety impacts to Unit 1 from the damaged Unit 2 reactor, and
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> (2) the financial impacts arising from the asserted failure to secure total funding for the Unit 2 decontamination effort.

Both issues identified by the Commonwealth previously have been addressed in this proceeding, one through litigation before the Licensing Board (issue 1) and the other through Commission Order with the support of the Commonwealth (issue 2). Licensee is thus at a total loss to understand the basis on which the Commonwealth seeks to have these issues reinjected into the proceeding at this time.

With respect to the safety impacts to Unit 1 from the damaged Unit 2 reactor and from cleanup operations at Unit 2, that issue was fully litigated before the Licensing Board; the Commonwealth participated through cross-examination of both Licensee's and Staff's witnesses; and the Commonwealth filed proposed findings of fact on the issue. In its partial initial decision of December 14, 1981, the Licensing Board accepted some of the Commonwealth's arguments and rejected others. See LBP-81-59, 14 N.R.C. 1211, 1424-55 (1981). The Board concluded:

> On our evaluation of evidence of Licensee's ability to maintain the Unit 2 reactor in a safe condition and of the potential radioactive releases from Unit 2 cleanup operations, we find reasonable assurance that the decontamination and restoration of Unit 2 will not affect safe operations at Unit 1.

Id., at 1432. The Commonwealth took no appeals from this aspect of the Board's 1981 decision nor otherwise questioned it in the intervening two and one-half years. Given the comprehensive treatment the Licensing Board devoted to this issue, it is not surprising that the Commonwealth filing contains no evidence of any adverse impact from Unit 2 cleanup activities on Unit 1 operations. Instead, it merely raises again a question which was adequately resolved by the Licensing Board, completely ignoring the existence of the record and the Board decision.

With respect to the financial impacts inquiry, that was an issue in the proceeding until removed by the Commission in its order of March 23, 1981. See CLI-81-3, 13 N.R.C. 291 (1981). In taking this action, the Commission described the Commonwealth's position as follows (Id. at 296, emphasis added):

> Counsel for the Commonwealth of Pennsylvania, representing the Governor of that State, believes that while it is important for the licensee to demonstrate its financial ability to operate TMI-1 simultaneously with the cleanup of Unit 2, the Commonwealth believes that the return of TMI-1 to commercial operation would improve, rather than impair, the licensee's financial health. For example, return of the unit would produce operating revenues and return of the unit to the utility's rate base also might increase the licensee's credit rating and its abilities to obtain capital. Therefore, the Commonwealth supports the staff position [to postpone the financial issues until after restart.]

The current Commonwealth position is inconsistent with this clear, unequivocal, and well-founded statement of position. In its recent filing, the Commonwealth totally ignores the inconsistency, introducing no new evidence to support their revised position. In fact, in the last two and one-half years substantial progress has been made in cleanup and in assuring funding for the cleanup. See, e.g. Letter of William G. Kuhns, Chairman, GPU, to NRC Commissioners, dated June 20, 1984. The Commonwealth's position should be rejected by the Commission.

The Commission's deliberations on the restart of TMI-1 have been stymied for about two years. In this intervening time the Commission has sought to resolve the meaning of the operator cheating incident, the implications of past practices brought to light in the GPU vs. B&W litigation and, during the past year, the MetEd indictment and the items enumerated in the Dircks memorandum of May 15, 1983. Repeatedly over this two year time period, Licensee's management and its operations have been scrutinized in unprecedented detail. Mere repetition of allegations has taken a toll. Innumerable investigations have not shown any conscious pattern of improper behavior on the part of management. However, the agency's concentration on allegations of wrongdoing has virtually excluded recognition of the aggressive and forward-looking actions that Licensee's management has initiated and implemented. To the extent that the investigations reveal imperfections, or focus on differing judgments, these realities need to be judged in the light of Licensee's total performance. A reading of the recent FOI release of the record of a number of closed Commission meetings during a portion of the past three years strongly suggests a need for the Commission to step back and review the matter of management's commitment to safe operations with the full record, positive and negative, in mind.

In this regard, we would urge the Commission to be mindful of what we consider to be the meaningful and positive indicia of management integrity, namely:

(1) The Company responded fully and cooperated with all investigations of the accident. From the beginning it felt a deep obligation to ensure that the learnings of the accident were fully derived.

(2) The Company moved immediately to embrace the major learnings of the accident, i.e., the need for more competent technical resources. A new, single purpose organization, GPU Nuclear, was formed; numerous senior experienced management personnel have been added; the people and dollar resources devoted to nuclear operations have been greatly increased.

(3) GPU Nuclear was designed with the overriding obligation of nuclear safety clearly in mind. The concept of a shift technical advisor was immediately embraced; the organization provides for multiple checks and balances; safety committees with meaningful outside participation continue to be a strong element.

(4) The Board of Directors of GPU Nuclear has been strengthened with an outside chairman and three additional outside members. These three members constitute a Nuclear Safety and Compliance Committee of the Board. That Committee has selected an outside contractor to provide independent support for visibility into plant operations and compliance.

(5) GPU Nuclear has greatly expanded the commitment to training. Today's GPU Nuclear training staff numbers 106; its 1984 budget is $7.6 million. This is more than an order of magnitude increase in both staff and budget since the TMI-2 accident. TMI-1 has enough licensed operators for six shift operations which allows one shift in six for training. A basic principles trainer is available and a full replica simulator with advanced software will be on site in 1985. INPO accreditation is in process.

(6) GPU Nuclear has responded aggressively to the lessons-learned requirements of NUREG-0737. Further, GPU Nuclear has played a lead role in the B&W Owners Group.

That the above steps have been effective is established by the very favorable 1983 and 1984 SALP reports for TMI-1. The positive impact of GPU Nuclear management on practices, hardware, and procedures and the current capability to safely operate TMI-1 is recognized in those reports.

In conclusion, neither ALAB-772 nor other recently available information bars a Commission decision to lift the immediately effective suspension placed on TMI-1 operation in 1979. The Commission remains legally obligated to act promptly on this decision. It has information sufficient to address the concerns which formed the basis for the 1979 shutdown and should act now to lift the immediately effective suspension. Completion of NRC Staff certification items as a prerequisite to actual restart can then p oceed as was contemplated in the August, 1979 Order which initiated this five-year long proceeding.

Respectfully submitted,

SHAW, PITTMAN, POTTS & TROWBRIDGE

Ernest L. Blake, Jr., P.C.
Counsel for Licensee

July 26, 1984

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

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

CERTIFICATE OF SERVICE

I hereby certify that copies of "Licensee's Comments in Response to Commission Order of June 1, 1984", dated July 26, 1984, were served on those on the attached Service List by deposit in the United States mail, postage prepaid, or where indicated by an asterisk (*) by hand delivery, this 26th day of July, 1984.

Ernest L. Blake, Jr., P.C.

DATED: July 26, 1984

UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

Before the Commission

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

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ATTACHMENT 1

GPU Nuclear

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July 20, 1984

Mr. Harold R. Denton
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. Denton:

Re: Metropolitan Edison Company
Three Mile Island Unit 2, Docket Number 50-320
NRC Office of Investigations Report #H-83-002,
Three Mile Island NGS, Unit 2, Allegations Regarding
Discrimination For Raising Safety Related Concerns,
May 18, 1984.

Based on a March 25, 1983 memorandum from the Chairman of the Nuclear Regulatory Commission, the Office of Investigations initiated an investigation of allegations presented to the NRC concerning alleged improper activities in the Three Mile Island, Unit 2 Recovery and Cleanup Program. The investigation conducted by the Office of Investigations culminated in a September 1, 1983 interim investigation report and a second investigation report dated May 18, 1984.

GPU Nuclear Corporation responded to the September 1, 1983 interim report in its letter to you dated January 16, 1984, which provided detailed comments on the subject and concluded "that the total information now available does not support the preliminary conclusions on the major issues which can be drawn from that memorandum [September 1, 1983 memorandum from the Director of OI to Chairman Palladino]."

This letter responds to the Office of Investigations Report #H-83-002 dated May 18, 1984, dealing with allegations regarding discrimination against individuals for raising safety related concerns. We have reviewed that report and have compared its findings and conclusions with those in a report by Mr. Edwin Stier of his investigation conducted on behalf of GPU Nuclear Corporation. Mr. Stier concludes in his report that the claims that GPU management was unconcerned about the safety of the TMI-2 recovery effort and retaliated against employees

who attempted to call deficiencies to management's attention are contradicted by the weight of the evidence. Our comparison attached shows the weakness of the bases for OI's views where they are contrary to Stier's.

Our review has focused on those aspects of the report which might be relevant to resolution of issues being considered in connection with the restart of TMI-1. We may submit further, more general comments at a later time.

GPU Nuclear Corporation has maintained and continues to maintain a policy of protecting its employees, contractors and subcontractors from discrimination as a result of raising safety concerns. This policy was recently confirmed in a letter from me to Mr. Darrell G. Eisenhut dated June 29, 1984 in which I set forth details regarding GPU Nuclear Corporation's policies on employee protection and Company communications.

GPU Nuclear Corporation believes that the subject OI investigation dealing with allegations regarding discrimination for raising safety related concerns does not disclose any findings adverse to a favorable determination by the Commission on the restart of TMI-1.

Sincerely,

P. R. Clark

P. R. Clark
President

PRC/fk

Attachment

cc: Shaw, Pittman, Potts & Trowbridge

ALLEGATIONS REGARDING DISCRIMINATION FOR

RAISING SAFETY CONCERNS (H-83-002)

OI REPORT #H-83-002

Edwin H. Gischel

In June, 1981 Edwin H. Gischel joined GPU Nuclear Corp. as the TMI-2 Plant Engineering Director. In this position he was responsible for supervision and technical direction of a staff of engineers that provided technical support for the operations and maintenance staffs of TMI-2. He also was assigned to the unit's emergency response organization as the supervisor for technical support to the emergency director.

In June, 1982 Mr. Gischel suffered a stroke and was absent from work until October, 1982 at which time he returned to work on a part time basis. In November, 1982 he resumed full time employment. Upon his return to work in October, Gischel consulted with Corporate Stress Control, Inc., (Stress Control) a contractor to GPU Nuclear Corp. (GPUN), concerning the visual and memory problems he continued to experience as a result of his stroke. Stress Control recommended to Mr. Gischel that he

take a neuropsychological evaluation to assess the extent of his intellectual impairment and made arrangements for the evaluation.

In March, 1982, upon being advised by Stress Control that Gischel was resisting taking the evaluation which Stress Control felt was necessary, GPUN began efforts to have Mr. Gischel comply with Stress Control's recommendation.

During the following months GPUN worked to accommodate both Gischel's concerns and Stress Control's recommendation. GPUN agreed to pay for the evaluation, to pay for his wife's expenses incurred in accompanying him to the evaluation and agreed to allow the evaluation to be done by anyone selected by Gischel provided the person selected was qualified as required by Stress Control.

On June 17 Gischel informed GPUN that he had decided to seek a transfer within the GPU System. He subsequently accepted such a reassignment.

Allegations

Mr. Gischel alleged that he was required to undergo the neuropsychological evaluation as a prerequisite to continuing as TMI-2 Plant Engineering Director to harass or retaliate

against him because he raised safety concerns.[1] It is undisputed that the recommendation that Gischel be evaluated was initiated by a GPUN contractor, Corporate Stress Control, Inc. (Stress Control) on the basis of information Gischel voluntarily gave to Stress Control. In support of his harassment allegation, however, Gischel suggests that GPUN conspired in the first instance to cause Stress Control to raise the neuropsychological matter with Gischel. Mr. Stier and OI investigated this contention and found no support for it whatsoever. On this point Mr. Stier concluded:

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(1) Mr. Gischel also alleged he was harassed by John Barton, Deputy Director of TMI-2, through criticism of the productivity of his staff, disapproval of excused time off with pay, requiring submittal of a weekly status report and installing windows in doors in Site Operations office areas. These allegations were made after Stier concluded his investigation and were therefore not addressed by him, however, OI apparently found nothing which supported those allegations and reached no conclusions regarding them.

In addition Mr. Gischel alleged that Mr. Arnold offered to back down from requiring the neuropsychological evaluation if Mr. Gischel refrained from testifying at an April 26, 1983 hearing by the Udall Committee and threatened further retaliation if he did testify. GPUN knows of no evidence which supports this allegation, and Arnold specifically denied it when questioned by OI. (Office of Investigations Report #11-83-002, "Three Mile Island NGS Unit 2, Allegations Regarding Discrimination for Raising Safety Related Concerns," May 18, 1984, (OI Report), Exhibit 16, pages 82-85). OI reaches no conclusion on the issue, and no suggestion has been made that anyone presently involved in the operation of TMI-1 was involved.

On February 10, 1983, Gischel had written a memorandum to King criticizing the Polar Crane Load Test Safety Evaluation Report (SER). From the 11th of February through the 17th, a series of meetings took place in an effort to resolve Gischel's concerns.

From the sequence of events that led to Jenkins' letter on February 10, it is clear that the dates of the Jenkins letter and the Gischel memorandum were purely coincidental. There was no participation in the preparation of the Jenkins letter by any representative of GPUN. That letter was written in the course of a series of efforts by Stress Control beginning in October aimed at encouraging Gischel to submit to the examination. Jenkins' expression of concern about Gischel not having taken the examination on January 15, 1983 was wholly consistent with the attitude he displayed in his February 10 letter. Therefore, no change in the level of concern occurred within Stress Control at the time Gischel began to raise objections to the polar crane Load Test in February. (footnotes omitted)(2)

In his oral presentation of the OI report to the Commission, Ronald A. Meeks, the lead OI investigator on this matter, said:

Our investigation, the evidence doesn't show any involvement of GPU Nuclear in trying to coerce or influence Stress Control in anyway to have Mr. Gischel take the examination at that time or at anytime did they try to influence Stress Control to have Mr. Gischel to take the examination. There's no evidence to indicate that.(3)

Gischel's suggestion, then, that GPUN somehow conspired with Stress Control against Gischel simply is incorrect. Likewise, Gischel's allegation that GPUNC was harassing Gischel by

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(2) Stier Report, Vol. III, "Gischel Harassment Allegations", pages 9 and 10.

(3) US NRC Public Hearing transcript, May 23, 1984, "Discussion of Completed TMI Investigations", Page 36.

requiring him to take a neuropsychological exam is wholly without merit. Mr. Stier, in his investigation and report, throughly analyzed this allegation and rejected it. OI in its investigation reached no final conclusion on the matter. However, OI in its summary makes a number of statements which might be read as supporting Gischel's allegation. These statements are factually incorrect or immaterial or both, and they do not support Gischel's allegations.

First is the statement that:

> Coincidentally, this [Gischel's evaluation] did not become a requirement until after Mr. Gischel raised safety issues concerning the TMI-2 recovery program.(4)

After reviewing the evidence, Stier concludes that the recommendations of Stress Control were formulated before Gischel made his safety allegations and

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(4) Memorandum from the Director, Office of Investigations to the NRC Commissioners, forwarding the Office of Investigations Report #H-83-002, dated May 18, 1984 (OI memorandum), page 1.

without the participation of GPUN. OI discovered no evidence to the contrary. OI's characterization of the timing of this event as "coincidental" i.e., not causally related, supports Stier's conclusion.

Secondly, OI states:

> This employment requirement [the evaluation] was pursued despite the fact that Mr. Gischel's supervisors did not consider that his physical impairments seriously affected his work performance.(5)

The basis for that statement is unclear. The following from the OI Report reflects that Gischel's first and second line supervisors recognized Gischel was not performing at full capacity in his assignment as TMI-2 Plant Engineering Director.

> Mr. BARTON stated that he was aware, through Mr. GISCHEL's supervisor, Lawrence P. KING, that Mr. GISCHEL was having vision and memory retention problems when he returned to work Mr. BARTON related that Mr. GISCHEL, upon returning to work, acted more as a consultant to Mr. Ronald P. WARREN, who was, operationally, assuming Mr. GISCHEL's functions. Messrs. BARTON and KING discussed how rapidly they should allow Mr. GISCHEL to assume full responsibilities and it was decided to allow Mr. GISCHEL to advance at his own pace as the Director of Plant Engineering.(6)

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(5) Id., pages 1 and 2.

(6) OI Report, page 14.

Barton further emphasized Gischel's limitations when, in responding to OI's questioning on why Gischel was treated differently than another person suffering a similar injury, he stated:

> ...[unnamed individual] unlike Mr. GISCHEL, returned to work fully recovered and performed very well in the function that he had before his illness.(7)

These statements clearly show that Gischel's supervisors felt that his physical impairments seriously affected his work performance. The impairments noticed caused the supervisors to accommodate Gischel by not requiring him to resume full responsibilities.

Arnold also stated to OI that it was his understanding that upon returning to work after the stroke, Gischel was permitted to work at a pace established by himself, being supported in his job function by Warren.(8)

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(7) Id., page 15.

(8) Id., Exhibit 16, pages 9-10.

Lastly, OI states:

> The examination requirement was also in conflict with the medical opinions furnished by both Mr. Gischel's personal physician and a GPUN contract physician. Both doctors examined Mr. Gischel and concluded that he was fit to perform his assigned duties at TMI-2.(9)

It is uncontested that neither of these two physicians were trained psychologists or psychiatrists. Also, GPUN upper management was unaware of the results of Mr. Gischel's routine annual physical examination by Dr. Imber, and Mr. Gischel never mentioned to GPUN management that he had been examined by Dr. Imber, despite having had many opportunities to do so. GPUN management can hardly be faulted for giving no importance to a subject to which Gischel himself apparently ascribed no importance until months later in his OI interview. Dr. Jones (Mr. Gischel's personal physician), for his part, believed Gischel was fit, but "strongly recommended" Gischel take the exam which was all the Company was requesting of Gischel.

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(9) OI Memorandum, page 2.

In any event, the situation was not one where management could balance the recommendations of independent professionals or even the views of fellow workers or supervisors. It was a situation where a trained, licensed clinical psychologist provided to GPUN his professional opinion that "Mr. Gischel's work performance is potentially seriously impaired by his disability, but that because of the intricate system of checks and balances at GPU Nuclear that Mr. Gischel's work impairment would be compensated for." (emphasis added)(10) GPUN management was thoroughly justified in not ignoring that information and resolving any uncertainty in a conservative fashion. The record shows clearly that both Mr. Kuhns and Mr. Arnold attempted to do that appropriately and with as much compassion for Mr. Gischel's anxieties as circumstances permitted. For example, Stier describes the interaction in the following excerpt from his report:

> Once GPUN became involved on March 9-10, 1983 in urging Gischel to take the examination, the company worked toward reaching an accommodation between Stress Control's recommendation and Gischel's concerns. GPUN agreed to pay for the examination. Gischel was permitted to have his wife present at the time of the examination. Finally and most significantly, Arnold agreed that Gischel could select the person to administer the examination as long as he possessed the qualifications specified by Stress Control. These are acts of accommodation, not harassment.(11)

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(10) Id., Exhibit 95.

(11) Stier Report, Vol. III, "Gischel Harassment Allegations", page 10.

Notwithstanding all of the above, OI concludes without support that:

> The requirements to take the neuropsychological examination appears to be more in response to something other than plant safety concerns and coincidentally follows Mr. Gischel's raising safety issues concerning the TMI-2 recovery program. (emphasis added)(12)

When asked by Commissioner Asselstine if that is a nice way of saying there is a reasonable basis for concluding that Gischel was asked to take the test in retaliation for raising safety concerns, the lack of evidence suggesting a causal relationship was confirmed. Mr. Hayes replied "Well, we cannot positively say we have the evidence to support that."(13)

Although Mr. Gischel refused to be interviewed by Mr. Stier, and Mr. Stier's investigation only covered events up until April 4, 1984, the parameters of the dispute between Mr. Gischel and GPUN were sufficiently developed by that date to permit Mr. Stier to make a judgment concerning Arnold's motivation over the initial three weeks of the episode. Stier concludes:

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(12) OI memorandum, page 2.

(13) US NRC Public Hearing Transcript, May 23, 1984, "Discussion of Completed TMI Investigations", page 47.

The decision to press Gischel to undergo the examination was made entirely by Stress Control which is an independent entity. The company's actions, in response to Stress Control's expressions of concern, were reasonable and limited.(14)

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(14) Stier Report, Vol. III, "Gischel Harassment Allegations", page 11.

CONCLUSION

Mr. Gischel's condition clearly raised substantive questions about how safely he could perform his normal work function. While OI, apparently because of the certifications of Drs. Jones and Imber and the investigator's own non-professional assessment of Mr. Gischel's intellectual capabilities, seems reluctant to positively conclude GPUN acted in good faith,[15] the Director of OI stated, in response to a Commission question:

> And I can't sit before you today gentlemen, and say, you know, which is right and which is wrong because I, I just don't have a feel for that, to put myself in corporate management's position if it were a member of my immediate staff here, and I'm concerned about them as well as this organization. And that's a tough one.[16]

Although it is a "tough one" in terms of the personal discomfort and misfortune for Mr. Gischel - few things are as precious to us as our physical and emotional good health - it is not a "tough one" in terms of the public and worker safety obligations of GPUN. Far from showing management lack of

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(15) US NRC Public Hearing transcript, May 23, 1984, "Discussion of Completed TMI Investigations", pages 49-51.

(16) Id., supra, page 58.

integrity, GPUN's actions demonstrate that management recognized its obligations and responded properly even though it was clear that its actions could be misunderstood and misrepresented.

KING ALLEGATION

Mr. King charges that GPUN terminated his employment because he raised safety concerns and not because of his outside business activities.

Neither OI nor Stier found evidence of any kind which indicated King was terminated because he raised safety concerns. OI's conclusions appear to be based solely on the opinion that Arnold's stated reasons at the time of terminating King were insufficient. OI stated:

> Although this action [King's termination] may have been appropriate based on information developed during an internal investigation initiated after Mr. King's termination, the evidence of alleged impropriety which was known at the time of the termination was not irrefutable.(17)

That conclusion is simply wrong. King could not have refuted the evidence Arnold had when he terminated him since everything Arnold knew or suspected was indeed true. The evidence was in fact "irrefutable." If the meaning of OI's conclusion is that, in their judgment, Arnold should have given King a further opportunity to refute the evidence against him, we believe

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(17) OI Memorandum, page 2.

ample opportunity was given Mr. King and that the nature of King's response justified Arnold's conclusion that King should have been discharged. One can only review what Arnold knew when he terminated King and then conclude, as Stier did:

> The evidence is clear that Arnold terminated King based on King's role in Quiltec.(18)

Stier stated in his report that Arnold knew, at the time he terminated King:

- Quiltec was incorporated in Virginia on June 23, 1981 by King, Benjamin Slone, John Hoade and Gloria King.

- King was the president of Quiltec and claimed to own 50% of the stock in that company. King had stated in his answers to questions posed by Arnold that his role was advisory in that all operations had been conducted by Slone. However, in Arnold's judgment King's position as a 50% owner of a closely held corporation, the chief executive officer and the chief operating

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(18) Stier Report, Vol. I, page 28.

officer of that company made King accountable for the activities of Quiltec regardless of King's claim that he played no active role in the operation of that company.

- Three former employees of GPUN, Slone, Rekart and Herlihy, had become employees of Quiltec. From King's answers to Arnold's questions, GPU personnel records, and Arnold's conversation with Pollack,[19] Arnold concluded that at least Rekart and Herlihy had been recruited on behalf of Quiltec prior to their resignation of employment with GPUN and that King was at least aware before they left the employ of GPUN that they were to be employed by Quiltec.

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(19) Milton Pollack is a vice president of Long Island Lighting Company who Arnold reported he contacted to independently determine whether former GPUN employees were working for Quiltec under contract with LILCO, the timing of when they were offered for employment, and when they commenced work at LILCO.

- During July or August of 1982, Parks had requested a Bechtel employee to type resumes during nonworking hours. She agreed and shortly thereafter received approximately 20 to 25 resumes and Quiltec letterhead stationary on which to retype the resumes she had been given. Most of the individuals whose resumes she was given were GPUN employees. The only names the typist could remember were King, Herlihy, Slone, Rekart, William Henry, Austin and Kenneth Lionarons. The typist was paid $75.00 in cash by Parks.

- During a discussion with Arnold, probably on March 9, King had admitted that he had provided to Parks the funds which were used to pay the typist. King denied, however, knowing any of the details of whose resumes were typed or who did the typing. He characterized his activity as an accommodation to Slone by providing payment to Parks for Quiltec. Arnold's purpose in raising the issue on March 9 with King was to test King's credibility since King had not indicated in his answers to Arnold's questions that Parks had any involvement with or knowledge of Quiltec.

Subsequent to a meeting between King and Arnold on March 12, 1983, King's role in the resume preparation was further confirmed. On March 15, 1983, Arnold was advised by Kanga that Parks had informed Bechtel that Parks arranged for the typing of the resumes on behalf of King. On March 16, 1983, Arnold informed King by a letter that his employment would be terminated on March 23. That date was selected to make King available to be interviewed by Griebe and Lowe, independent experts hired by GPUN, concerning his management and safety allegations. Arnold intended to assure King's participation in that interview by retaining him as an employee of GPUN until that time.(20)

In a letter on his own behalf to the Commissioners,(21) Arnold identifies the following as also known to him at the time he decided to discharge King:

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(20) Stier Report, Vol. III, "King Harassment Allegations", pages 15-17.

(21) Letter to the NRC Commissioners from R. C. Arnold, dated June 8, 1984.

1. Mr. William Austin, one of the GPUN engineers that the typist had identified as being included among those whose resumes she had typed, stated he did not consent to or know of Quiltec's use of his resume.

. . .

2. King had claimed that his association with Quiltec was well known by management at TMI-2 prior to Dr. Thiesing's report of that fact to Mr. Barton, the Deputy Director of TMI-2. However, when asked to substantiate that claim he was either unable or unwilling to do so.

. . .

3. From discussion with Mr. Pollack, it was clear that Quiltec was "marketing" GPUN employees who worked for King well before those employees told GPUN they were going to resign.(22)

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(22) Id., page 5.

CONCLUSION

The information Arnold had, summarized above, was more than sufficient to support the termination of King. The Department of Labor concluded in its initial determination that King's discharge was not in response to his raising safety concerns. Thus, since there is no evidence to the contrary, the only conclusion that can be reached is that King's termination was based on his Quiltec activities.

PARKS ALLEGATIONS

Parks, an employee of Bechtel North American Power Corp. at TMI-2, alleged that he was discriminated against because he raised safety concerns.

Parks made his allegations in a Complaint against Bechtel filed with the Department of Labor. DOL's initial determination supported Parks. While that determination was under appeal, Bechtel and Parks settled the claim, GPUN and Parks executed mutual releases and the Complaint was withdrawn. OI conducted no independent investigation of Parks' allegations.(23) None of Parks allegations charge any of the current GPUN officers, directors or other management associated with the operation of Unit 1 with any involvement in the action claimed by Parks to be discriminatory and GPUN considers the matter resolved.

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(23) US NRC Public Hearing transcript, May 23, 1984, "Discussion of Completed TMI Investigations", pages 27 and 28.

ATTACHMENT 2

GPU Nuclear

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July 20, 1984

Harold R. Denton, Director
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. Denton:

Re: Metropolitan Edison Company
Three Mile Island Unit 1 - Docket Number 50-289
NRC Office of Investigations Report #1-83-028, Three Mile Island Nuclear Generating Station (NGS) Unit 1 - Possible Falsification of Reactor Coolant System Inventory Leak Rate Tests, April 16, 1984.

As a result of an NRC Region 1 Special Investigation Report (Report No. 50-289/83-20) and its revision which identified possible instances of hydrogen and water being added to the TMI-1 Reactor Coolant System ("RCS") Make-up Tank during the performance of RCS leak rate surveillance tests, without these additions being properly accounted for in the test calculations, the Nuclear Regulatory Commission's Office of Investigations conducted an investigation of TMI-1 leak rate test practices over a one-year period during 1978-1979. The results of that investigation are set forth in the referenced report.

GPU Nuclear Corporation also had an independent investigation of TMI-1 reactor coolant inventory balance testing conducted. The results of that investigation are provided in a report prepared by Mr. Edwin H. Stier, dated June 13, 1984. Copies of the Stier Report have been sent to the Commission and the Parties to the TMI-1 Restart proceedings. Mr. Stier's report covered the areas reviewed by the Office of Investigations and went beyond. In particular Mr. Stier reviewed leak rate testing throughout the full period of TMI-1 operation. He also had additional technical analysis conducted and looked in detail at GPU Nuclear Corporation's response at TMI-1 to the TMI-2 leak rate test deficiencies and at the "loopseal" question.

Neither the OI investigation or the Stier investigation found any evidence or testimony of falsification of leak rate test results at TMI-1.

We have reviewed the Nuclear Regulatory Commission's Office of Investigations Report 1-83-028. The results of that review and our comparison to the later investigation report prepared by GPU's investigator, Mr. Stier, are enclosed.

This review has focused on any facts or conclusions that conceivably could be pertinent to the Commission's review of lifting the immediate effectiveness of the TMI-1 Orders. Further review may develop other comments not pertinent to this issue. Any such additional comments will be provided separately.

Based upon the conclusions of the Nuclear Regulatory Commission's Office of Investigations Report 1-83-028, the conclusions of Mr. Stier's investigative report and a comparison of the two reports, GPU Nuclear Corporation concludes there are no findings in those reports adverse to a favorable determination on the restart of TMI-1.

Sincerely,

P. R. Clark

P. R. Clark
President

PRC/fk

Enclosure

cc: Shaw, Pittman, Potts & Trowbridge

ANALYSIS OF THE OI AND GPU NUCLEAR CORPORATION INVESTIGATIONS OF POSSIBLE FALSIFICATION OF TMI - UNIT I LEAK RATE TESTS OI REPORT #1-83-028

Below is a comparison of the essential conclusions of the OI investigation[1] and the GPU Nuclear Corporation sponsored investigation completed by Edwin H. Stier[2]. Neither investigation found any evidence or elicited any testimony of falsification of leak rate test results.

The following represents the concerns explored by the investigators:

1. Was there a systematic pattern of falsification of TMI-1 reactor coolant system (RCS) leak rate surveillance tests?
2. If any falsification of RCS leak rate surveillance tests did occur, what management personnel, if any, were involved or knew of any falsification?

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(1) OI Report #1-83-028, "Three Mile Island Nuclear Generating Station (NGS) Unit 1 - Possible Falsification of Reactor Coolant System Inventory Leak Rate Tests," (OI Report) April 16, 1984.

(2) "TMI-1 Reactor Coolant Inventory Balance Testing," by Edwin H. Stier (Stier Report), June 13, 1984.

3. Did the TMI-1 personnel meet the requirements of plant Technical Specifications or procedures relative to documentation of RCS leak rate testing?

4 Did GPU Nuclear Corporation management respond adequately to information available to them that TMI-1 might be vulnerable to the problems identified in 1980 with RCS leak rate surveillance testing in TMI-2, especially with regard to the TMI-1 makeup tank level instrumentation?

Concern 1; Systematic Pattern of Falsification. The OI conclusion on this issue is:

> Based on the testimony received and the documents and analysis reviewed, we have concluded that there was no systematic pattern of falsification of leak rate surveillance tests at TMI-1 during the time period in question nor can we prove that any individual operator knowingly and willfully attempted to manipulate leak rate surveillance test results. At the same time, we cannot exclude the possibility that individual operators may have attempted to manipulate test results for unknown reasons. The explanation given by the operators and licensee management, as to why the hydrogen and particularly the water additions are present during the test periods, are plausible given the numerically small number of tests actually involved(3) and the magnitude of the responsibilities assigned to the shift operators.(4)

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(3) The OI Report identified 25 out of 720 leak rate tests conducted (3.5%) during which additions of hydrogen or water were made. (OI Report, page 16 and Exhibits 18 and 19).

(4) Memorandum from the Director, Office of Investigations to Regional Administrator, NRC Region I, dated April 16, 1984, forwarding Investigation Report 1-83-028, (OI Memorandum) page 2.

Stier's conclusion on this issue is:

> The overwhelming weight of the evidence demonstrates that TMI-1 personnel did not manipulate or otherwise improperly influence the outcome of reactor coolant inventory balance tests.(5)

Concern 2: Involvement of Management personnel in falsification of leak rate testing. Stier's conclusion on the first concern makes the second issue moot for his investigation. OI does not reach a conclusion on this concern, although it identifies considerable testimony to reject and no evidence to support an adverse finding.(6) OI summarizes the results of its investigation of this issue as follows:

> During the investigation, every licensed operator employed at TMI-1 during the time period covered by this investigation was interviewed under oath. All of the operators interviewed adamantly denied that they had ever attempted to manipulate the leak rate test results. The operators interviewed denied that they had ever been directed to manipulate test results in any fashion and denied that there was any management pressure exerted on them that would have forced them to attempt to alter leak rate surveillance tests results. The Shift Foremen, the current Shift Supervisors and the Supervisor of Operations denied any knowledge or participation in the falsification of leak rate surveillance tests at TMI-1. The supervisory and management personnel interviewed during the investigation echoed the operators' testimony that there was no reason to attempt to manipulate leak rate surveillance test results.(7) and,
>
> Subsequent to the completion of the Department of Justice's (DOJ) criminal proceedings regarding the alleged falsification of TMI-2 RCS leak rate surveillance tests, additional

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(5) Stier Report, page 9.

(6) OI Report, page 2.

(7) OI Memorandum, page 2.

interviews were conducted with witnesses to that proceeding who were previously unavailable to OI investigators at DOJ's request...none of these witnesses provided any information that would contradict testimony given by other attestants in this investigation. In sworn testimony these interviewees denied that they were either cognizant or involved in the falsification of TMI-1 RCS leak rate surveillance tests. During the questioning of these witnesses, particular emphasis was directed to determine if the current TMI Operations Supervisor was either aware of or involved in the falsification of TMI-2 leak rate surveillance tests. None of these interviewees implicated this individual in any improprieties either at TMI-1 or 2.(8)

Concern 3; Fulfillment of the requirements of plant Technical Specifications and procedures. OI's conclusion on this matter is:

Interviews of the operators and their supervisors indicated that it was a common practice to discard test results that were deemed invalid. The testimony provided by the operators and supervisory personnel does not give any indication that the intent in discarding an invalid test result was to conceal information from regulatory officials, but rather was an apparent lack of understanding among the operators and their supervisors as to what their record keeping requirements were.(9)

Stier reaches a similar conclusion on this issue, namely:

In September 1974, a practice of discarding and not otherwise documenting test results determined by plant personnel to be invalid was established at TMI-1.
- This practice was not intended to conceal actual reactor coolant system leakage.

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(8) Id., page 3.

(9) OI Memorandum, page 3.

- The failure to document the invalidation of test results was contrary to the intent of TMI-1 Technical Specifications and procedures.(10)

Hence, both investigations conclude there was a failure on the part of Metropolitan Edison Company prior to March 1979 to meet record keeping requirements set forth in the plant's Technical Specifications and administrative procedures. However, both investigations conclude this did not result from improper motives. In addition, GPU Nuclear Corp. has taken action sufficient to provide reasonable assurance that the failures described above will not be repeated. After an inspection initiated to evaluate the effectiveness of GPU Nuclear Corp. actions to ensure adherence to procedures the U.S. NRC Region I Division of Engineering and Technical Programs concluded:

-- That the licensee's policies and practices related to adherence to procedures and license conditions, as reflected in its management organization, procedures, training, reviews and commitment to safety and quality are acceptable and do support the restart of TMI-1.

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(10) Stier Report, pages 9 and 10.

-- The numerous changes and improvements in organization, procedural adherence and personnel at TMI-1 that have occurred since the Hartman allegations provide assurance that these allegations do not now present health and safety concerns that require resolution prior to the restart of Unit 1.

-- Management initiatives observed during the inspection were found to be positive toward safety and reflected a desire and commitment to operate TMI-1 safely.(11)

GPU Nuclear Corporation acknowledges that prior to the TMI-2 accident, there were shortcomings in Metropolitan Edison's implementation of requirements for record retention and documentation of RCS leak rate surveillance testing results. There is no indication that upper level management of Licensee at the time was aware of that failure nor do the facts reflect adversely on the integrity of any of the current TMI-1 operators and GPU Nuclear Corporation management. The corrective action taken by GPU Nuclear Corporation is sufficient to provide reasonable assurance that such failures will not be repeated in the future.

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(11) NRC Region I Inspection Report Number 50-289/83-10, page 16-1.

Concern 4; Management response to available information. This is the one issue on which the conclusion of OI and Stier differ substantively. The Hayes memorandum accompanying the OI report states:

> What was also identified during this investigation is that a significant amount of information was available to Plant Management (specifically, the Faegre and Benson Investigation Report at TMI-2 and various Unit 1 plant maintenance memorandums) regarding the hydrogen effect caused by the "loop seal" in the RCS MUT and its apparent cause and effect on the leak rate surveillance test. Despite this information, no affirmative actions were initiated at TMI-1 to determine if the potential for the same problem existed until the NRC Region I Special Inspection in September 1983.(12)

In his memorandum, Hayes arrives at this conclusion notwithstanding the fact that the OI Report itself indicates that various management personnel at TMI-1 were interviewed to determine if TMI-1 was examined in light of the Faegre & Benson Report and all but one manager recalled that TMI-1 leak rate procedures and hardware were examined as a result of the Faegre & Benson report.(13)

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(12) OI Memorandum, page 3.

(13) OI Report, page 24.

Based on facts developed during Stier's investigation of this matter, OI's conclusions that no affirmative actions were initiated at TMI-1 are not correct. Stier concludes:

> In May 1980, Robert C. Arnold, the senior GPU management representative at Three Mile Island, held a meeting with members of the group that had conducted the Faegre & Benson investigation. One of the purposes of the meeting was to discuss further steps to be taken in the investigation of leak rate testing at TMI-2. Arnold felt it was important to use their findings as a guide to examine whether problems found at TMI-2 also existed at TMI-1. Although his recollection is somewhat unclear about the details, at the meeting or shortly thereafter, Arnold asked whether the loop seal problem found at TMI-2 was also present at TMI-1. Later he was advised that there were not similar hardware configuration defects at TMI-1. Problems were found, however, in the TMI-1 leak rate test procedures. Those problems were corrected in a procedural revision dated August 25, 1981 [before the plant was first placed in an operational mode requiring leak rate testing].
>
> In the spring of 1983, prior to the NRC inspection, Arnold specifically requested Henry D. Hukill, Director of TMI-1, to review all of the findings of the Faegre & Benson report and to assure that all of the issues raised in that report had been addressed at TMI-1. The existence of a loop seal was one of the issues about which Arnold inquired. Arnold and Hukill were each advised that a loop seal problem found at TMI-2 did not exist at TMI-1. Neither Arnold nor Hukill can specifically recall who provided them with that information. Our efforts to identify who received the assignment and reported to Arnold and Hukill have been unsuccessful.
>
> Nevertheless, the conclusions in 1980 and again in 1983 were essentially correct. A review of the Faegre & Benson report, the installation records relating to the makeup tank level transmitter, and the vendor's installation instructions, clearly reveal that the TMI-1 makeup tank level transmitter had been properly installed and that the TMI-2 loop seal defect as described in the Faegre & Benson report, did not exist at TMI-1.(14)

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(14) Steir Report, pages 33 and 34.

Further:

> The company did not create or permit a defect in makeup tank level instrumentation that provided a means to manipulate leak rate tests.
>
> - The makeup tank level transmitter was installed according to manufacturer's specifications, which called for the installation of a condensation collection point and drain valve on the low pressure line below the level of the transmitter.
> - No discernible inaccuracy existed in the makeup tank level transmitter until September 1977, when water collection in the low pressure line became excessive.
> - The Maintenance Department took steps to remove water from the low pressure line, but was not successful in preventing excessive accumulation.
> - It is not likely that water accumulation in the low pressure line of the level transmitter had a significant effect on the evaluation of reactor coolant system leakage during any period of TMI-1 operation.(15)

Stier amplifies these conclusions as follows:

> At the time the low pressure line of the makeup tank level transmitter was installed at TMI-1, it included a condensation loop below the level of the transmitter which was intended as a collection point for any water in the line. To assure that water accumulation in the line would not interfere with the operation of the level transmitter, a 5-inch pipe and drain valve were installed at the low point of the condensation loop. This design was specifically recommended by the manufacturer and was completely consistent with the installation manual, a copy of which can be found in the records at TMI-1.
>
> The construction of the low pressure line at TMI-1 was, therefore, fundamentally different from the TMI-2 low pressure line, which had no similar drain valve. The defect identified by Faegre & Benson at TMI-2 was not simply the existence of a loop in the low pressure line, but the absence of a drain valve at that point. The combination of a condensation loop and a drain valve provides an

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(15) Id., page 10.

easy means of keeping water away from the transmitter, collecting it and removing it from the low pressure line. Without the valve, the condensation loop causes water to be trapped and difficult to remove. The makeup tank level instrumentation at TMI-1 did not suffer from this defect. To the extent that the NRC's inspection and OI reports imply that the configuration of the low pressure line was defective, they are incorrect. (footnotes omitted)(16)

and,

The possible existence of a loop seal in the low pressure line of the makeup tank level transmitter at TMI-1 was not raised with company management until the preliminary findings of the Faegre & Benson report on TMI-2 were presented in 1980. At that time, upper management was unaware of the history of problems with the TMI-1 makeup tank level transmitter. Knowledge of the work requests and the responses by the Maintenance Department did not rise above supervisors in the Operations and Maintenance Departments.(17)

CONCLUSION

Neither OI nor Stier discovered any conduct by GPUN in connection with RCS leak rate testing at TMI-1 which adversely impacts on any issue relevant to a decision on the restart of TMI-1.

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(16) Id., pages 28 and 29.

(17) Id., page 32.

ATTACHMENT 3

GPU Nuclear

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July 20, 1984

Mr. Harold R. Denton
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. Denton:

Re: Metropolitan Edison Company
Three Mile Island Unit 1, Docket Number 50-289
NRC Office of Investigations Report #1-83-013, General Public Utilities Nuclear - Alleged Failure to Provide BETA and RHR Consultant Reports to the NRC in a More Timely Fashion, April 16, 1984;
Report #Q-1-84-004, General Public Utilities Nuclear (GPUN) Possible Training Irregularities, March 22, 1984

In June of 1983 the NRC's Executive Director for Operations requested the NRC's Office of Investigations to investigate the circumstances and reasons why GPU Nuclear Corporation did not provide the BETA and RHR reports to the NRC at an earlier date. On April 16, 1984 the Office of Investigations released the results of their investigation. The OI report, #1-83-013, states that "[t]he investigation did not disclose any evidence of a deliberate attempt or conscious management decision by GPUN to withhold the information in the BETA and RHR reports from the NRC."

We conclude that the findings of OI #1-83-013 support a favorable determination on the restart of TMI-1. This conclusion is also supported by the Atomic Safety & Licensing Appeal Board determination that a licensee is entitled to a reasonable period of time for internal corporate review of documents like reports prepared by outside consultants and that "the time during which licensee reviewed the RHR and rather comprehensive BETA reports, before any mention or disclosure of them to the NRC, is in our view such a reasonable time" (ALAB 774, 19 N.R.C. ____(June 19, 1984), slip. op. at 12-13). A more detailed discussion of this matter is attached.

The Office of Investigations also undertook an investigation into possible training irregularities in Metropolitan Edison's preaccident training program, concern with which arose out of the Office of Nuclear Reactor Regulation's review of the GPU v. B&W lawsuit papers (reported in NUREG-1020LD). The results of that investigation were set forth in report #Q-1-84-004 dated March 22, 1984. OI found no substantive reasons for any adverse conclusion. Their investigation did not reveal information, allegations, or testimony relating to these matters that could form a basis for continuing the immediate effectiveness of the NRC's shutdown orders. We conclude that their findings support a favorable determination on the restart of TMI-1.

Sincerely,

P. R. Clark

P. R. Clark
President

Attachment

cc: Shaw, Pittman, Potts & Trowbridge

Alleged Failure to Timely Provide BETA and RHR Consultant Reports to the NRC in a Timely Fashion OI Report #1-83-013

On April 16, 1984, the Office of Investigations (OI) issued Report 1-83-013, entitled "General Public Utilities Nuclear - Alleged Failure to Provide BETA and RHR Consultant Reports to the NRC in a Timely Fashion." This investigation examined whether there is any evidence of a lack of integrity by Licensee or its management relating to the timing of Licensee's disclosure of the BETA and RHR Reports. OI Report 1-83-013 is supported by some 500 pages of backup documentation, which entailed some 50 days of NRC Staff work on this inquiry. Commission Public Meeting of April 26, 1984 at transcript (Tr.) 13, 14 (Messrs. K. Christopher and B. Hayes, OI).

This extensive inquiry unquestionably supports the lifting of the immediately effective TMI-1 suspension order. Specifically, "[t]he investigation did not disclose <u>any</u> evidence of a deliverate attempt or conscious management decision by GPUN to withhold the information in the BETA and RHR reports from the NRC," OI Report 1-83-013 at 4 (emphasis added), nor did it otherwise find evidence that impugned Licensee's character or integrity.

To the contrary the facts related to the disclosure of these reports emphasize Licensee's determination to fulfill its affirmative disclosure obligations and, in doing so, to act with integrity.

The initial disclosure to the NRC Staff of the RHR and BETA Reports was made by the Vice President of TMI-1, who voluntarily showed these reports to onsite regional inspectors in an effort to establish Licensee's continuing positive actions to improve itself. OI Report 1-83-013 at 2 and Exhibit (Exh.) 11 at 20-21 (H. D. Hukill). This action dispells any suggestion that Licensee intended to conceal the substance of the reports. Cf. OI Report 1-83-013, Exh. 1 at 28-29 (company management expectation that BETA Report would be come public). We did not believe the reports were of safety significance and needed to be publicly released. Licensee's position on these reports simply reflected our understanding of the law and our sensitivity as an employer about the public disclosure of (i) its operators' confidences to a psychologist, which were part of an ongoing study (RHR Report) and (ii) suggested company staffing reductions (BETA Report). Id., Exh. 1 at 17-18, 24-29, 38-40, 55 (R. C. Arnold); Exh. 2 at 6-8, 14-16-22, 29-31, 34-36, 44-46 (P. R. Clark); Exh. 11 at 12, 18-19, 20-22, 25-26, 35-37, 42-45, 49-53 (H. D. Hukill); Exh. 21 at 6-8, 11-13, 15-20, 22-27 (H. M. Dieckamp).

The record shows that GPUN has submitted innumerable reports and information to the restart proceeding participants and tribunals in an effort to satisfy its affirmative disclosure obligations under the so-called McGuire doctrine. See, e.g., letters of June 4, Oct. 1 and Nov. 3, 1981, March 11, April 22, Aug. 10, Oct. 5, Oct. 7 and Dec. 3, 1982, Jan. 31, April 14, May 4, May 6, May 16, June 28, Sept. 7, Nov. 3

and Nov. 22, 1983, and Jan. 9, April 4 and June 1, 1984 from Licensee's counsel to the Licensing Board (and/or Appeal Board) and the parties. These submittals demonstrate that we have been responsible in fulfilling our affirmative disclosure obligations.

There is considerable uncertainty about the detailed implementation of the law with respect to affirmative disclosure obligations. We believe the necessary premise of the OI investigation was that before the NRC Staff expressed its view on the subject of disclosure of the BETA and RHR reports, Licensee indeed was obligated to publicly disclose the reports. This premise has not been established. See n.1, infra. Most recently, the uncertainty regarding implementation of the law on affirmative disclosure is reflected in the agency's statement of intent to reconsider what constitutes a material false statement. See NRC General Statement of Policy and Procedure for Enforcement Actions, 49 Fed. Reg. 8583, 8584 (1984). Recognizing the importance of its affirmative disclosure obligations, the ambiguitities in the law and its responsibility to act properly, Licensee has actively sought guidance from the NRC staff on how it should decide what information must be publicly disclosed. See OI Report 1-83-013, Exh. 2 at 20-21 (P. R. Clark). In the interim, Licensee has adopted a procedure which is designed to ensure that documents, such as the BETA and RHR Reports, are systematically reviewed to establish their reportability. Letter from P. R. Clark to H. R. Denton, Oct. 21, 1983.

Finally, the Commission has added assurance that the BETA and RHR Reports controversy does not reflect adversely on Licensee's character from the Appeal Board's consideration and rejection of two motions to reopen the TMI-1 restart proceeding on the BETA and RHR Reports filed by intervenor Three Mile Island Alert (TMIA). See ALAB-738, 18 N.R.C. 177, 197-99 (1983); ALAB-774, 19 N.R.C. ____ (June 19, 1984).

In May of 1983, TMIA filed a motion to reopen the record on the basis of the BETA and RHR Reports and the timeliness of Licensee's disclosure of these documents. See Three Mile Island Alert Motion to Reopen the Record, May 23, 1983. The Appeal Board denied the motion, noting that it was premature to consider these matters because the NRC Staff investigation was still underway. ALAB-738, 19 N.R.C. at 197. However, the Appeal Board also found that "TMIA has failed to call to our attention anything so far that might have made a difference in the Licensing Board's decision." Id. In the Appeal Board's judgment, some portions of these reports were critical of TMI management; other portions were favorable. Id. Noting that the BETA Report did not focus on safety matters, id. at 1983, and that the RHR Report was described by a co-author as "one-sided" and possibly included confusing questions and answers, and was not designed to address management integrity directly, the Appeal Board concluded:

> Given the limitations in both reports and -- more important -- the fact that the ground covered therein (including the criticisms) was well traversed at the hearing below, we are

unable to conclude that any of the matter called to our attention might have made a difference in the Licensing Board's decision. Further, we would not want to discourage any licensee from undertaking such reviews of its management and operations (and disclosing their results) for fear of reopening a closed record. Our perusal of the BETA Report, in particular, shows it to be an extremely useful document, upon which licensee can rely to improve its operation overall.

ALAB-738, 18 N.R.C. at 198-99. Thus, on the basis of the substance of the BETA and RHR Reports, themselves, and the information developed on Licensee's disclosure of these reports, the Appeal Board found no basis to reopen the restart proceeding and consider the matter further.

After issuance of the OI Report and supporting materials on the reportability of the BETA and RHR Reports, TMIA filed another motion to reopen the proceeding on the adequacy of Licensee's disclosure of the BETA and RHR Reports. In ALAB-774, the Appeal Board rejected this TMIA motion. The Appeal Board first made clear that "there is no basis" for it to alter its view that the proceeding need not be reopened to consider the substantive content of the BETA and RHR reports. ALAB-774, slip op. at 9. The Appeal Board stated:

Instead, TMIA contends that licensee's failure to submit the BETA and RHR reports earlier and without reluctance shows a lack of integrity on the part of licensee's management. The necessary predicate of such a conclusion, however, is that licensee was legally obligated to release the materials more promptly and "voluntarily" than it, in fact, did. We are unable to reach such a conclusion on the facts of this case.

. . . .

Id. at 10. Although the Appeal Board did not decide whether the BETA or RHR Reports are "material," and thus subject to the affirmative disclosure obligation in the first instance,(1) it did conclude that once License knew that there was "reasonable doubt" as to the reports' materiality based on the NRC Staff's views, Licensee was obligated to disclose the reports. Id., slip op. at 12-13.

> Thus, even though licensee disputed staff counsel's claim that the material should be submitted via a Board Notificaton, the proper course was to disclose the reports. That is exactly what licensee did, within a matter of days from being confronted squarely with the issue by the staff. The question then is whether licensee's expressed reluctance to do so and failure to provide the reports even earlier constitute culpable conduct. We think not.
>
> As to the latter point, an applicant or a licensee is entitled to a reasonable period of time for internal corporate review of documents like reports prepared by outside consultants. Indeed it is during such time that an applicant or a licensee should also review the document in the context of its reporting responsibilities. The time during which licensee reviewed the RHR and rather comprehensive BETA reports, before any mention or disclosure of them to the NRC, is in our view such a reasonable time.

---

(1) In the Appeal Board's view, "[w]hether the BETA or RHR report can be properly characterized as material evidence is a question not readily answered." ALAB-774, slip op. at 12. This view suggests that before Licensee knew of the Staff's contrary view on the subject, Licensee was not wrong in not publicly disclosing the reports because of its view that they did not contain material information.

> We also believe that an applicant or a license — indeed, any party -- has a right to assert a reasonable position as to any claimed obligation -- including the disclosure of ostensibly material information. Nothing in the OI report or its underlying.
>
> documents gives us a reasonable basis upon which to doubt licensee's motives in openly resisting for a limited time the full public disclosure of the BETA and RHR reports.

Id. at 13-14 (footnotes and citation omitted; emphasis added).

In summary, the Appeal Board has carefully considered the very question before the Commission in connection with the issue of the reportability of the BETA and RHR Reports, namely, whether Licensee's actions reflect negatively on Licensee's character. The Appeal Board has unequivocally rejected such claims.

In conclusion, the investigation into the reportability of the BETA and RHR Reports, which is closed, presents no obstacle to a restart decision by the Commission; in fact, it offers some additional assurance of Licensee's integrity because of its proper handling of this matter. After an exhaustive investigation, OI found no evidence of bad faith or a lack of integrity by Licensee in its disclosure decision with respect to the BETA and RHR Reports. The Appeal Board has echoed this view in ALAB-774. Licensee has now instituted a procedure designed to ensure that systematic consideration will be given to all such reports, particularly in view of the uncertainties in the law in this area and the BETA and RHR studies experience. In sum, the Commission has conclusive assurance that Licensee has handled this matter properly, and will handle other affirmative disclosure matters properly in the future.

ATTACHMENT 4

Nuclear

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July 25, 1984
5211-84-2191

Office of Nuclear Reactor Regulation
Attn: John F. Stolz, Chief
Operating Reactors Branch No. 4
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Mr. Stolz:

Three Mile Island Nuclear Station, Unit I (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
Resolution of Emergency Planning Deficiencies

The ASLB Partial Initial Decision (PID) on the restart of TMI-1 identified several emergency planning conditions to be satisfied prior to restart. Item 2010g of the PID required a communications drill to be held as a result of problems identified by FEMA in the June 2, 1981 TMI Annual Exercise. This drill was conducted on October 14, 1981 and judged sufficient by the NRC Staff and NRC restart certification item #144 was certified as complete (see NRC Letter dated July 25, 1983).

The November 16, 1983 TMI Annual Exercise, however, identified communications deficiencies similar to those discussed in the PID. On June 25, 1984 Mr. William Dircks wrote a memorandum to the NRC Commissioners providing the staff's recommendations toward the resolution of emergency preparedness related TMI-1 restart issues. GPU Nuclear met with representatives of FEMA Region III and NRC Region I to discuss resolution of the communications deficiencies. Subsequently, a communications exercise with all 5 risk counties was conducted July 17, 1984. Attached is a letter of July 16, 1984 from GPUN to FEMA Region III describing the objectives of the exercise and the scenario used. GPUN provided observers, through the use of Emergency Management Services, Inc. (EMS) at all County EOC's. A detailed analysis by EMS of the communications exercise is included (Attachment 2). The report indicates that the exercise successfully demonstrated the communications capability of the five counties surrounding TMI. As is to be expected, areas needing further attention were identified and GPUN, through the efforts of EMS, will address these matters as part of its continuing program of assistance to the counties.

Prior to the July 17, 1984 communications exercise, a special communications drill was conducted to address communications deficiencies in Dauphin and Lancaster Counties identified by FEMA in the 1983 TMI Annual Exercise. This drill, held June 18, 1984, involved TMI, TMI risk counties and the Bureau of Radiation Protection (BRP). The drill scenario simulated a breakdown in the notification scheme between TMI and the Pennsylvania Emergency Management Agency (PEMA) thereby requiring Dauphin County to assume the lead role in the notification process. In addition, the scenario included the protective action recommendation of sheltering to be passed. Representatives from FEMA Region III and PEMA were observers. The drill identified the need for the development of a Standard Operating Procedure and for conducting specialized training dealing with notifications and communications. Emergency Management Services, Inc. provided specialized training dealing with notifications for Dauphin County. EMS also developed a Standard Operating Procedure which was adopted for use by all five TMI risk counties. These actions were performed prior to the July 17, 1984 Communication Exercise.

GPUN believes that the July 17, 1984 communications exercise resolves the communications aspects of the deficiencies identified in the 1983 TMI Annual Exercise and forms the basis for the NRC Staff to re-certify completion of PID item 2010g.

The Category A deficiencies identified in the 1983 TMI Annual Exercise will be further addressed in exercises scheduled for the third quarter of 1984. These exercises should resolve any remaining concerns about the adequacy of offsite Emergency Planning for TMI.

Sincerely,

H. D. Hukill
Director, TMI-1

HDH/GJC/SMO/djb

Attachment (2)

cc: D. Matthews, NRC Headquarters
R. Conte, Senior Resident Inspector
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R. Wilkerson, FEMA Headquarters
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J. Patten, PEMA

ATTACHMENT 1

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July 16, 1984

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Sixth and Walnut Streets
Philadelphia, PA 19106

Dear Mr. Asher:

Pursuant to our meeting of July 3, 1984 and in accordance with Mr. William J. Dircks' June 25, 1984 memo to the NRC Commissioners, a communications exercise is scheduled for July 17, 1984. This exercise will involve the Pennsylvania Emergency Management Agency (PEMA), Bureau of Radiation Protection (BRP), Dauphin, Lancaster, York, Cumberland and Lebanon Counties and TMI risk municipalities. Attached for your information is the scenario for this exercise.

The objectives for the exercise include:

- Satisfactorily perform the TMI-1 restart condition item 2010g (NRC certification item #144) imposed by the Atomic Safety and Licensing Board.

  There must be held prior to restart of TMI-1 at least one communications drill similar to that suggested by the Commonwealth (PF 1118). The drill should include ideally, communications between: Licensee and PEMA, PEMA and each risk county and its key officials and each municipality and its key officials. Such a drill should be structured to test telephone service and the various radio systems. If possible, stress should be placed on the communications systems to test the possible effect on an emergency overload situation.

- Dauphin County will demonstrate its ability to promptly implement the notification and alerting responsibility upon a breakdown in communications between PEMA and TMI. Notifications shall include other TMI risk counties, PEMA and Dauphin County risk municipalities.

- Lancaster County will demonstrate its ability to promptly notify the Lancaster County risk municipalities of TMI emergency declarations and protective action recommendations.

Please inform me at your earliest convenience as to whether the objectives have been satisfactorily accomplished.

Again, I would like to thank you for the support and cooperation you have provided towards the prompt resolution of exercise deficiencies.

Sincerely,

G. J. Giangi
GPUN Manager,
Emergency Preparedness

lsg

Attachment

cc: R. Wilkerson, FEMA Headquarters
P. Giordano, Director, FEMA Region III
D. Mathews, NRC Headquarters
B. Crocker, NRC Region I
J. Patten, PEMA
D. Taylor, PEMA

SCENARIO

Clocktime/Scenario time

1000 T = 0

TMI-1 Control Room notifies Dauphin County and PEMA that a Site Emergency was declared at TMI-1 at 0950 due to a large leak within the Reactor Building. Minor amounts of radioactivity is being released to the environment but is expected to terminate within 30 minutes.

Expected Actions:

PEMA should contact BRP and the TMI risk counties. Dauphin County should contact the risk municipalities. BRP should contact TMI-1.

1030 T = 30

TMI-1 recommends sheltering for a 2 mile radius around TMI to BRP. At this point it will be assumed that neither BRP nor TMI can contact PEMA requiring Dauphin County to assume the lead role.

Expected Actions:

Dauphin County should contact the risk counties, Dauphin County risk municipalities and attempt to contact PEMA.

ATTACHMENT 2

EMS Emergency Management Services, Inc.

Suite 105
355 North 21st Street
Camp Hill, PA 17011
(717) 737-5677

July 18, 1984

JUL 19 1984

Mr. George Giangi
Manager, Emergency Preparedness
GPU Nuclear
P.O. Box 480
Middletown, PA 17057

Dear George:

In accord with your instructions, EMS assigned personnel to each of the five TMI risk counties to independently observe player participation in the communications exercise. The observers were orally briefed on the general scheme of the drill and instructed to observe the effectiveness of message handling (authentication and accuracy), dissemination of messages (both internally and to risk municipalities), the amount of realism (actual play vs. simulation), and finally to assess the overall demonstrated capability of the observed county to conduct operations under emergency conditions. Due to some early concerns expressed by county EMCs, the introduction of these observers into the framework of the exercise were not as official critics. Consequently, the observations listed below should be treated as a basis for GPU/EMS continuing effort to assist the counties in the development of more effective organizations and improved operational procedures. The comments are not listed in any priority manner.

Favorable comment:

a. The counties participated to the degree to which they had planned to participate, and notified all risk municipalities in an acceptable time frame, which in itself is a major undertaking that severely tests the saturation point of the inplace telephone communications system.

b. All counties demonstrated that their respective listing of municipal EMCs and institutional points of contact were up to date.

c. The existing notification systems were adequate.

d. Telephone communications, although slow, were sufficient to meet the initial message dissemination requirements.

e. On duty shifts (full time employees) were adequate to handle the initial message dissemination surge.

f. Initial response personnel demonstrated their general knowledge of the RERP as it applied to dissemination of the triggering message.

g. In two instances, Lebanon and York Counties, second echelons of leadership demonstrated their respective capacities to fill the EMC roles due to the absence of the EMC. The Dauphin County EMC handled the responsibilities of the assistant EMC during the initial notification requirement and demonstrated that the county has the capability to accommodate the loss of key personnel and operate effectively.

h. Dauphin County demonstrated that it has the capacity to assume net control from PEMA in the event of a communications failure by use of existing radio and/or telephone channels.

i. Of special interest were the actions of Lancaster County. This county extended the drill beyond the communications objectives to include setting up of the EOC; activating RACES, PEMARS and local government radio nets; and, the planning and preparation for triggering of the public alert system. Two volunteer* staff members physically reported to the EOC and set-up for continued operations.

j. Dauphin County is to be commended for its full call-out effort which included municipalities, school districts, nursing homes, etc. Especially noteworthy was the effort to locate primary points of contact and the cooperation and coordination among those disseminating the initial message in sharing the notification burden.

k. Positive attitudes toward the drill and its importance for preparedness were observed in all counties.

Areas needing attention:

a. The recording of emergency notification messages needs additional practice to insure completeness, accuracy and timeliness.

b. All messages, incoming and outgoing, should be in writing. This would ensure that when several individuals are disseminating information that the identical information is being delivered.

c. Lebanon County did not receive the initial message from PEMA.

d. During drills and tests (communications) some administrative arrangements need to be developed which does not require the personal response of the municipal EMC. The present system of calling the business or work place of the EMC and having the individual called or paged only to discover that it is a communications drill is not received enthusiastically by either the employee (EMC) or the employer.

* Per July 25, 1984 telephone conversation between G. J. Giangi (GPUN Mgr Emergency Preparedness) and Oran K. Henderson (EMS), the word "volunteer" is incorrect and should be deleted.

e. Four of the five county RERPs include an Incident Notification Form, designed to be used for the transmission of information from the State to the County. The Lancaster County RERP does not include the form. The forms being used by the four counties are not identical. (York County uses a form shown as Change #1, July 1983 and the remaining counties use the form distributed with their initial RERP). The York County form includes redundant information in paragraph II. and III.8.

f. The initial notification message from some counties to municipalities and institutions was too lengthy.

g. The role of the log/journal needs to be emphasized during subsequent training sessions and a"log/journal clerk" needs to be identified and instructed in its maintenance, in some instances.

EMS provided observers to the Counties as follows:

Cumberland County.....M. Starry
Dauphin County.....K. Henderson
Lancaster County.....R. Carroll
Lebanon County.....W. Vinnette
York County.....D. Thomas

The FEMA provided J. Asher as an observer to the Dauphin County and K. Lawson to the Lancaster County. The PEMA similarly assigned P. Robbins to Dauphin County and R. Foor to Lancaster County. FEMA and PEMA did not have representatives at the other EOCs.

Sincerely,

ORAN K. HENDERSON

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