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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)	)	
	)	

UCS COMMENTS ON TMI-1 RESTART IMMEDIATE EFFECTIVENESS

By Order of June 1, 1984, the Commission sought comments from the parties on

> whether, in view of ALAB-772 and all other relevant information, including investigative reports by the Office of Investigations, the management concerns which led to making the 1979 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.

The Commission's action appears to have been prompted by a Licensee filing of May 30, 1984, which argued that the Commission has sufficient evidence available to it to lift the immediate effectiveness of the 1979 shutdown orders. The Licensee's position depends upon material not in the record of

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the adjudicatory hearing and upon the proposition that the Commission need not confine itself to the adjudicatory hearing record in making its decision.

Licensee's position is incorrect. First, under its own order establishing the rules for this proceeding, the Commission may not order restart of TMI-1 unless the decisions of its licensing and appeal boards are favorable to restart. ALAB-772 is not favorable to restart. Second, any decision to allow the restart of TMI-1 would necessarily depend upon a wide range of license amendments that the Licensing Board found to be necessary in the light of the TMI-2 accident to protect the public health and safety in the event of restart of TMI-1. Thus, a restart decision would not, in the Licensee's words, "restore the original rights under the license when it has sufficient information to do so." To the contrary, any decision to permit restart of TMI-1 would involve and explicitly rely upon many license amendments. Indeed the restart decision itself constitutes issuance of a license amendment. UCS was entitled to an adjudicatory hearing on the sufficiency of these amendments and is entitled to a restart decision that is based solely upon the adjudicatory record.

Accordingly, the Commission must base any restart decision on the adjudicatory record. It may not lawfully consider "all other relevant information" or other extra-record material.

In ALAB-772, the Appeal Board identified specific deficiencies in the hearing record that prevent a finding that

Licensee has the competence and character to operate TMI-1 without threatening the public health and safety. In light of ALAB-772, any restart decision prior to resolution of the issues identified by the Appeal Board would be arbitrary and capricious. Unless reversed by the Commission, ALAB-772 prevents the Commission from authorizing restart until the remanded hearing has been completed.

UCS argues further that, even if off-the-record material is considered, the Commission cannot find that GPU possesses the competence and integrity necessary to safely operate TMI-1.

Background

In its Order and Notice of Hearing of August 9, 1979, the Commission established the standards and procedures that govern any restart decision. First, the Commission identified four safety concerns unique to TMI-1 that it said must "be resolved prior to restart." Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit No. 1), CLI-79-8, 10 NRC 141, 143-44 (1979). These included "questions about the management capabilities and technical resources of Metropolitan Edison," id., which are the subject of ALAB-772.

In light of those concerns, the Commission ordered that TMI-1, in contrast to other B&W reactors, remain in a cold shutdown condition until satisfactory completion of such short-term actions as the Commission determines are necessary based upon a review of the Licensing Board's decision. Id. at 144. Thus, the purpose of the adjudicatory proceeding that the

Commission instituted on August 9, 1979, was to determine what actions are necessary and sufficient to protect the public health and safety and to determine whether the actions have been taken such that restart may be allowed.

Having established the issues that must be resolved prior to restart, the Commission set out the standard and procedure that would govern its own decision whether to lift immediate effectiveness of the suspension of the license for TMI-1:

> If the Licensing Board should issue a decision authorizing resumption of operation upon completion of certain short-term actions by the licensee . . . , and subsequently if staff certifies that those short-term actions have been completed to its satisfaction, the Commission will issue an order . . . deciding whether the provision of this order requiring the licensee to remain shut down shall remain immediately effective. . . . The Commission shall issue an order lifting immediate effectiveness if it determines that the public health, safety, or interest no longer require immediate effectiveness.

Id. at 149 (emphasis added). Since the Commission established this standard and procedure to govern its restart decision, it has inserted the Appeal Board into the decisionmaking process, CLI-81-19, 14 N.R.C. 304 (1981), and it has ruled that the Appeal Board has no authority to stay a Licensing Board decision. CLI-81-34, 14 N.R.C. 1097, 1098 (1981). It has not, however, altered the fundamental premise that the Commission will consider allowing restart only on the basis of an adjudicatory decision favorable to restart.

I. The Appeal Board's Determination That The Record Does Not Support Restart Prohibits The Commission From Authorizing Restart.

When the Commission ordered the shutdown of TMI-1, it established a clear standard that must be met before the Commission will consider whether to authorize restart. There must be a licensing board decision "authorizing resumption of operation upon completion of certain short-term actions by the licensee." Thus, by the Commission's own order, it may not authorize restart of TMI-1 unless there is a decision favorable to restart based upon the record compiled in the formal adjudicatory hearing.

In light of ALAB-772, the Commission's condition has not been met. When the Commission issued its August 9 order, it did not envision Appeal Board involvement in the restart proceeding. Since then, however, the Commission has inserted the Appeal Board in its normal role of intermediate review of the Licensing Board's decisions. CLI-81-19, 14 N.R.C. 304C (1981). As in any judicial hierarchy, the validity of a decision at any given time depends upon the most recent ruling. Thus, since ALAB-772 overturned the Licensing Board's management decision and held that the record does not support a finding that restart would not be inimical to the public health and safety, there is today no Licensing Board decision that meets the standard set by the Commission when it instituted this proceeding.

The Commission may not avoid the effect of ALAB-772 by interpreting its August 9 order as permitting it to allow restart regardless of any Appeal Board decision. To do so would be the height of arbitrary action since it would ignore a decision by a body expressly established by the Commission to review the decisions of the Licensing Board. It would also render the Appeal Board's role in this adjudication a complete and transparent sham. Unless and until the Commission completes appellate review and reverses the Appeal Board, it is bound by ALAB-772, which supersedes the previous Licensing Board decision. Since ALAB-772 is unfavorable to restart, it prevents the Commission from authorizing restart.

The Commission also may not avoid the effect of ALAB-772 by altering the standard and procedure that it established in 1979. Once an agency has established procedures to govern a particular proceeding or a particular decision, it must not alter those procedures, particularly if to do so would prejudice any parties to the proceeding. Pacific Molasses Co. v. F.T.C., 356 F.2d 386, 387 (5th Cir. 1966).

Commission action at this late date to authorize restart on the basis of off-the-record information and arguments filed in response to the Commission's order of June 1, 1984, would violate this principle. It would also severely prejudice UCS' rights as a participant in the decisionmaking process.

First, for nearly five years all of the parties have been bound by and presumably have acted in light of the principle that the Commission would not even consider authorizing restart in the absence of a favorable decision from its adjudicatory bodies. All parties have developed their evidence, prepared their cases, conducted their investigations, and otherwise acted on that premise. The parties are entitled to rely upon that standard throughout the proceeding, and the Commission may not suddenly alter that threshold for a restart decision. Port Terminal Railroad Association v. United States, 551 F.2d 1336, 1343 (5th Cir. 1977) (I.C.C. could not deny rate increases on the ground of incorrect methodology in presentation where common carriers had based presentation on methods used in support of a previous favorable rate decision, and I.C.C. had not apprised parties of changes in standards or rules).

Second, Commission action based upon off-the-record information would prejudice UCS by denying the fundamental right of cross-examination. This is particularly important in this case since the facts do not involve solely technical or hardware issues, but the demeanor, character, and credibility of witnesses. In fact, in the prehearing conference held by the Licensing Board on June 28, 1984, in response to ALAB-772, the Chairman emphasized the importance of having the Board itself be able to hear and judge the various witnesses, moreover, particularly "when we are talking about issues of credibility." Tr. 12,305-06. These are precisely the types of

evidentiary questions for which cross-examination is most important.

Third, a Commission restart decision based upon filings in response to the June 1 order would prejudice UCS by denying UCS either an opportunity to confront and rebut new information provided by Licensee and the Staff, and by depriving UCS of an opportunity to understand and respond to the bases for a Commission decision. See infra Part III.

II. The Restart Proceeding Involves The Issuance Of License Amendments On Which Intervenors Are Entitled To An Adjudicatory Hearing.

A. Restart Involves More Than Merely Lifting A License Suspension.

The Commission's attempt to consider extra-record evidence and thus to avoid the Appeal Board's adverse conclusions in reaching a restart decision depends upon the proposition that the Commission would merely be lifting the 1979 immediate suspension of GPU's license. The essence of the Commission's position, as reflected in the Licensee's recent arguments, is that the Commission must "restore the original rights under the license when it has sufficient information to do so." Thus, in order to force this proceeding within the rubric of the mere lifting of a suspension, the Commission would have to permit restart under the license as it existed in 1979.

This position ignores the extensive developments of the past five years and the fact that restart would not involve a return to the pre-suspension status quo. It is utter fiction to suggest that the Commission has simply examined the situation at TMI-1 as an enforcement matter, found that its

enforcement concerns have been answered, and will now lift the suspension and allow GPU to recover the rights that it had under the pre-suspension license.

The licensing status quo of this reactor is one of shutdown, not of operation. There has never been any indication by the Licensing Board, the Appeal Board, the NRC Staff, or the Commission itself that it would be acceptable to allow the operation of TMI-1 under the terms of the license as they existed before the accident at Unit 2 and before the suspension. Every Licensing Board decision favorable to restart has depended heavily upon new license conditions as essential to protection of the public health and safety. See, e.g., Metropolitan Edison Company (Three Mile Island Unit No. 1), LBP-81-32, 14 N.R.C. 381, 578-82 (1981).

Accordingly, assuming arguendo that the Commission must lift a license suspension once the concerns that prompted the suspension have been resolved, that principle does not apply to Three Mile Island Unit No. 1. The Commission has never proposed, and it undoubtedly would not permit the reactor to operate under its 1979 license without the conditions that are embodied in the license amendments found necessary by the Licensing Board.[1]

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[1] In its filing of May 29, 1984, Licensee cites four Commission decisions in support of its argument that the Commission must lift the suspension once its concerns have been resolved. Sacramento Municipal Utility District (Rancho Seco Nuclear Generating Station), CLI-79-7, 9 N.R.C. 680 (1979), aff'd, Friends of the Earth, Inc. v. United States, 600 F.2d 753 (9th Cir. 1979); Pacific Gas and Electric Company (Diablo

(footnote continued on following page)

Under the Commission's theory, the Commission could lift the suspension only if the Licensee had demonstrated that no new license conditions were needed to assure safety in the event of restart. That is not what happened. Once the Licensing Board determined that many license amendments were necessary to assure safety in the event of restart, the proposition that this is merely an enforcement proceeding to resolve the concerns that led to an immediately effective shutdown became obsolete. Thus, if the Commission is to consider extra-record evidence and reach a restart decision without completing the formal adjudicatory process, it must do so on some other theory.

Licensee relies upon Northwest Airlines v. Civil Aeronautics Board, 539 F.2d 748 (D.C. Cir. 1976), for the proposition that an agency must terminate an immediate suspension once the concerns that gave rise to the suspension have been resolved. Far from supporting Licensee's position,

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(footnote continued from preceding page)
Canyon Nuclear Power Plant), CLI-83-27, 18 N.R.C. 1146 (1983); Public Service Co. of Indiana (Marble Hill Nuclear Generating Station), CLI-80-10, 11 N.R.C. 438 (1980); Consumers Power Company (Midland Plant), CLI-73-38, 6 A.E.C. 1082 (1973). None of these decisions addressed the question of whether the Commission may lift a suspension without completing an ongoing adjudicatory hearing where the justification for lifting the suspension depends in part upon new license conditions and amendments found necessary by the Atomic Safety and Licensing Board. Thus, whatever their validity, these decisions provide no guidance here. Indeed in the Diablo Canyon case, the Commission declined to do exactly what is proposed by GPU; that is, it rejected the Applicant's request to reinstate a suspended low power license because the Appeal Board had reopened the adjudicatory record with respect to the quality assurance issues that had led to the original suspension. 18 N.R.C. at 1150.

this decision highlights the distinction between this case and one in which an agency must return to the pre-suspension status quo.

In Northwest Airlines, the CAB approved immediate route changes in order to alleviate imminent financial harm to two major airlines, and it left the changes in effect for up to two years without providing affected parties an opportunity for a hearing. The court held that although the agency had the authority to take immediate temporary action, it could not leave those temporary changes in effect for such a long period without a hearing. Rather, the agency should have instituted "narrowly focused, expedited hearings - looking toward a decision on permanent changes in certificate authority." Id. at 752. Since the agency had not held such a hearing, the court overturned the temporary route changes.

Here, the Commission took temporary action to meet the emergency, and it instituted a hearing to determine conditions for restart, if any. Thus, it met the requirements of Northwest Airlines. Rather than recommending a return to the pre-suspension status quo, however, the Licensing Board found that a number of license amendments were necessary conditions to restart, and the Appeal Board has held that the record is not sufficient to support a finding that restart would not threaten the public health and safety. The Commission may not now ignore the Licensing and Appeal Boards' findings. Similarly, had the CAB in Northwest Airlines held a hearing in

which it reached a decision on permanent changes in certificate authority, the agency could not have returned to the pre-emergency status quo without further hearings.[2]

B. The Restart Decision Involves License Amendments On Which Interested Parties Have The Right To A Hearing.

Section 189(a) of the Atomic Energy Act, 42 U.S.C. § 2239(a), establishes that those affected by a license suspension or amendment are entitled to a hearing:

> In any proceeding under this chapter, for the granting, suspending, revoking, or amending of any license . . ., the Commission shall grant a hearing upon the request of any person whose interest may be affected by the proceeding, and

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[2] Licensee also cites Interstate Commerce Commission v. Oregon Pacific Industries, Inc., 420 U.S. 184 (1975), and City of West Chicago, Illinois v. United States Nuclear Regulatory Commission, 701 F.2d 632 (7th Cir. 1982). Neither supports Licensee's position. The latter holds only that the Atomic Energy Act does not require full adjudicatory hearings for materials licensing cases. It is irrelevant here. The former involved emergency action by the I.C.C., which was upheld by the Supreme Court. Licensee cites a concurring opinion in which Justice Powell argued that the case should be remanded to the agency for full proceedings since the emergency had passed. The case could be cited as support for the proposition that the Commission had the authority to take emergency action to shut down TMI-1. Otherwise, it has no bearing on this case, particularly since the Commission has already held the hearing that Justice Powell's concurrence suggests should be held. Licensee's problem here is not that it has not had a hearing, but that the the outcome of the hearing has consistently been unfavorable to restart under the original terms of the license. First, the Licensing Board held that several license amendments are necessary to protect the public health and safety. Second, the Appeal Board has held that the existing record is insufficient to support a finding that restart would not be inimical to the public health and safety. Even under the authorities cited by Licensee, Licensee has had the hearings to which it would be entitled, and the outcome of those hearings precludes restart of TMI-1 at this time.

> shall admit any such person as a party to such proceeding. . . (Emphasis supplied.)[3]

The restart of TMI-1 falls squarely within that provision. Since 1979, the reactor license has been suspended such that operation of the reactor is prohibited. A restart decision would permit the reactor to resume operation for the first time in five years. There is no doubt that this would involve a "significant change in the operation of a nuclear facility." Sholly v. United States Nuclear Regulatory Commission, 651 F.2d 780, 791 (D.C. Cir. 1980), vacated on other grounds, ___ U.S. ___, 103 S. Ct. 1170 (1983), on remand, __ F.2d __, 19 ERC 1055 (April 4, 1983). Since a restart decision would modify an existing order and "grant[] the licensee authority to do something that it otherwise could not have done under the existing license authority," id., the restart decision itself constitutes issuance of a license amendment. See, also, Bellotti v. N.R.C., 725 F.2d 1380, 1983 (D.C. Cir. 1983), where the court recognized that members of the public would have a right to a hearing in a circumstance such as this, holding

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[3] The only exception to the hearing requirement arises when a license amendment involves "no significant hazards considerations" under the Sholly Amendment, 42 U.S.C. § 2239(a)(2). Even that provision, however, only authorizes the Commission to make an amendment immediately effective. The Commission still must grant a later hearing opportunity, and it must base its decision on the adjudicatory record. The Commission has never claimed, nor is there any basis for an assertion that restart does not involve significant hazards considerations. Indeed, since the license amendments involved in a restart decision are necessary to reverse the Commission's 1979 decision that it no longer had confidence that TMI-1 "could be operated safely, those amendments necessarily involve significant hazards considerations.

that, "public participation is automatic with respect to all [section 189(a)] Commission actions that are potentially harmful to the public health and welfare." Id. at 1383. See Union of Concerned Scientists v. Nuclear Regulatory Commission, No. 82-2053 (D.C. Cir. May 25, 1984), slip op. at 13.

Equally important, the very purpose of the restart proceeding, unlike most license amendment proceedings, was not only to determine whether a particular proposed license amendment is necessary to protect the public health and safety, but also to determine whether a set of license amendments were necessary and sufficient to assure safety if restart were permitted. Consistent with that purpose, the Licensing Board decisions to date establish that restart will be permitted only after a number of new conditions are incorporated in the reactor license.

Indeed, far from supporting a lifting of the suspension imposed in 1979, the Licensing Board decisions confirm that the pre-suspension license was not adequate to protect the public health and safety. Thus, TMI-1 is not comparable to a facility against which enforcement action is being taken under its own license, but to a facility applying for an operating license. In both cases, the question is what license conditions and limitations are necessary to protect the public health and safety. And in both cases the Commission action authorizing operation is a licensing action.

Interested persons are entitled to hearings on each of the license amendments at issue here and on the sufficiency of

those amendments to assure the safety of the reactor.[4] Indeed, the Commission itself specifically recognized this right when, in its order of August 9, 1979, it ruled that parties would be entitled to litigate both the necessity and the sufficiency of the actions that th Commission had established as conditions of restart. CLI-79-8, 10 N.R.C. at 148.

For these reasons, the restart hearings were not simply a discretionary "enforcement" proceeding, but a license amendment hearing under the Atomic Energy Act. UCS and the other intervenors were entitled to participate.

C. The Commission Must Base Its Restart Decision On The Record Of The Adjudicatory Hearing.

As the Commission has long recognized, section 189(a) of the Atomic Energy Act requires that the Commission hold adjudicatory hearings subject to the full panoply of hearing rights established by the Administrative Procedure Act, 5

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[4] This case is distinct from Bellotti v. NRC, 725 F. 2d 1380 (D.C. Cir. 1984), in which denial of a license amendment hearing was upheld because the Attorney General of Massachusetts did not oppose the action called for by the license amendment. The same is not true here. In the Bellotti case, the reactor in question remained in operation throughout; the only issue was whether additional license conditions would be imposed. Thus, NRC reasoned that the amendment could not conceivably harm the interests of the citizens of Massachusetts. On the contrary, TMI-1 is out of operation. The intervenors oppose operation, and their interests would be adversely affected if the Commission permitted resumption of operation. Moreover, unlike Bellotti, the Commission's August 9, 1979, Order establishing this proceeding specifically permitted issues to be raised concerning both the need for and sufficiency of a set of remedial measures. 10 N.R.C. at 148.

U.S.C. §§ 554, 556, 557.[5] The Administrative Procedure Act prohibits the Commission from considering information that is not on the record when its makes any decision, including this one, that is governed by the adjudicatory hearing requirements.

The APA provides that

> A sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence. . . . A party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. . . .

5 U.S.C. § 556(d). It also defines the "exclusive record for decision" as the "transcript of testimony and exhibits, together with all papers and requests filed in the proceeding. . . ." 5 U.S.C. § 556(e).

The Commission may not go beyond that record to find support for its decision. Seacoast Anti-Pollution League v. Costle, 572 F.2d 872, 878, 881 (1st Cir. 1978).

D. The Commission's Regulations Require The Commission To Base Any Restart Decision On The Adjudicatory Record.

The Commission instituted the restart license amendment hearing through the issuance of an Order and Notice of Hearing on August 9, 1979. The Commission's regulations governing notices of hearing and hearings themselves are quite specific. They provide for only one type of hearing and one mechanism for appellate review. They also provide for only one mechanism

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[5] See, e.g., Union of Concerned Scientists v. Nuclear Regulatory Commission, No. 82-2053 (D.C. Cir. May 25, 1984), slip. op. at 16 n. 12, for a discussion of the requirement to grant adjudicatory hearings.

through which a decision with respect to a reactor licensee may be made immediately effective prior to completion of appellate review. Under these provisions, the Commission may not authorize restart of TMI-1 without completing appellate review.

Section 2.104(a) governs the notice of hearing issued by the Commission on August 9, 1979. In that order, the Commission stated that it had "determined that hearing . . . is required." Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit No. 1), CLI-79-8, 10 N.R.C. 141, 142 (1979). Thus, § 2.104(a) governs regardless of whether the Atomic Energy Act requires the restart hearing, as UCS contends, or whether the Commission instituted the hearing as a matter of discretion in order to serve the public interest.

According to 10 C.F.R. § 2.700, "The general rules in [Subpart G] govern procedure in all adjudications initiated by the issuance of . . . a notice of hearing." The only exception to this provision is for adjudications involving military or foreign affairs functions, which this does not. Since this adjudication was instituted by a notice of hearing, Subpart G applies.

Subpart G does not allow the Commission to consider off-the-record material in reaching a restart decision. First, 10 C.F.R. § 2.760(c) provides that the initial decision must be based "on the whole record." There is no provision that would permit the licensing board to consider material not included in the adjudicatory record, nor is there any provision that would permit an appellate body, whether the Appeal Board or the

Commission, to consider such evidence. Thus, under the Commission's own rules, this proceeding must be decided on the adjudicatory record.

Moreover, the Commission's immediate effectiveness rule, 10 C.F.R. § 2.764 demonstrates that TMI-1 is precisely the sort of case in which licensee activity may not be permitted prior to completion of appellate review. Section 2.764 permits licensing board decisions favorable to the license applicant to become immediately effective under certain conditions. These are the only situations in which a license applicant may be authorized to operate a reactor or otherwise act under a license before appellate review is completed.

Both the letter and the logic of the Commission's immediate effectiveness regulation preclude immediate effectiveness of the licensing board decisions that would authorize restart of TMI-1. The regulation permits immediate effectiveness only where the current status of the adjudicatory process is favorable to the license applicant. The regulation makes no provision for permitting immediate licensee action where an intervening Appeal Board decision is unfavorable to the applicant. Indeed, since an unfavorable Appeal Board decision would eliminate the on-the-record basis for licensing, § 2.764 could not permit immediate effectiveness in the event of an appeal that is decided against the applicant. For the same reason, the Commission may not now permit the immediate operation of TMI-1 because the appeal board has held that the record does not support it.

III. Due Process Requires That The Commission Grant A Hearing On Restart And Adhere To The Adjudicatory Record.

Regardless of whether the Commission must reach its restart decision on the basis of the adjudicatory record, it may not reach that decision simply on the basis of filings submitted in response to its Order of June 1, 1984. That Order invites all parties to address "all other relevant information," regardless of whether other parties have been privy to the information, and regardless of whether other parties have had an opportunity to address that information. The Order also indicates that the Commission intends to reach a restart decision without giving the parties an opportunity to comment on a draft decision or to respond to partial extra-record material, or otherwise giving the parties any indication of the criteria on which its decision will be based.

A Commission decision without further opportunity for public comment would violate due process. "An opportunity to meet and rebut evidence utilized by an administrative agency has long been regarded as a primary requisite of due process." Ralpho v. Bell, 569 F.2d 607, 628 (D.C. Cir. 1977). See also Sea-Land Service, Inc. v. Federal Maritime Commission, 653 F.2d 544, 551 (D.C. Cir. 1981), and North Alabama Express, Inc. v. United States, 585 F.2d 783, 786 (5th Cir. 1978). It is fundamental that UCS has the right to confront and rebut whatever evidence the Licensee or the staff may assert supports their positions and that UCS has the right to answer any new arguments or positions that the Commission intends to adopt.

Thus, due process alone requires that UCS have the opportunity to confront and rebut any extra-record material and supporting arguments put forward by other parties. It also requires that UCS be apprised of the criteria and bases for any Commission decision and that it have an opportunity to address the relevant issues.

IV. Allowing TMI-1 to Operate In the Face of The Appeal Board Decision (ALAB-772) Would be Arbitrary and in Violation of NRC's Duty to Protect Public Safety.

The heart of the Appeal Board decision in ALAB-772 is the ruling that the record does not support a finding that GPU has the competence to operate TMI-1:

> As we explain below, the present state of the record in several areas does not permit us to make an ultimate judgement on the licensee's competence.

ALAB-772, Sl. Op. at 3.

Nor does the record support a finding that the TMI-1 operators are competent to operate the plant:

> The Licensing Board correctly framed the issue: 'is the instruction adequate to prepare the operators to operate the plant safely?' . . . We disagree with the Board, however, on its affirmative answer to that question...

Id. at 63.

The questions raised by the evidence adduced in the cheating hearings include those most fundamental to operator competence:

> For example, does the training program actually enhance the operators' knowledge or simply encourage memorization for test-taking purposes? Are the licensees and NRC examinations an effective way to measure an operator's ability to run the plant? Do the format and content of the examinations encourage cheating?

Id.

As the Appeal Board noted, one-fourth of those who took the April, 1981, NRC examinations were either directly involved in cheating or were implicated in some manner that could not be satisfactorily explained. Several of these were and still are in supervisory positions. Beyond the actual cheaters, the record is overwhelming that the operators and training staff did not take the training or examination process seriously, but treated it as a technical obstacle that the NRC had erected for them to overcome. Id. at 63-64.[6]

The ASLB based its endorsement of GPU's training program on the testimony of a panel of witnesses who spoke in glowing terms of the GPU training program. Id. at 65 and citations therein. Unfortunately, after these "experts" had left the scene, the evidence brought out during the cheating hearings disclosed not only widespread cheating (or "cooperation") on

[6] This is consistent with GPU's pattern as a licensee. The Unit 2 leak rate falsification, possible falsification of Unit 1 leak rates, failure to close the PORV block valve prior to the accident to identify the source of excessive leakage. (Investigation Evaluation of Remaining Allegations Relating to Harold Hartman, p. 9). Failure to take effective steps to correct the surveillance procedures and equipment for the emergency feedwater pump surveillance tests (Id. at 3-4 and Ex. 1 at 12-13) are all indicative of a utility that treats NRC requirements as technical formalities and lacks an understanding of or a commitment to the procedures and processes necessary to assure safety.

company-administered exams and a thorough disdain for the training and examination process, but also that the content of the program was gravely deficient. The training and testing program relied upon rote memorization and did not attempt to actually teach operators material in areas where they had demonstrated weakness, Report of the Special Master, "RSM," ¶¶ 245, 251, 15 N.R.C. 918, 1016, 1020.[7] The same questions were repeated on makeup exams (some take-homes) week after week until the operators finally learned to parrot the approved words. Id. at ¶ 246, p. 1017. "From this pattern one must conclude that the training department did not take seriously the licensee's obligation to teach the subjects required by the Commission's orders and that the operators did not take seriously their obligation to learn it." Id.

The Special Master also found in these paragraphs explicitly endorsed by the ASLB that "[o]perators were taught words without being taught what the words meant." (Id. at ¶ 251, p. 1020) and that many of the questions were "unrelated to the candidates' ability to operate the reactor." Id

Given these devastating glimpses of the reality behind

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[7] The ASLB specifically agreed at ¶ 2334 (16 N.R.C. 281, 360) with the findings in ¶ 242-251 of the Report of the Special Master.

the curtain of soothing promises,[8] it is obvious that the expert evidence relied upon by the ASLB was fantasy.

The ASLB "resolved" this basic problem by adopting a few remedial measures to improve the "quality assurance" of the GPU training program. The centerpiece of these measures is a future audit of some aspects of the training program. ALAB-772, Sl. Op. at 62 and citations. As UCS emphasized and as the Appeal Board noted, at the most, such remedial measures offer the promise that at some indefinite time in the future operator competence may possibly be assured; they do not provide a basis for finding either GPU or the operators competent now. Plant operation cannot be permitted unless GPU is competent (and can be shown on the record to be competent) now.

The Commission appears to have decided that questions of GPU integrity can be "separated" from restart.[9] This

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[8] The ASLB remarked: "In fact, the cheating incident and the reopened proceeding flowing from it appear to have been the first stimulus sufficient to cause Licensee to pull back the 'paper curtain' and actually view its training and testing program at its point of delivery." 16 N.R.C 281, 357 (1982).

[9] On April 26, 1984, the Commission issued a schedule of steps necessary to a restart vote, looking to a vote on June 27. It stated in a footnote that it had determined that integrity issues can be separated from restart. We are at a loss to understand when or on what basis such a determination was made since, in its January 27, 1984 Order, the Commisssion noted that it had solicited the views of the parties on precisely that subject and that its "preliminary" views were therefore subject to revision based on consideration of those comments. The parties dutifully filed their comments, but no Commission decision has ever been forthcoming. We assume that the footnote in the April 26, 1984, Order was not intended to serve as a decision.

principle cannot extend to competence. For one thing, questions about the competence of this utility were specifically included in a short list of "unique circumstances at TMI" that the Commission found to justify treating TMI in a different manner than other B&W plants - i.e., requiring shutdown pending hearings -- and which were required to "be resolved prior to restart." CLI-79-8, 10 N. R. C. 141, 143 (1979) (emphasis added), ALAB 772 at 3. In addition, the Commission founded that among the "short-term actions" that the company is require to complete as a condition of safe operation, are

> 1. (e) [The licensee shall] [a]ugment the retraining of all Reactor Operators and Senior Reactor Operators assigned to the control room including training in the areas of natural circulation and small break loss of coolant accidents including revised procedures and the TMI-2 accident. All operators will also receive training at the B&W [Babcock & Wilcox] simulator on the TMI-2 accident and the licensee will conduct a 100 percent reexamination of all operators in these areas. NRC will administer complete examinations to all licensed personnel in accordance with 10 CFR 55.20-23.
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> * * *
>
> 6. The licensee shall demonstrate [its] managerial capability and resources to operate Unit 1 while maintaining Unit 2 in a safe configuration and carrying out planned decontamination and/or restoration activities. Issues to be addressed include the adequacy of groups providing safety review and operational advice, the management and technical capability and training of operations staff, and the adequacy of the operational Quality Assurance program and the facility procedures, and the capability of important support organizations such as Health Physics and Plant Maintenance.

Id. at 144-45. See id. at 146, 149.

Thus, the Commission ruled five years ago that the prerequisites for restart must include successful retraining of all TMI operators and a demonstration of management competence. The program undertaken by GPU to fulfill the post-accident requirement is the precise program that the evidence has shown to be egregiously inadequate. RSM, ¶ 328, 15 N.R.C. 918, 1049-1050. There is no record evidence showing that it has improved over what is described by the Special Master, the ASLB and the Appeal Board. The mere passage of time does not transform bad into good, nor is GPU due any presumption that its reconstituted experts are now credible when their previous testimony fell so short of describing reality.

Moreover, as The Appeal Board noted, competence is beyond question directly related to safety. While the Commission may be of the belief that dishonesty and failures of integrity do not bear on safety, (a view with which UCS strongly disagrees)[10] competence is another matter entirely. As the Appeal Board noted:

> In sum, proper training is essential to the safe operation of the plant and requires the closest scrutiny. This is especially so here, where because of the role of operator error in the TMI-2 accident, training has been of key importance in this proceeding from the outset. There is no substitute for a complete and convincing record.

ALAB-772 at 76, emphasis added.

In addition, in this case in particular, numerous

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10 See "Union of Concerned Scientists Brief on Exceptions to Partial Initial Decision (Reopened Proceeding), September 30, 1982, pp. 6-7, 10-18.

design-related issues raised by UCS and others were resolved by the ASLB on the grounds that design changes or improved equipment would not be necessary because the greatly improved level of competence of GPU, assured by the augmented post-accident training program, would obviate the need for these hardware improvements. The ASLB explicitly acknowledged this:

> In Part II above we have made many determinations favoring restart dependent upon improvements in the TMI-machinery. However, it can be readily observed that our determinations also depend very heavily upon correct operator procedures essential to safety. Operators whose competence has been ensured by appropriate training which has been verified by NRC and company-administered examinations are an indispensable element of nuclear safety despite the many improvements in plant design.

¶ 2017, 14 N.R.C. 1211, 2017 (1981) (emphasis added).

At some points in the original ASLB decision where operator action was heavily relied upon to ensure the protection of public safety, the Board explicitly noted that the outcome of the cheating hearings had the potential to change its decision. One example concerns the ASLB's crucial reliance on the so-called feed-and-bleed mode of core cooling:

> We do not disagree with the UCS claim . . . that extensive training and well-conceived procedures are required when the feed-and-bleed cooling mode is relied upon to dissipate the heat from the core, but the complete record as it stands today supports the conclusion that these procedures and training can be provided. However, we have reopened the record in this proceeding to inquire into the significance of the test cheating disclosures on the effectiveness of operator training.

14 N.R.C. 1211, 1231 (1981), (emphasis added).

A number of other hardware issues were addressed by the ASLB in a similar manner by relying substantially on greatly enhanced operator training and competence to 1) make core uncovery incredible (Id. at 1229-1230); 2) provide sufficient reliability of decay heat removal by a combination of emergency feedwater and feed-and-bleed (Id. at 1230-1231); 3) avoid the need to install direct core volume measurement prior to restrart (Id. at 1236-1238); 4) avoid the need for installation of safety-grade pressurizer heaters (Id. at 1267-1270); 5) avoid making the PORV safety-grade. A full discussion of the relationship between these and other hardware issues and the ASLB's reliance on a very high level operator competance is found in the Union of Concerned Scientists' Comments on Report of the Special Master, May 18, 1982. In addition, the Appeal Board found that "[t]he record in this proceeding is replete with examples of where it is essential for an operator to be fully conversant with plant design and procedures" and listed many of these examples. ALAB-772, n. 61 at 76.

In summary, ALAB-772 establishes that there is no basis in the record for the necessary confidence that GPU management or operators have the requisite competence to operate this plant safely, particularly considering the extraordinary reliance which GPU and the ASLB placed in this case on the program of enhanced post accident training. The record shows not only widespread cheating

and disrespect for the training program, particularly at relatively high supervisory levels, but also an intolerable attitude on the part of the company which continued to deny even obvious cheating and presented as sworn testimony in the hearing a purportedly "independent" investigation which presented only exculpatory evidence and discounted or ignored evidence of cheating. These are the findings of the ASLB not the Special Master.[11] This took place after the TMI-2 accident had graphically shown the urgent need for improved operator training and, in recognition of this, the Commission had directed requalification of all TMI operators. If the accident and its aftermath had not sufficiently attracted GPU's attention (the current GPU, not the "old" company) to the training of its staff, little credence can be placed in its current promises.

In addition to the broad disrespect for training, and quite likely a major contributor thereto, the record shows a training program geared largely to mechanical rote memorization. The ASLB tried to avoid the force of this evidence by stating: "Whatever the quality of instruction methods, the intense and repeated exposure to the course material necessarily must contribute to the competence of the operators." 16 N.R.C. 281, 381 (1982). This

[11] See Union of Concerned Scientists' Brief on Exceptions to Parial Initial Decision (Reopened Proceeding), September 30, 1982, pp. 14-17 and citations therein.

remarkable sentence attests strikingly to the weakness of the reed upon which the public health and safety stands. In fact, it is far from self-evident that memorization exercises contribute to competence. They will certainly contribute to short-term retention of words and phrases. They will not necessarily contribute to competence, nor even to retention of the memorized material after a short period of time. [13] They will certainly not assure the high level of judgement and competence required, for example, to assure that the "case will never be uncovered" (14 N.R.C. 1211, 1229-1230) or for bleed-and-feed (Id. at 1231) or to cool the reactor in a solid water condition using High Pressure Injection to control pressure (Id. at 1269).

Nor can the requisite assurance be found in the fact that operators passed the NRC exam. The NRC exam suffers from weaknesses very similar to GPU's. The staff has no intention to review GPU's future plans to qualify candidates for the NRC examination. ALAB-772, pp.73-74. It's new "procedures" go only to proctoring and protection against cheating, not to substantive improvement. Both the ASLB and Appeal Board note that the staff's lack of

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[13] For example, Operator H, despite repeated instruction on natural circulation and the TMI-2 accident lessons learned and participation in GPU's training program, was unable on the witness stand to state the conditions for natural circulation. He told GPU's "independent" investigator that the question "required a lot of straight memorization." RSM, 15 N.R.C. 918, 1015 (1982).

meaningful oversight is inconsistent with NRC's rules and the TMI-2 lessons learned requirements. Id. at 74-75. The NRC exams are structured to conform with GPU's training program, rather than the actual plant design. The answers sometimes reflected obsolete and inaccurate information and, like GPU's tests, the questions looked for rote memorization of specific phrases rather than a reliable demonstration of knowledge and ability to safely operate the plant. The Special Master, ASLB and the Appeal Board are all in agreement here. See 16 N.R.C 281, 369-371; 15 N.R.C. 918, 1034-5; ALAB-772, pp.72-77. As the Special Master said:

> The final problem is this: the operators' opinion of the examination may be right. The examination may not in fact be measure their ability to operate the reactor safely.

15 N.R.C. 918, 1034.

The enhanced training and requalification requirements imposed following the TMI-2 accident flowed from the fact that all of the investigations of the accident had reached conclusions similar to those of the Kemeny Commission which were paraphrased by the Special Master as follows:

> The Kemeny Commission found that operator training was greatly deficient; that the depth of understanding was far too shallow. It also found that the branch of the N.R.C. that monitored operator training was "weak and understaffed" and that the N.R.C limited itself to "giving routine exams." It concluded that no quantity of "fixes" would cure the basic problem, which it found to be the attitude of the people who were involved.

15 N.R.C. 918, 1032.

There are just two ways in which operator competence can be instilled and verified. One is the company's training and testing program. The other is the NRC examination process. Both must be independently reliable checks on competence; the evidence in this case shows that neither has been.

In light of ALAB-772, operation of TMI-1 cannot be permitted.

V. Off-the-Record Material Does Not Support TMI Restart.

UCS argues in preceding sections of these comments that the Commission may not lawfully rely on untested and self-serving extra-record assertions and promises to authorize operation of TMI-1. We fully expect GPU to take the opportunity of these comments to construct an alternative "record" composed of carefully selected excerpts from the literally thousands of pages of its own internal reports, OI investigative material and miscellaneous documents that have been generated since the record was closed in this case. As the Appeal Board observed: "these and other such subjective documents are not evidence and have not been fairly tested through litigation." ALAB-772 at 157. This case is rife with examples where the rosy picture put forward by GPU and the staff did not withstand scrutiny when presented under oath and subject to questioning. As discussed above, the record in the cheating hearings alone provided many such examples.

In just the last few weeks, some 30 inches of OI material covering many issues have been released. It can scarcely be imagined that the intervenors, or the Commission for that matter, have had the ability to assimilate that material or to make a complete assessment regarding its ultimate significance for the questions of whether GPU has the requisite competence and integrity to hold a license to operate a nuclear power plant. By offering its comments on some of the extra-record material, UCS does not concede that the procedures adopted by the Commission are fair, adequate or lawful.

A. The SALP Report is Not a Reliable Indicator of Competence.

The Commission can not rely on the NRC staff's Systematic Assessment of Licensee Performance (SALP) report, dated April 2, 1984, as a basis for permitting restart of TMI-1. The SALP report is not part of the evidentiary record in this proceeding. The Appeal Board recently noted that the SALP report is a subjective document which is "generally favorable" to Licensee's restructured, new management, but it has "not been fairly tested through litigation." ALAB-772, Sl. Op. at 157.

In UCS's view, the staff's laudatory language in the SALP report is likely, perhaps certain, to be shown without rational basis if the report is introduced into evidence. The SALP report is internally inconsistent and in conflict with the staff's inspection reports, notices of enforcement, ALAB-772, and reality. For the record, we give here only a few examples

of why the SALP report is unlikely to withstand discovery and cross-examination unscathed.

First, it is important to recognize that the SALP program is designed so that every SALP report must find the licensee's performance at least "nominally satisfactory" with respect to operational safety. SALP report, p. 6. The April 2, 1984, SALP report for TMI-1 is no exception.

In discussing licensee performance in the area of plant operations (shutdown mode), the staff praises the administrative policies and procedures pertaining to conduct of operation in glowing words. Procedures are said to be "well stated" and "well understood," and to "reflect a resolve to instill a sense of professionalism in personnel." The procedures are portrayed as including "good management concepts," and the staff claims that "individuals generally use these concepts in an effective manner." In summation, the staff says that licensee's policies and procedures applicable to operations are, overall, "quite good." SALP report, p. 7, emphasis added.

Much of the subsequent discussion in the SALP report is devoted to downplaying the numerous instances where the "quite good" policies and procedures were not implemented or were not effective.

For example, the staff refers to "procedural adherence problems" during hot functional testing last fall. The staff claims that those problems were "primarily errors by nonlicensed personnel" who "indicated a lack of attention to

detail or thoroughness in task implementation" with contributing factors of inadequate management attention and "the pace and number of activities during the hot functional testing period." Id.

What significance the staff attaches to errors by nonlicensed personnel is not apparent. The effects on the public of a radioactive release are not influenced by whether licensed or nonlicensed personnel caused the release. More importantly, the procedures that nonlicensed personnel apparently used were themselves inadequate. As the staff notes, "some difficulties were experienced by the licensee in producing high quality procedures in certain instances." The procedures "should have been more comprehensive in requiring checking of flow path and boundary isolation valves." Id. at 8-9.

The staff claims that "[t]he training progr m does not appear to be a factor in the poor individual performance noted in the procedure nonadherence events discussed above." Id. at 9. No basis whatever for this assertion is given, nor does the staff offer an alternative cause for the "procedure adherence problems." If the training program is so praiseworthy, what is the cause of the problems?

In fact, the staff has nothing but praise for the licensee's training program. However, the Appeal Board, restricted to considering the evidentiary record and weighing the other parties' views was unable to find in the affirmative whether the training program is adequate -- "The most

significant issue requiring further hearing is training." ALAB-772, Sl. Op. at 155.

The staff's praise of licensee's radiological control program (SALP report pp. 11-13) is flatly inexplicable in view of the staff's own finding that violations during the SALP assessment period "represent an apparent breakdown in the proper implementation of your radiological control program." Richard W. Starostecki, Director, Division of Project and Resident Programs, to H. D. Hukill, Director, TMI-1, October 28, 1983. Mr. Starostecki was a member of the SALP board which prepared the April 2, 1984 report. SALP report at 1.

The staff's praise of the licensee's preoperational and startup test program (Id. at 16-17) is likewise at odds with its claim that the procedure adherence problems were due in part to "the pace and number of activities during the hot functional testing period." Id. at 7.

The staff gives the licensee's fire protection program the highest possible rating in the SALP report. Lost are the details of the staff's findings that out of twenty five brigade members whose records were reviewed, none had received the required quarterly training and thirteen had not received training for periods greater than eight months. Combined Inspection Report No. 50-289/83-18, 50-320/83-10, September 6, 1983, p. 11. Instead, the SALP report attributes this violation of the TMI-1 operating license to "a misunderstanding, on the licensee's part..." SALP at 18.

Similarly, the SALP report claims that licensee has demonstrated "a sincere desire to understand and effectively implement the technical issues of Appendix R." Id. The SALP report does not discuss the fact that for fire protection modifications which require neither prior NRC staff approval nor plant shutdown, the licensee proposed an implementation schedule more than a year longer than other licensees. Darrell G. Eisenhut, Director, Division of Licensing to Henry D. Hukill, GPU Nuclear, March 6, 1983, p. 1. Nor does the SALP report discuss the fact that the licensee intends to wait until the first refueling after restart to implement those fire protection modifications that require plant shutdown, but do not require prior NRC staff approval. The licensee proposes this unconscionable delay despite the fact that TMI-1 has been shut down for more than five years and has had more than ample time to make the needed changes. Id., p. 2.

In sum, the SALP report is a cheerleading document, not an objective assessment of licensee's performance. It was presumably written by the staff expecting its authors would never be called upon to justify under oath the sweeping praise of the "new" management at TMI-1. UCS has no doubt that fair scrutiny in a hearing would confirm not only the inconsistencies and inaccuracies we have documented here, all of which are based on NRC's own conflicting documents, but many more.

The SALP conclusions contain a telling statement f the degree of GPU's genuine commitment to long-term safety, as opposed to its commitment to getting approval to restart. In assessing management performance in the area of licensing activities at TMI-1, the staff found that GPUN management "has been more responsive to those issues that impact restart." SALP at 30. The prime example of this given by the staff was that "the steam generator recovery activity consistently involved the highest levels of GPUN management." SALP at 29.

In sharp contrast is the level of GPUN management involvement and responsiveness to the environmental qualification issue. Based on a review of TMI-1 environmental qualification submittals, meetings with GPUN personnel and an audit of the TMI-1 environmental qualification files, the staff found "little evidence of extensive planning for the TMI-1 environmental qualification program." Id. at 29. Furthermore, the SALP report states that: "Review of the environmental files provides no indication of previous management or quality assurance involvement." Id., emphasis added.

The summary statements in the SALP report do not convey the seriousness and breadth of the environmental qualification problems. First of all, the staff's audit examined the records for only eight types of components. In each and every instance the documentation was inadequate to resolve the deficiencies identified in the

Technical Evaluation Report sent to GPU on December 10, 1982, or otherwise demonstrate that the component type is environmentally qualified. John F. Stolz, NRC to Henry D. Hukill, GPUN, April 25, 1984, enclosure, "TMI-1 EQ Audit Components." UCS has been informed that a number of follow-up audits subsequent to the staff's March 20-21, 1984, audit have examined the same eight component types and are not yet able to find adequate evidence of qualification.

The staff formed an "impression that the two GPU individuals assigned to this work are relying to a great extent on our input to them, and that their efforts on EQ are based in large part in reaction to that input." Memorandum for John F. Stolz from Vincent S. Noonan, "Results of Electrical Equipment Environmental Qualification Audit for Three Mile Island, Unit 1," April 6, 1984, p. 1, emphasis added. Furthermore, the staff found that: "It appears questionable if those files have been subjected to a QA audit. * * * Since the licensee informed us that the EQ files have been audited by its QA people, it is not clear what was audited or what QA requirements the licensee is imposing on its EQ files." In other words, GPU either misrepresented that it had done a QA audit or did a clearly incompetent job. Memorandum for Darrel G. Eisenhut from Richard H. Volmer, "Quality Assurance Requirements for TMI-1 Electrical Equipment Environmental Qualification Files," April, 25, 1984.

The staff subsequently concluded as follows:

> Based on our audits of the EFW system to date, we believe that the identified deficiencies raise generic issues requiring resolution. Principally, these questions relate to the methodology used to identify equipment that must be environmentally qualified as well as the adequacy of existing supporting documentation. We have, therefore, been unable to conclude that you are presently in compliance with 10 CFR 50.49 as stated in your letter of February 10, 1984 (as modified).

Darrell G. Eisenhut, NRC, to Henry D. Hukill, GPUN, May 25, 1984, p. 1.

In summary, GPUN management has demonstrated that it is more interested in restart then in long-term safety. Management attention and involvement is with items that would prevent or delay restart. GPUN management virtually ignores safety issues that the Commission has decided are outside the scope of the restart proceeding (but nevertheless within NRC jurisdiction) or are the subject of the "reasonable progress" category of the 1979 shutdown orders. [13]

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[13] The SALP report identifies many more instances where GPUN management has not been responsive than we have discussed herein. For example, "[t]here also have been delays in licensee submittals for NUREG-0737 [TMI Lessons Learned] items that require post-implementation review and certain other submittals requested by the staff." SALP, p. 30. The SALP report identifies neither the nature nor the number of these "other submittals." Of course, GPU's grudgingly slow progress toward installing a core water volume instrument is well known to the Commission.

B. The Long List of Failures of Integrity on the Part of GPU and its Predecessor License Holder, Met. Ed. Disqualify GPU From Holding an NRC License.

1. Lack of Integrity is a Disqualifying Factor for a Nuclear Licensee.

The list of examples of dishonesty, lack of integrity, and disrespect for the basic requirements necessary to assure safety is a long one. The pattern begins before the TMI-2 accident but extends thereafter, as does the consistent inability of GPU to understand or acknowledge the nature of its conduct. We will discuss some of the more blatant and easily-understood examples below. First, however, the importance of absolute integrity on the part of a nuclear plant licensee should be placed in perspective.

The integrity or "character" requirement is embodied, although not defined, in the Atomic Energy Act. 42 USC §2232a. Character is commonly defined as "a composite of good moral qualities typically of moral excellence and firmness blended with resolution, self-discipline, high ethics, force and judgement." Websters Third New International Dictionary 376 (unabridged ed. 1971). "Integrity" is "an uncompromising adherence to a code of moral, artistic or other values: utter sincerety, honesty and candor; avoidance of deception, expediency, artificiality or shallowness of any kind." Id. at 1174. ALAB-772 n.9 at 12. See also Houston Lighting and Power Co. (South Texas Units 1 and 2) LBP-84-13, Sl. Op. at 15-16 (March 14, 1984).

Lack of candor or truthfulness is one defect that can,

without anything more, disqualify a company from holding a license to operate a nuclear power plant. Id. at 23. In addition, either abdication of responsibility or abdication of knowledge during construction or operation can be a sufficient basis for revoking a license for lack of competence or character. Houston Lighting and Power Co., supra, CLI-80-32, 12 N.R.C. 281, 291 (1980). See also ALAB-772 at 13-14.

The character or integrity requirement is clearly intended as a means of assuring safety, relevant to the extent that it indicates "a willingness and propensity, or lack thereof, on the part of an applicant to observe the Commission's health and safety standards." Houston Lighting and Power Co., LBP-84-13, Sl. Op. at 15-16. In the context of nuclear power, ethics cannot be separated from competence. The success of the NRC's regulatory program, and the extent to which it protects public health and safety depend heavily upon self-policing by the nuclear utilities. NRC is able to audit only a very small fraction of the activities of its licensees; the saga of the Grand Gulf technical specifications is just the latest example. NRC depends upon its licensees to honestly and timely identify and report safety problems, to accurately describe those problems, to perform objective analyses, to propose solutions, and to provide a great deal of data necessary for NRC to review safety issues. Indeed, the ASLB in this case noted with some frustration that regulations are not themselves sufficient to ensure public safety; unless the licensee is fully committed, "it is beyond the power of regulators and

regulations to put an appropriate program in place." 16 N.R.C. 281, 358 (July 1982). Licensees are the first and last line of defense; NRC must be able to rely implicitly upon the word of its licensees.

In recognition of this, the Commission "has clearly and forcefully stated its need for truthful and accurate information in order to discharge its responsibilities for the public health and safety: 'nothing less than candor is sufficient.'" Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), LBP-75-54, 2 N.R.C 498, 508 (1975). See also, Hamlin Testing Laboratories v. A.E.C., 357 F.2d 632 (6th Cir. 1966).

Other agencies whose activities touch far less on the public health and safety have revoked licenses on the basis of lack of candor. In upholding the FCC's revokation of a license on such grounds, the court observed that because effective regulation is premised upon the agency's ability to depend upon the representations made to it by its licensees, the fact of concealment is more significant than the facts concealed. LeFlore Broadcasting Co. v. FCC, 636 F. 2d 454, 461 (D.C. Cir., 1980), citing FCC v. WOKO, Inc., 329 U.S. 223, 227, 67 S. Ct. 213, 215 (1946). The Court continued:

> Indeed, the FCC would be derelict if it did not hold broadcasters to 'high standards of punctilio,' given the special status of licensees as trustees of a scarce public resource." Id. at 461.

The FCC has thus held that principals are liable for the deceptive acts of their subordinates. Continental

Broadcasting Inc. v. FCC, 439 F. 2d 580 (D.C. Cir., 1971). In WADECO, Inc. v. FCC 628 F.2d 122, 128 (D.C. Cir., 1980), the company president was held accountable for misrepresentation of Counsel where he could have avoided them had he exercised better control.

Under the Federal Alcohol Adminstration Act, wholesale permits will be revoked or withheld if misrepresentations reflect on the character of a licensee or applicant. Henry County Beverage Co. v. Sec'y of Treasury, 454 F.2d 413 (7th Cir., 1972).

It can scarcely be disputed that the consequences to the public of permitting operation of a nuclear plant by a company lacking in character and/or technical competence could be far greater than permitting such a company to hold a broadcast license or a wholesale liquor permit. "We can imagine no area requiring stricter adherence to rules and regulations than that dealing with radioactive materials, from the viewpoint of both public health and national security." Hamlin Testing Laboratories v. A.E.C. 357 F.2d 632, 638 (6th Cir., 1966). NRC must surely be more diligent in guaranteeing the integrity of its licensees than other agencies, not less so.

2. GPU and its predecessor, Met. Ed. have demonstrated a long pattern of lack of integrity.

At this point, five years after the TMI-2 accident, it is convenient for GPU to claim that its acts of dishonesty are all in the past and that a new regime has taken charge. We will

show on the contrary, that certain patterns of behavior intolerable on the part of a nuclear licensee persist. In addition, of course, the highest echelons of pre-accident GPU management remain in place, as well as an unknown but substantial number of middle and upper management shuffled between GPU Service Corporation (the GPU subsidiary responsible for TMI-2 until December, 1978, well after the period for which the pattern of leak late falsification has been established [14]) and GPUN, (the current TMI-1 license holder), as well as former TMI-2 operators holding jobs in training and other areas at TMI-1. This will be discussed more fully below. Perhaps most important, beyond individuals, is the persistence of the attitude that problems are to be denied, minimized and buried under the rug, that individuals are not to be held accountable unless and until it becomes absolutely unavoidable to push them from the lifeboat one at a time in order to gain the NRC's permission to restart. Even then, their guilt is denied and, in the case of upper management, they are gently nudged laterally into "non-nuclear" activities.

In this regard, the treatment of Messrs. Arnold, Dieckamp,

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14 The NRC staff first discovered the practice of leak rate manipulation in October, 1978. GPU promised it would never happen again. This was a falsehood. United States of America v. Metropolitan Edison Co., Statement of Facts Submitted by the United States, February 28, 1984, pp.11-17. This matter is discussed more fully below.

Herbein, G&H (cheaters)[15], Husted[16], Long[17], Shipman[18], etc., stands in stark contrast to the treatment of Parks and King. The latter are two clean-up

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15 G&H, who were found to have obviously cheated on NRC licensing examinations despite GPU's denials, were disciplined by a two-week suspension. The ASLB said it gave consideration to directing GPU to fashion a disciplinary remedy, "but given the fact that the licensee continues to maintain that G&H did not cheat, we have no confidence that the Licensee can proceed in an acceptable manner." 16 N.R.C. 281, 308. G left sometime later voluntarily, and in exchange for the Commonwealth's agreement to drop its objections, H was removed from licensed operator responsibilities. GPU deserves no credit for this belated settlement with the state. Its failure to act long before on its own is the significant point.

16 Husted, a licensed training instructor until recently, failed to cooperate with NRC investigators, 15 N.R.C. at 957-961, gave "incredible" testimony under oath at the hearings, and displayed such disdain for the training program that the ASLB found his attitude to be "a partial explanation for the widespread disrespect for the program." 16 N.R.C. at 318-319. Husted was promoted by GPU to Supervisor of Non-Licensed Operator Training. ALAB-772 at 45. The Appeal Board finally directed his removal from that position. Id. at 46.

17 Robert Long was Director of Training and Education of GPUN during the cheating. The ASLB found itself unable to "determine from Dr. Long's testimony that he fully understands that his Training Department failed in its responsibility and that the failure was the principal and proximate cause of the breakdown in the integrity of the training and testing program." 16 N.R.C. at 381. Dr. Long has been promoted by GPU to be Vice President of Nuclear Assurance, succeeding Mr. Herbein. Id. at 380. See ALAB 772, n. 56 at 71.

18 Shipman is TMI-1 Operations Engineer, second in the chain of operations command. He gave untruthful testimony at the cheating hearings, as the Special Master, ASLB and Appeal Board agree. ALAB-772 at 35-38. A letter of reprimand was placed in his file. Id.

engineers who blew the whistle on practices at the TMI-2 clean-up that are now acknowledged by NRC to have been in violation of NRC regulations. These two, whose competence was never questioned even by GPU, were fired. GPU could find no place in its large organization for two competent engineers whose disregarded concerns over safety led them to speak out. By contrast, it has had no problem placing those of lesser competence and integrity.

We begin, therefore, with probably the most serious and, at this point, virtually undisputed, pre-accident event: the widespread, systematic falsification of leak rate calculations. There is no need to rehearse the details of the leak rate falsification. Met. Ed. has been indicted and pled guilty to one and nolo contendere to six felony counts charging that it intentionally manipulating leak rate tests in violation of its license in order to avoid shutting TMI-2 down. This occurred over a period of many months and contributed to the accident.

What is less widely known, but is in our view even more damning, is that an NRC inspector discovered on October 18, 1978, that Met. Ed was discarding "bad" leak rates and believed this to acceptable if a "good" leak rate could be obtained within 72 hours. The inspector told a meeting of the Supervisor of Operations, two Shift Supervisors and a Shift Foreman that he found this interpretation "shocking" and a "fundamental misinterpretation of the safety requirement." U.S.A. v.

Met. Ed., Statement of Facts, supra at 11-13. He was specifically assured by the Superintendent of Technical Operation that this would change. The Inspector took no enforcement action.[19] An LER was prepared by Met Ed which essentially portrayed the incident as an isolated event and promised to instruct all operations personnel that a "bad" leak rate required going into the "action statement," i.e., moving toward shutdown.[20] This never happened. The training never occurred, and the practice did not stop. In fact, the situation grew progressively worse. After January, 1979, virtually all leak rate calculations had to be manipulated in order to get "good" results. Id. at 13-17. Thus, Met Ed deliberately continued to violate its license on a daily basis after having been informed at high levels that this was "shocking" and intolerable.

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19 This may explain why IE did no follow-up investigation of Hartman's information given to them in May, 1979 until a story appeared on New York television in 1980. IE, it is apparent, was a silent partner from before the accident.

20 LER-78-62.

What happened after the accident -- and continues today -- is a coverup. Harold Hartman went to NRC in May 1979 and disclosed the leak rate falsification in a sworn statement to IE investigators. IE took no action until the story broke publicly on a New York television station in early 1980. It then began an investigation which belatedly culminated in the guilty and nolo contendere pleas.

GPU, which must have known of the Hartman charges, likewise did nothing until 1980. It then commissioned Faegre and Benson to do an internal investigation, ALAB-772, n.43 at 57, although they were allowed to interview no one other than Hartman. Faegre and Benson substantiated the charges in all important respects. GPU has never to this day taken any disciplinary action against anyone involved nor held anyone accountable for this in any way. Indeed, it withheld the Faegre and Benson report until 1983. This inaction on GPU's part is complete and utter refutation of the claim that it is a "new" company. A company genuinely committed to safety, committed to instilling the necessary values and honesty in its organization, with a decent respect for the consequences of its actions on public health and safety, would have identified those responsible for leak rate falsification and for lying to the NRC and summarily removed them. GPU, the "new GPU," has done neither.

Another problem with its roots firmly in the pre-accident period is the consistent failure of Met Ed's and then GPU's training program. This was emphasized by the Kemeny

Commission,[21] although GPU had ample internal evidence prior to the accident which it chose to ignore.[22] Moreover, as discussed in detail above, GPU was ordered by the Commission as a pre-condition of operation to retrain all operators in an enhanced training program and to assure their competence by testing. The record is abundantly clear that this commitment was not met. The post-accident training program, conducted by the "new" GPU, was a sorry failure which the operators and instructors treated as a formality rather than a commitment to excellence. This culminated in the discovery of cheating on the NRC exams.[23] We will not repeat the facts discussed

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21 Kemeny described the training program as "quantitatively and qualitatively understaffed as well as conceptually weak." Report of the President's Commission on the Accident at Three Mile Island, p. 50. "Training of Met. Ed. operators and supervisory was inadequate and contributed significantly to the seriousness of the accident." Id. at 49.

22 See, e.g., B&W Trial Exhibit 304 (half of operations staff are not attending requalification training); B&W Trial Exhibit 776 (attendance decreasing); B&W Trial Exhibit 462 ("on-the-job" training).

23 This, in turn, led to the belated "discovery" that James Floyd ("VV"), Supervisor of Operations at Unit 2, had cheated on his 1979 annual qualification examination and that the Company had falsely certified his requalification process to NRC. See 16 NRC at 348-355. GPU was assessed a $140,000 fine in connection with this, and Floyd is currently under indictment in the Federal Court in Pennsylvania. Robert Arnold, then president of GPU, testified at the hearings that he did not consider Floyd's handing in another's work for his own make-up exam as cheating, 16 NRC at 346. Although Mr. Arnold has been reassigned to non-nuclear activities, GPU stated at the time of his reassignment that it considers him to be a man of unimpeachable integrity.

earlier in this connection. The points which require emphasis here concern the "new" GPU's response to the cheating.

In short, GPU denied all but the absolutely undeniable, the cheating of O and W, both shift supervisors. W admitted that he had cheated. 11 NRC at 301-302. As to all others, it assigned a lawyer, John Wilson, purportedly to investigate and to present independent evidence. He testified under oath to the Special Master. Wilson presented considerable information to support innocence, but virtually none of the evidence that indicated guilt. 16 NRC at 339. He "unreasonably allowed G and H to convince him" they had not cheated, although the cheating was obvious. Id. See also 15 NRC at 998-1004. Wilson uncritically accepted as true the oral denials of operators accused of cheating. 16 NRC at 342. He sought no technical help to understand whether the explanations given him were credible. Id. In sum, the Special Master termed Mr. Wilson as "an advocate for the Licensee's interest." 15 NRC at 1004. Most telling is that Wilson and presumably therefore, GPU, "viewed that interest as being advanced by minimizing the evidence of copying." Id. While more forgiving to GPU than the Special Master, even the ASLB concluded that "Licensee was culpable in its uncritical acceptance of Mr. Wilson's work when there are so many indications of its inadequacy." 16 NRC at 342.

Indeed, Wilson represented GPU's position at the hearing, testifying under oath to GPU's view of the facts. UCS considers this episode extremely significant since it confirms the continuation of GPU's pattern of evading rather than facing, painful truths. There is no room for legalistic pettifogging when a licensee's actions can so gravely affect the public health and safety.

Finally, GPU hired a consultant, RHR, to do an internal report on its training program. RHR reported in 1983, inter alia, that only 60% of the operators responding agreed that the content of the examinations was job relevant and only 1/3 agreed that the oral exam tested the skills needed in an emergency. A number of its other findings are likewise unfavorable. GPU withheld this report from the NRC, knowing that its release would be damaging. See, e.g., Report of Investigation, Case #1-83-013, Ex. 18. Interview with Jack Goldberg, Office of Executive Legal Director.

GPU will now undoubtedly claim that its training program is greatly improved, citing the opinions of the same experts who testified before the cheating episode to how well the program was designed and implemented. There is nothing in the record of this case which could persuade a reasonable decisionmaker to accept such an assertion as true, when previous promises and assertions were empty. Considering the sorry history of this case and this issue particularly, if the Commission still entertains the

possiblity of giving GPU another chance to prove that it can meet the requirements for a license, it must subject GPU's assertions to the test of public hearings, confrontation and questioning.

Another issue which has received much attention because it relates directly to Unit 1 is the question of potential falsification of leak rate calculations for that unit. GPU is trumpeting the recent OI report on this issue, OI-1-83-028, as favorable to itself. The truth is neither so simple nor so reassurring. The fact is that OI identified a number of instances where water and hydrogen were added during leak rate testing. The hydrogen was added in short spurts of up to a few minutes only; no operator could identify a legitimate operational reason for adding hydrogen in such spurts. The facts are further that "bad" leak rates were routinely discarded at Unit 1 just as at Unit 2, contrary to NRC requirements and that tests showing negative leak rates within 1 GPM were accepted as valid "good" tests, even though the operators were well aware that such tests could not reflect actual plant conditions because a negative leak rate is impossible.

It is true that far fewer instances of leak rate manipulation were found at Unit 1 than at Unit 2 because it was not so difficult to get a good leak test for Unit 1. OI therefore professed itself unable to find a

"motive" for leak rate falsification. Nor can it find a convincing benign explanation for the hydrogen additions. Perhaps falsification was necessary only occasionally; the rich man who embezzles once or twice to cover a temporary shortage is no less guilty. In any case, even if one were to believe that intentional manipulation did not occur, or occurred only infrequently, it is clear that by throwing out "bad" tests and treating negative tests as valid, the Unit 1 operations staff, which was and is led by Michael Ross, showed that its attitude toward basic safety surveillance requirements is unacceptable. These requirements were treated again as if they are hyper-technical obstacles to be overcome rather than indications of the condition of the plant which must be carefully heeded.

In this connection, it is remarkable that both Ross and his assistant, Shipman, claim that they did not know the effect that adding hydrogen could have on leak rates. OI-1-83-028, Ex. 17, p. 19; Ex. 107, p. 61. The NRC investigator believes that they must have known, considering the available evidence. Id., Vol. 1, p. 21; Ex. 16, p. 1-2. Most operators knew, e.g., Id. at Ex. 36, p. 43; Ex. 40, p. 27, Ex. 41, p. 25. Virtually everyone admitted knowing that "bad" leak rates were discarded. Ross claims that he is not sure what was done with them. Id., Ex. 107 at 13. Considering the acknowledged fact that Ross was totally involved in all aspects of TMI-1

operations, this equivocation is not believable. The Unit 1 leak rate evidence was referred to the Department of Justice, but considering that the statute of limitations had all but expired by then, NRC's General Counsel termed this a "gesture." Transcript of Commission Meeting, January 10, 1984, p. 54. The Unit 1 leak rate investigation hardly qualifies as favorable to GPU.

Another recent OI investigation which merits close attention relates to the so-called "Keaten Report," GPU's only investigation of the causes of the TMI-2 accident. The material developed by OI has been referred to the Department of Justice for possible criminal action.

The report was authored by a task force headed by Robert Keaten. It went through numerous drafts even after the task force had unanimously approved it and sent it to management. Drafts went to, among others, Messrs. Arnold, Kuhns, Dieckamp, Clark, Finfrock, Hukill, and Wilson. NUREG-1020 at 10-4. The revisions went in the direction of sanitizing the report to remove statements admitting to violations of procedures and requirements and to minimize management's role in co tributing to the conditions which caused the accident. See Ben B. Hayes to Harold R. Denton, "OI Investigations Into Matters Discussed in NUREG-1020, Nov. 7, 1983, Attachment: "Summary of Additional Information Relevant to NUREG-1020, Category 10," pp. 4-17.

Perhaps most significant and, we assume, the action of the potential criminal significance is that the Keaten report contained material which indicates the falsity of GPU's December 5, 1979 response to the NRC's Notice of Violation regarding TMI-2. GPU stated to NRC that "there is no indication that ... the history of [elevated] PORV discharge line temperature delayed recognition that the PORV had stuck open during the course of the accident." Id. at 20. On the contrary, the Keaten report draft and underlying interviews contained much evidence to that effect. Id. at 20-23. It was inaccurate for GPU to state that there was "no indication" that the elevated discharge temperatures interfered with recognition that the PORV was open. Id. at 22-23.

It is disclosed that Edward Wallace served as Mr. Arnold's delegate for the purpose of drafting GPU's response to the Notice of Violation (01-1-83-012 at 2) and that he also worked with the Keaten task force to assure that it was "consistent" with the NOV response. Wallace, who sat next to and advised GPU counsel during virtually all of the restart hearings on the design issues, apparently saw his duty as removing from the Keaten report any "damaging" material that could contradict the position taken by GPU in responding to NRC's NOV.

This issue captures what UCS believes to be the essence of GPU's instinctive attitude: rather than facing up to its problems, it denies them. Rather than stating

the whole truth, it clouds the record with legalities. Rather than accepting the need to fully identify and remedy the causes of the TMI-2 accident, it sanitizes and restricts the scope of its only internal review and meets the NRC with evasion and half-truth. This is intolerable.

CONCLUSION

In the summer of 1979, the GPU Service Corporation and Met. Ed. were integrated. GPU Nuclear, the current license holder was established about a year later. The license transfer was perfunctory. GPU is the parent company of all. Mr. Kuhns is and has been for the past 10 years the Board Chairman and Chief Executive Officer of GPU and a Director of all subsidiaries. Mr. Dieckamp, considered by Mr. Kuhns to be the lead man for operation of the plants, [24] was until last December President of GPU and GPUSC, CEO and Chairman of GPUN and a Director of all subsidiaries. He still remains in every position but CEO and Chairman of GPUN. There can be little doubt that the men in charge remain the same.

We have given many examples above showing that personalities aside, the attitude at GPU also remains essentially unchanged. The Commission should not be suprised that in the effort to regain its license, GPU proclaims itself a cleansed and new organization and that,

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24 Keaten Investigation, Ex. 14 at 6-7.

it promises to adhere strictly to the precepts of safety. The consistent and repeated actions of the organization tell a different story.[25] So do its personnel policies. Repeatedly, persons showing lack of integrity are promoted. Those protesting shortcuts around the safety requirements are fired. As the revelations have painfully emerged into the public domain over five years, GPU has dropped a few persons one by one over the lifeboat. In the case of upper management personnel, the shifts have been only lateral to "non-nuclear" GPU operations. GPU continues to profess itself fully satisfied with the honesty and integrity of each.[26]

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25 Even as Admiral Rickover's group was writing a favorable report on GPU management, a report which specifically excluded consideration of the TMI-2 clean-up mismanagement issue and the cheating issues, the NRC staff was discovering "an apparent breakdown in proper implementation of [GPU Nuclear] radiological control program." See E.R. Weiss and R. D. Pollard to NRC Commissioners. "TMI-1 Restart/Rickover Task Force Management Review," November 23, 1983.

26 It should be noted that not all TMI-2 operators will be isolated from TMI-1 under GPU's resart plan. Michael Ross, who was licensed at both plants, is Supervisor of Operations at Unit 1. Other TMI-2 operators will appear in different roles. For example, Mr. Zewe, the Unit 2 Shift Supervisor present during the accident was promoted to Radwaste Operations Manager for TMI-1. Our information is that he left in early 1984, but was replaced by Brian Mehler, also a former Unit 2 Shift Supervisor. D. B. Bauser to the Appeal Board, January 27, 1984. We do not know how many other persons from TMI-2 will likewise be at TMI-1 in a variety of roles affecting safety.

The patterns of behavior include:

disdain for safety requirements [27]

failure to acknowledge errors or problems

failure to fully investigate evidence of wrongdoing

failure to accept fault and take full and timely remedial action

failure to hold management or employees accountable for lack of integrity or competence

failure to instill throughout the organization the values necessary for a nuclear licensee

failure to lead by example.

GPU's plan for TMI-2 Restart further requires NRC to accept three unacceptable premises. The first is that, while the TMI-2 staff was deeply compromised, the TMI-1 staff within the same corporation was and is pristine. The proposition is not believable. The second is that while Kuhns and Dieckamp were sufficiently removed from

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[27] The events we have discussed in this pleading are far from exhaustive. For example, Harold Hartman, whose testimony regarding Unit 2 leak rate falsification has been proven accurate, has made a series of other allegations not yet resolved. Among those are that a request was made to shutdown Unit 1 to identify the source of increasing reactor coolant system leakage which was denied by the load dispatcher. He also alleges that emergency feedwater pump surveillance criteria were essentially "backfit" when existing criteria could not be met. See n. 6, supra.

It is also known that GPU management deliberately decided not to close the PORV block valve prior to the accident to identify the source of excessive leakage. This was known to be in violation of the procedures. NUREG-1020 at 10-7-10-10.

daily TMI activities to be unaware of the leak rate falsification, the inept training, the cheating, the laundering of the Keaten report, the inaccurate response to the Notice of Violation, the NRC can depend upon the effectiveness of their current promises to ensure strict adherence to high standards of integrity and competence throughout the organization. Top management cannot have it both ways; if they are not responsible for failure, they are not in a position to ensure success.

The third premise is that a small group of GPU personnel hired after the accident can cure the problem. Indeed, Harold Denton stated in a public meeting to the Commission that he gets his faith in the "new" GPU from Messrs. Clark and Hukill. For one thing, as we have shown, the "new" GPU continues the patterns of the old. Perhaps the clearest example is its failure to this day to hold anyone accountable for the leak rate falsification, Messrs. Clark and Hukill notwithstanding. It is wishful thinking to imagine that two people can change the course of this ship, nor have they. Messrs. Clark and Hukill report to the same Board of Directors, as does the new "independent" safety oversight group, and they direct an organization whose fundamental instincts are unchanged.

We conclude by recalling that the traits of integrity and character demanded of a licensee should include "moral excellence, firmness, resolution, self-discipline, high ethics, force and judgement." Integrity requires "utter sincerity,

honesty and candor: avoidance of deception, expediency, artificiality or shallowness of any kind ALAB-772 n. 9 at 12. Those qualities are not characterstic of GPU. It should not be permitted to operate TMI-1.

Respectfully submitted,

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July 26, 1984

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

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

Docket No. 50-289 -SP
(Restart)

CERTIFICATE OF SERVICE

I hereby certify that copies of "UCS COMMENTS ON TMI-1 RESTART IMMEDIATE EFFECTIVENESS" have been served on the following persons by deposit in the United States mail, first class postage prepaid, this 26th day of July 1984, except as indicated by an asterisk.

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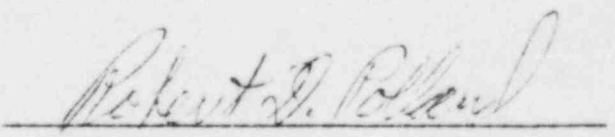

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