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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING APPEAL BOARD

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

TMIA MOTION TO REOPEN THE RECORD ON TRAINING PROGRAM IRREGULARITIES AND REPORTABILITY OF BETA AND RHR CONSULTANT REPORTS

Three Mile Island Alert ("TMIA") hereby moves the Atomic Safety and Licensing Appeal Board to reopen the management record in the above captioned case, because of new evidence resulting from the investigation reports released by the Office of Investigations ("OI") on evidence discovered in the B&W trial record of training irregularities, and evidence of impropriety for GPU's failure to provide the BETA and RHR consultant reports to the NRC. Both investigations evidence serious integrity problems by Licensee's management.

The issues have been raised in a timely manner, are directed to a significant safety related issue, namely management integrity, and would dictate a different result from that reached by the Atomic Safety and Licensing Board. Moreover, failure to reopen the record in this case, where the integrity of Licensee

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has already been called into serious question, most recently by convictions for criminal violations of the Atomic Energy Act, would clearly subvert the public interest. Hudson v. Federal Power Commission, 498 F.2d 827, 832-833,(2d Cir. 1974). In support of this motion, TMIA states as follows:

I. Background

On July 27, 1982, the Atomic Safety and Licensing Board rendered its third and final "Partial Initial Decision" ("PID") in this case. During the course of the Appeal Board's review of this case, the Staff issued a memorandum to the Commission in which it explained that it could no longer draw a conclusion regarding the integrity of Licensee's management.[1/] The Staff based its decision on five new "open" issues which potentially impacted upon the integrity of Licensee management. Among those issues were questions raised by statements in the record of the GPU v. B&W court proceeding, and questions as to whether the Licensee failed to promptly notify the Commission or the Appeal Board of relevant and material information contained in the BETA or RHR reports.[2/]

1/ Letter of May 19, 1984 from William Dirks, Executive Director of Operations to the Commission.

2/ Other issues were: the veracity of the Hartman allegations; the Parks and King allegations; and any concerns raised by the contents of GPU consultant reports which were not considered by the staff in revalidating its position on Licensees' management competence or integrity. Page 2 of the May 19, 1983 memo.

In response to this memo, TMIA filed a May 23, 1984 motion to reopen the management record, requesting that the record be reopened on each of the five "open" issues. TMIA argued that the Staff's new position represented a major reveral of previously unwaivering Staff support for Licensee's management, such support heavily relied upon by the Licensing Board in reaching a finding favorable to restart. See, TMIA's Motion to Reopen the Record, pp. 1, 5.

By Memorandum and Order dated August 31, 1983, the Appeal Board ordered the reopening of the record for further hearings on the Hartman allegations. ALAB-738.[3/] As to the other four "open issues" addressed in TMIA's motion, the Appeal Board denied the motion, stating,

> TMIA has failed to call to our attention anything so far that might have made a difference in the Licensing Board's decision. Moreover, the staff review in each instance (including that of OI) is still under way and may yet disclose other related information that does warrant further hearing. If that proves to be the case, intervenors may then seek again to satisfy the Diablo Canyon criteria for reopening.

Id.

In September, 1983, the Staff produced NUREG 1020, entitled GPU v. B&W Lawsuit Review and its Effect on TMI-1, which documents a review by the Staff of the lawsuit record in the case of GPU v. B&W. A "public version" of NUREG 1020 was released to the parties. The staff found that lawsuit doucments in seven areas raised potential management competence/integrity issues of

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3/ By Order dated October 7, 1983, the Commission stayed the reopened "Hartman" hearings.

sufficient importance to impact upon a restart decision. One of those areas was "training program irregularities." NUREG 1020, p. 10-24.

These lawsuit issues, along with three others including "the effect on management integrity of the licensee's failure to report the BETA and RHR reports and any other failures to promptly notify the Commission or its hearings boards of other relevant and material information," id. were referred to OI for investigation. Id. The Staff further explained that the outcome of these investigations were to be important elements in the staff's overall position on management integrity, and would be evaluated and integrated into an overall position on management integrity. Id.

In early May, 1984, the Commission released two of these investigations: Report No. Q-1-84-004 entitled "General Public Utilities Nuclear (GPUN) Possible Training Irregularities"; and Case No. 1-83-013 entitled "General Public Utilities Nuclear - Alleged Failure to Provide BETA and RHR Consultant Reports to the NRC In A More Timely Fashion."

TMIA received the exhibits which provide the basis for support for OI's conclusions one and a half weeks later.[4/]

4/ Also released were exhibits to OI's investigation of Unit 1 leak rate falsification. Together, these exhibits involve hundreds of pages of documents and over a dozen volumes. Having examined the documents, TMIA believes the investigations raise questions regarding the soundness of the record on a number of issues. In addition, TMIA believes the investigations themselves proved to be deficient.

II. Management Integrity

On July 2, 1979, the Commission directed that TMI-1 be maintained in a shutdown condition, further determining it to be in the public interest that a hearing precede any possible restart of TMI-1. The Commission based its action on a conclusion that

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

The hearings which followed were for the implicit purpose of determining whether the Licensee had learned the lessons of the accident and could be trusted to safely operate a nuclear reactor.

Concern about the Licensee's competence was specifically enumerated as an issue in need of resolution prior to restart. See, Order and Notice of Hearing dated August 9, 1979, Metropolitan Edison Company (Three Mile Island Nuclear Station Unit No. 1), CLI-79-8, 10 NRC 141 at 143-145, (1979), (further expanded upon by the Commission's Order of March 6, 1980, CLI-80-5, 11 NRC 408). While "management integrity," was not explicitly mentioned as an unresolved issue, it became a clear focus of the reopened "cheating" hearings, PID ¶ 2032, and has recently been recognized as the major, unresolved element in the NRC's overall evaluation of management capability. See, e.g., NUREG 1020 at 10-1, 10-2.

Management intergrity is fundamental to a corporation's overall character, which is a distinct requirement for a license under the Atomic Energy Act Houston Lighting and Power Co. (South Texas Units 1 and 2), ASLBP 79-421-07 OL (Slip. Op. March 14, 1984) p. 8. Further, corporate character is a separate quality from corporate competence. "Character and competence are quite different: character is, among other things, a measure of the likelihood that an applicant will apply its technical competence to effect the Commission's health and safety standards." Id. at 13.

Corporate integrity is the quality which insures that Licensee will perform to the highest standards of excellence. For the licensee to do less, and particularly for the licensee to permit conditions adverse to safe operation to develop, would violate the trust which the NRC must place in the license. This means that when problems arise, the licensee must be capable of rapidly analyzing the problem, the sources of the problem, and the solution to the problem. The licensee must have the requisite level of integrity to insure that it will meet the test of excellence and will consistently work to prevent conditions adverse to quality, and to insure that problems are not only recognized, but solved.

Further, the NRC must depend on the licensee to accurately represent operating conditions at all times. Where the problem is detrimental to safe operation, the NRC must be precisely informed in order to have confidence in Licensee's remedial measures. Indeed, "a lack of truthfulness or candor could prove

disqualifying." Houston Lighting and Power Co. at 23. These qualities are key factors in determining whether the licensee has an appropriate level of intergrity to operate a nuclear reactor. 5/.

II. Training Irregularities

A. Background

The quality of training not only determines whether or not management and operators are competent to run a nuclear reactor under both normal and accident conditions, but also reflects strongly upon the committment management has to safety. Since the NRC does not have the resources to compensate for major training deficiencies on the part of licensees, the NRC, and the public, demand an independent, self motivated Licensee who can not only recognize training problems, but works effectively to resolve them. As the ASLB pointed out in these proceedings, "if the Licensee does not itself exercise the requisite quality control, quality assurance, and feed-back mechanisms to assure high-quality training and testing, it is beyond the power of regulators and regulations to put an appropriate program in place." PID ¶2327. The willingness of any company to abide by these necessarily high standards of performance depends in large measure on the integrity of the company's management.

5/ This company's record in this area is particularly atrocious. Not only has it been charged by the NRC with withholding vital information from State and Federal officials during the accident, (see NUGEG 0760), but it has recently been fined for submitting material false statements to the NRC in connection with the cheating of former TMI-2 Supervisor of Operations. Statement of Commission, CLI-83-20.

Without question, Licensee's training department has been the subject of intense scrutiny in the restart hearings because of the widely held belief that inadequate training contributed significantly to the seriousness of the accident. See, e.g., Report of the President's Commission on the Accident at Three Mile Island, Vol. 1 at pp. 49-50. The role of company management in allowing significant and wide-spread training department problems to develop, resulting in among other things post-accident cheating at Unit 1, and management's response to those problems has been the subject of much controversy in the restart hearings.

During the reopened management hearings examining the cheating incidents in November/December 1981, it was discovered that extremely lax exam testing procedures allowed significant cheating to occur on company and NRC exams from at least the time of the accident, through the 1981 NRC licensing exams. The ASLB defined the problem as a failure to extend quality control (QC) procedures to exam testing which would insure exam integrity, PID ¶2401, and to Licensee's "naivete" which would be corrected by new exam testing procedures. PID ¶2396. Yet at the time the cheating was occurring, this "naive" Licensee was developing and enthusiastically presenting to the ASLB a revised training and testing program in response to severe criticism Licensee's training department had received after the accident -- a specific subject of concern discussed in the Commission's August 9, 1979 Order, supra. At the time of its alleged "naivete," Licensee

management was also already aware of the 1979 cheating incident involving VV and O, and of significant internal criticism of training as it related not only to VV's cheating, but to the overall quality of training. See, Section C, infra.

The B&W trial record reveals that training problems were long-standing and well-recognized for years before the accident, and that management was either unwilling or unable to correct them until after the accident when to do otherwise would have risked their license. Further, Licensee has misrepresented the most serious aspects of these deficiencies to the Commission and to the public. To assume that a "new management structure" or "new procedures" provide reasonable assurance that Licensee can now objectively police itself is to ignore this long history of failure to take independent action to correct training deficiencies and an unwillingness to be forthright with the NRC and the public concerning these training problems.

The trial record which TMIA has examinined is replete with examples which illustrate this. Unfortuneately, OI's investigation of "training irregularities" is so narrow in scope that OI easily glosses over this evidence, particularly as it relates to manangement's direct and indirect involvement and response to these problems. 6/

6/ It should be noted that having referred the "training irregularities" issue to OI, the Staff deleted from the public version of NUREG 1020 at OI's request the relevant lawsuit documents pertaining to the issue. NUREG 1020, p. 10-6. Until release of Report Q-1-84-004, no party other than the Staff has had knowledge of the specific evidence being considered by OI so as to even speculate on what ultimate conclusion it could reach regarding the broader issue of management integrity.

B. The OI Investigation

The investigation was initiated for the specific purpose of determining if management had knowledge of failures to comply with NRC training requirements. Possible Training Irregularities Q-1-84-004 Report of Investigation, ("Training Report") p. 1. In its entire review of the B&W record, the Staff seems to have identified one memo which raises integrity questions, an April 27, 1976 memo from A. Tsaggaris, Supervisor of Training-Nuclear, to J.G. Herbein, J.J. Cotitz, and G.P. Miller, which states,

> ...1. After reviewing this year's performance of non-shift personnel in the Requalification Program, three problem areas are apparent. a). Poor lesson attendance (in some cases no lesson attendance), b). Inordinate amount of time before makeup material is returned. c). Not enough time scheduled and spent in the control room.
>
> 2. It has become obvious to me that these problems will continue unless more stringent guidelines are established. I have written many memos pointing out these problem areas to the individuals concerned and am finally getting assignments turned in. I feel strongly that when a person obtains a license it is his responsibility to keep it current. This is not being done. We are required by federal law to meet certain requirements for licensed individuals and in several cases we do not meet them....

Training Report, Exhibit 1; B&W Ex. 886. (emphasis added).

Thus, the OI investigation begins with a prede termined conclusion that the only issue of relevance is whether one sentence, emphasized above, demonstrates that management was aware of specific regulatory violations in the training department. Not surprisingly, OI concluded that

> This investigation has not produced any information to indicate that the TSAGGARIS memorandum was in reference to actual conditions of noncompliance with any requirements of the requalification program, nor was there any testimony to indicate that the licensee willfully concealed information

> concerning noncompliances from the NRC. Additionally, an NRC Region I inspection performed within several months of the TSAGGARIS memorandum did not identify any instances of noncompliance which should have been reported.

Training Report, p. 2. But even as to this narrow question, the evidence does not support OI's conclusion.

First, it is hard to imagine a clearer statement than "[w]e are required by federal law to meet certain requirements for licensed individuals and in several cases we do not meet them." That OI manages to accept belated explanations by training and other management, few of whom even admit to remembering the memo eight years after the fact, which conflict with the memo's plain language, raises questions about the integrity of this investigation.

Second, in his first sworn testimony, taken January 31, 1984 Tsaggaris himself states

> ...I can't really recollect whether by that statement I was saying that we were in violation of 10 CFR 55 or whether I just didn't feel we were meeting the intent of our own internal program.

Exhibit 4, p. 18.

When later interviewed on Monday, March 5, 1984, he suddenly remembered what he was unable to remember in January telling OI,

> I do not believe that we were ever in violation of the 10 CFR 55 Requirement, to have so many hours, in a 2-year period. What I believe that I am referring to there is that we were not meeting our own internal Program Requirement.

OI adopts Tsagarris' belated explanation that he intended no suggestion that NRC requirements may have been violated, standing alone, as more persuasive than the clear evidence pointing the other way, namely the plain language in the memo, and two other

training memos which raise suspiciously similar concerns. 6/ See, Training Report p. 6; Exhibits 2 and 3.

However, even apart from the narrow issue of NRC regulatory violations, these memos as well as other evidence in the lawsuit

6/ These memos are contained in Exhibits 2 and 3. Exhibit 2 is a handwritten undated note from Larry Noll to George Kunder, which states in pertinent part "...I don't have time to give 2 or 3 lectures, so I can't meet this NRC requirement and I'm not going to fake it anymore like other shifts do....Its about time training dept. trains people -- instead of keeping up paperwork only," (emphasis added), written in response to another memo from N.D. Brown, Admin. Nuc. Tech. Training, to Shift Supervisors and Shift Foremen (Unit 1 Licensed), which states in pertinent part, "[b]etween July 11, 1977 and August 12, 1977 you will be tested, as part of the Unit 1 Requal Program, on the following procedures which are to be reviewed on shift.... NOTE: Items *5 and *6 require Auxiliary Operator participation, this is an NRC Requirement..."

Exhibit 3 is a note dated June 17, 1977, by Unit 1 shift foreman T.L. Book to Unit 1 superintendent James P. O'Hanlon, which states, "[s]ince taking the requal exam this past February, I have not been in a single training lecture or received any guidance as to what course of study to pursue to best fulfill the NRC requirements meaningfully. Also, I do not believe that sending out a casual memo or documenting on green sheets that an E.P. was read on back shift constitutes good training practice. Like all else the S/F & S/S's have become the Godhead of 60 hrs. required training per year. Its time to put training back in the training dept. where it belongs and in a responsible fashion. This means more training space, people and expertise. This also means 6 shifts for CRO's, S/F and S/S's. While I fully realize that there is no pat answer for our complex training problems, I like many other operations people have made suggestions to various training personnel. However it seems as though those fall on deaf ears or end up in the circular file. We have been told "write up your suggestions and concerns or call us." We did! Nothing happened. Besides being just plain frustrated over all of this, it is my opinion that it is somewhat erroneous to say we fulfill the NRC requirements when they are based on documentation of subject matter supposedly covered on shift. Many times more hours are documented than were actually used for training. I am willing to listen to or discuss anything on the topic with anybody. I am willing to help solve the problem if I can help in a meaningful way. Something must be done !!!" (emphasis in the original). B&W Ex. 564.

record raise much larger questions in terms of overall management integrity, specifically whether management is able to prevent conditions adverse to quality, face up to problems honestly, rapidly analyze problems as they occur as well as the problems' sources and solutions, and then works to resolve them. This analysis is most relevant to determining whether Licensee can be trusted to run its training department in such a manner that TMI-1 can be expected to be operate safely-as proven by the accident. Indeed, the Kemeny Commission found as much, concluding,

> ... 2. The TMI training program conformed to the NRC standard for training. Moreover, TMI operator license candidates had higher scores than the national average on NRC licensing examinations and operating tests. Nevertheless, the training of the operators proved to be inadequate for responding to the accident.
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> * * *
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> 4. Met Ed had primary responsibility for the training of operators. The quality of the training program at TMI was low.

Report of the President's Commission on The Accident at Three Mile Island, Vo. 1, pp. 49-50.

Even Licensee approached its own post accident training analysis in that fashion. In Exhibit 7, which is the Investigative Interview of Robert Winn Keaten, head of Licensee's internal accident investigation Task Force, Keaten states that the Task Force's purpose was not so much to see if training met some "defined set of requirements", but "whether training might have been technically deficient or deficient programmatically in

the sense that had the training been better in these regards it might have prevented the accident." Id., p. 25.

C. Evidence of Training Irregularities

The B&W record raises questions of sufficient magnitude based on evidence concealed from the ASLB, concerning whether Licensee is fundamentally incapable of preventing the kinds of conditions in its training department which eventually led to the accident. This undermines the ASLB conclusions that "the issues in the reopened proceeding have been resolved in favor of restarting TMI-1," PID 2089, and require further examination on the record of this proceeding.

For example, a particular issue of controversy during the restart hearings was the adequacy of the requalification program and the related problem of the Licensee's policy on non-attendance and take-home make-up training packages and exams. Lax procedures created an environment which allowed Supervisor of Operations at Unit 2, Mr. VV, to cheat on his exam in July of 1979. PID ¶2272 et seq.

Among the major problems with training, including one of VV's most significant training shortcomings even after the accident, was non-attendance See PID ¶2274. Aside from the memos already discussed, supra, is B&W Ex. 304, a September 1, 1978 memo by Beers of the training department, which states, "... but overall approximately 1/2 of the licensed people are not attending requalification training." In a November 2, 1978 memo, Beers writes to Station Superintendent Gary Miller, "decrease in attendance from last

report." B&W Ex. 776. This caused training instructors to spend substantial amounts of time making up take-home training packages. Arnold, B&W Lawsuit Tr. 1703-1704. Ironically, Tsaggaris told OI on March 5, 1984, that "[t]he fact that I don't believe that we ever violated the 10 CFR 55 requirement, to my recollection, indicates to me that we got it more under control." Exhibit 5, p. 25. The evidence clearly shows otherwise.

Further, B&W Ex. 462 is a March 1, 1977 memo from Tsaggaris to a number of people, including Gary Miller, Jack Herbein, and L. L. Lawyer of the training department, concerning the Unit 2 on-the- job training program. Tsaggaris states in a handwritten comment,

> We are in trouble on this program! Progress for the last two weeks has almost been nonexistent. All groups have fallen way off the required curves... I don't know what the problem is but we had better find out now or we will never make it by 7-1. This matter will be discussed at G.P. Miller department head meeting on March 3, 1977.
> There were other significant problems known to management.

On June 2, 1977, Miller sent to Lawyer a memo regarding the training program, in which he stated,

> ...As is typical with every startup, we are attempting to complete a year's worth of effort in about 6 months. The Unit 2 information at the critical detail level is just now becoming available in usable form.

B&W Ex. 774. Miller testified in his lawsuit deposition that this memo meant that he did not feel the classroom training was directly applicable to the operation of the units. Miller dep. at 466.

In 1978, management auditors made the following finding about the training department: "The quality of operations

personnel is on a continuous downhill trend." B&W Ex. 843 at 45229. Miller voiced similar concerns in his post-accident investigation interview, B&W 360. There he stated,

> ... everytime I went to a shift foreman or shift supervisor meeting one of the single most emotional complaints was training. Lack of. Lack of real training.

Further, in the B&W record, it was discovered that Mr. Richard Zechman, the acting supervisor of training, not only did not have his operator's license, but at a time of major training deficiencies within the department, a decision was made to have Zechman spend full time studying for his license, spending no time running the department. Arnold at Tr. 1706. Moreover, some time between the fall of 1978 and the accident, Zechman took the examination and failed to pass it. Id. See, also, Exhibit 9, Report of Interview of Richard Zechman, p. 1. Miller believed that the department suffered because of Zechman. B&W Ex. 360 at 29. Indeed, Zechman admits to having no knowledge of the 1976 memo or of the actual basis for Tsaggaris putting the identified weaknesses in writing. Exhibit 9, p. 1.

All of the above discussed deficiencies raise serious questions about management's committment to resolve problems of which it is fully aware. Robert Keaten, head of the company's task force investigating the accident, explained when questioned about the response the Task Force discovered was made to the memos discussed supra,

> .... [T]he sense of the discussions, as I remember them, was that the reporting relationship to the Training Department had been changed in order to try to help promote the training activities. That's the only specific response that I remember.

Exhibit 7, p. 13.

These very deficiencies discussed two and three years before the accident were not only recognized by senior management, but resulted in lose of their own licenses. In Exhibit 10, Report of Interview of Joseph J. Colitz, then Unit 2 Superintendent Colitz stated that at the time the 1976 Tsagarris memorandum was written he was working 70 to 80 hours per week at TMI and felt that it would have been impossible to absent himself from his normal duties for one week out of every six in order to attend training sessions. Colitz explained that he tried to keep up with the requalification program by studying the make-up lesson plans but that this self study course assumed a lower priority than his normal plant superintendent duties.

In Exhibit 12, Report of Interview of John G. Herbein, former Station Manager and Met Ed Vice President for Generation, claims no recollection of the memo. But his attorney found in his files a memo signed by Colitz and Gary Miller of which he also claims no recollection, which addresses some of the same points. OI reported that "Herbein thinks that the TSAGGARIS memorandum was addressed to himself, COLITZ and MILLER because of their managerial responsibilities and not because they were falling behind in the requalification program training." Herbein's license lapsed in early 1977. See, Training Report, p. 3. Herbein then instructed Miller to allow his license to lapse, Exhibit 13, p. 1, as with Colitz, supra. Miller was

Energency Director during the accident. Significantly, the Kemeny Commission determined that one reason the quality of training was so low, was because

> With NRC approval, the unit superintendent and the station manager at TMI were only required to acquire the experience and training necessary to be examined for a serior reactor operator license, but were not required to hold such a license.

Report of the President's Commission on The Accident at Three Mile Island, Vo. 1, p. 50.

But even with sufficient awareness by members of senior TMI management, nothing changed. Problems were so deeply rooted that serious deficiencies not only continued, but led to the accident. See, e.g., Exhibit 15, handwritten notes of Ronald L. Williams from a "Keaten Task Force" Interview on October 18, 1979, where he notes complaints by training staff,

> poor attendance, very poor attendance, the inability of the Training Department, did not have enough clout to force people to improve, different priorities for licensing purposes, and that they had to prepare numerous what they called care packages, which I assume are those makeup lesson plans.

Moreover, even as personnel, policies and procedures changed after the accident, abuse of the requalification program continued, 7/, management misrepresented the seriousness of

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7/ Licensee has been fined for failures to properly implement its Operator Accelerated Retraining Program (OARP), and for submitting material false statements certifying to the Commission that then Unit 2 Supervisor of Operations, VV, had satisfactorily completed his accelerated requalification program, and for renewal of his SRO license, when in fact he had cheated on his requalification exam. In addition, it appears that the Keaten Task Force also covered up the VV/O cheating incident which among other things highlighted problems with the requalification program. At p. 22 of Exhibit 7, Keaton indicates that during the Task Force investigation he learned about the VV/O cheating incident, but it did not become part of the investigation.

training department problems to the NRC, 8/, misrepresented to the ASLB that corrective action had been taken when it had not been, 9/, and new training department problems surfaced. See, generally, Report of the Special Master, April 28, 1982; PID, July 27, 1982. See, also, discussion of BETA and RHR reports, infra.

D. The "Keaten" Investigation

Moreover, management continued on a course of deception in preparing its own internal investigation report, which according to Keaten's July 23, 1979 memo to then Met Ed Vice-President for Generation John Herbein, was being prepared to be "closely scrutinized by the NRC, the public, and perhaps the courts, and it is our mission to develop a full and complete assessment." B&W Ex. 342.

The question which OI investigated was "the extent to which General Public Utilties' (GPU) internal investigation report of the March 28, 1979 accident ... included the problems identified

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8/ In the cover memo accompanying Licensee's December 5, 1979 response to NRC's Notice of Violation, the seriousness of the training problem is downplayed. The memo states, "[d]uring the period from 1975 to 1978, operators at Three Mile Island had a failure rate on their NRC written and oral exams half the industry average. NRC performance evaluations ranked the Three Mile Island facility above the average for comparable plants. Metropolitan Edison does not feel that there was any significant decline in the Company's performance."

9/ GPUN Vice-President for Nuclear Assurance, Robert Long, misrepresented to the Licensing Board that inappropriate utilization of open-book quizzes had been stopped by changes in the relevant plant procedure. But the "cheating" hearings revealed this was not done. PID ¶2323.

in the TSAGGARIS memorandum and certain other negative information regarding the training program at Three Mile Island." Training Report, p. 1.

Again, however, OI glosses over the evidence. OI concludes, "[t]he investigation determined the TSAGGARIS memorandum did not come to light during the KEATEN Task Force investigation and, thus, did not influence the task force reports." Id. at p. 4.

Exhibit 18 is a GPU Service memorandum dated July 26, 1979 from R.W. Keaten to R.C. Arnold with a one page attachment. The document states, "[a]ttached is a specific plan of action which has been developed by the Investigative Task Force in response to the seven items of investigation in your memo of July 2, 1979." Item 5 deals with training or lack of training, and was assigned to Tsaggaris. The question then arises why Tsaggaris did not bring his memo to the attention of the Task Force.

OI determines that he did not, because he was not a primary member of the task force's investigation in the training area, and that he in fact was not involved in the training aspects of the report because it was felt that he may not have been able to be objective about training problems. Training Report, p. 5. This misrepresents the evidence.

In Exhibit 7, p. 4, Keaten stated to OI that actually

> ....Lex was interested in the training aspects because of his background... he was particularly specializing in the area of the emergency response to the accident. And so while during periods when we were discussing training, he was a very active participant. But his activities outside of the meeting tended to be more concentrated in the emergency response area.

(emphasis added). At p. 8 of his interview, Keaten told OI,

> To the best of my memory, that was -- let me be careful. The sections of the report that dealt with training -- and there is really more than one of those -- were sections that tended to be worked on by the Task Force as a whole, as part of the meetings that we discusesd earlier.

(emphasis added).

Dr. Robert Long, current GPUN Vice-President for Nuclear Assurance, who according to Keaten shared with himself and Ronald Williams primary responsibility in the training area, (see Training Report p. 5), and who now has direct supervision over current TMI training, rationalizes in his January 19, 1984 OI interview,

> I don't think it would have come up as a subject for the Keaten Task Force, because we did not really spend all that much effort on training. It wasn't a big area of our responsibility.

Yet of all sections in the final task force report, the "Training Section" was one of the longest. See, Exhibit 8. B&W Ex. 356.

Licensee's willingness to write new training programs and procedures and to make committments to implement them need not be questioned; it is the honesty and strength of Licensee's desire to seeing to it those committments are carried out that presents the true test of integrity. Without question, a poor record is one of the best indications of whether this test will be met in the future.

The B&W record shows that the serious training irregularities revealed in the cheating hearings, still considered significant by operators interviewed RHR, are not

isolated failures. They reflect a clear pattern. For the NRC to take a risk by granting an operating license to this company, knowing this record, only benefits the Licensee, while being inimical to the public health and safety. The burden is on the company to prove this record is unrelated to its current integrity, and cannot be attributed to fundamental flaws in the corporation's character.

Until closely evaluated further on the record of this proceeding, there can be no confidence in the ASLB decision which asserts that this company can be trusted to maintain quality training necessary to avoid another accident.

III. Failures to Provide BETA and RHR Consultant Reports

1. Background

In January, 1982, Licensee hired the consulting firm of Basic Energy Technology Associates, Inc. ("BETA") to conduct what it has deemed as "efficiency study" for the TMI-1 and Oyster Creek Plants. Report of Investigation, Case No. 1-83-013, ("Reportability Report"), p. 1. On February 28, 1983, BETA issued its report to Licensee. Id.

In June, 1982, Licensee requested the firm of Rohrer, Hibler and Replogle, Inc. ("RHR") to assess the attitudes of licensed operators. RHR issued its findings March 15, 1983 to Licensee. Id. While the reports were released to NRC Regional Inspectors during the week of April 25, 1983. Board Notification did not occur until May 16, 1983. Id.

On May 17, 1983, NRC inspection report #50-289/83-10 was released, in which Region I inspectors stated "[i]n summary, when the inspection teams' findings from the BETA and RHR reports were integrated with the onsite inspection findings, the team's findings regarding management integrity and procedure adherence were not changed." Id., p. 2. These Region I inspecters also saw no need for Board Notification of these reports. Id. Yet the reports were of sufficient concern to senior NRC staff that on May 19, 1983, the NRC's Executive Director for Operations cited "concerns raised by the contents of GPU consultant reports" and "the issue of whether the Licensee failed to promptly notify the Commission or the Appeal Board of relevant material information contained in the BETA or RHR reports or any other

documents, which failure may reflect on the Licensee's management integrity," as two of five "open issues" causing the Staff to conclude that it "can draw no conclusion regarding management integrity at this time." See, §I, supra.

On May 23, 1983, TMIA requested that this Appeal Board reopen the management record on the basis of, inter alia, these two issues. See, §I, supra. In its August 31, 1983 decision, ALAB-738, the Board did not reopen the record on the substantive contents of BETA and RHR, ruling it was "unable to conclude that any of the matter called to our attention might have made a difference in the Licensing Board's decision." Slip. Op., p. 40. But the Board also ruled that while the record reopening criteria could not be satisfied at that time, the Board would consider later motions to reopen as new information developed as a result of OI investigations into this and other matters.

The Board also expressed its view that its ruling should not be interpreted as a statement that the matters initially raised by TMIA were unimportant. To the contrary, regarding the "reportability" issue, the Board stated, "[t]he untimely provision of significant information is also an important measure of a licensee's character, particularly if it is found to constitute a "material false statement." p. 39.

Similarly, the Licensing Board recently stated in Houston Lighting and Power, supra,

> ... there may be some character defects that are so serious that they are in fact uncorrectable, at least in the absence of a "radical change in the control of [the] corportation." One of these defects might be evidenced by an intentional lack of truthfulness or

> candor condoned by management. As we have observed, the Commission in CLI-80-32 emphasized the importance of truthfulness and candor, and it explicitly pointed out that a lack of truthfulness or candor could prove disqualifying,....12 NRC 291, nn. 4,5. Further, the Commission cited cases suggesting that willful misrepresentations to the Commission, or representations made with disregard for their truth, could be grounds, without more, for license denial.

Slip. Op. p. 23.

The NRC's Executive Legal Director concluded on June 14, 1983 that Licensee's witholding of the BETA and RHR can be interpreted as a material false statement by omission. Exhibit 27. The ELD determined that "[t]he licensee can be considered to have failed to meet its duty to make Board Notification and its obligations under Section 186 (of the Atomic Energy Act) by failing to provide the BETA and RHR reports in a more timely fashion." Id. Based on this conclusion, the NRC's Executive Director for Operations requested that OI investigate the circumstances surrounding this incident.

That investigation report was released in early May, 1984, with supporting documents released a week and a half later. OI concluded, in pertinent part,

> The investigation did not disclose any evidence of a deliberate attempt or conscious management decision by GPUN to withhold the information in the BETA and RHR reports from the NRC. Further, GPUN does not view their reluctance to release the reports to the Board as contradfictory to the action of the VP, TMI-1, wherein he disclosed the reports to the NRC Region I Inspection Team. Corporate management did not consider that release a formal submittal or disclosure but rather as simply making the information in the reports available to the NRC.
>
> No single individual or organization group within GPUN was identified as being resonsible for evaluating the BETA and RHR reports for purposes of reportability. Corporate officials testified that prior to the release of the reports becoming an issue, GPUN did not have a specific mechanism in place for evaluating a report's

> relevancy and materiality as they pertained to the NRC's reporting requirement. Although steps have been taken to better fulfill this responsibility, GPUN officials still exhibit a certain degree of un certainty relative to the parameters and threshold to be employed in evaluating a report for purposes of Board Notification.

It is unclear what the Staff intends to suggest by this language. If the intent is to downplay the seriousness of Licensee's conduct, one must question the objectivity of the investigators. No reasonably unbiased investigator could find other than a serious lack of integrity by Licensee's management on the basis of the evidence obtained in this investigation. This evidence demonstrates not only a past failure to comply with reporting requirements, demonstrating a clear lack of responsible performance by current management relating directly to its integrity, or more precisely the lack thereof, but also that Licensee argued, and continues to argue with the NRC about what its reporting responsibilites are. This is particularly disturbing. Irrespective of whatever statement OI makes here, the record of this investigation provides not a shred of objective evidence upon which one could conclude that Licensee can be trusted to be forthright with the NRC with information potentially damaging to the company.

2. Safety Significance

The standard by which a Licensee must judge whether a document should be provided to the NRC is not the perceived "safety significance" of the document. This issue was specifically addressed in the context of the BETA and RHR reports

after the Staff determined that "...the team could identify no information which raised significant safety or regulatory concern." TMI-1 Restart SER, NUREG 0680, Supplement 4, p. 2-1. 10/. In a December 13, 1983 memo to Ben B. Hayes, Director OI, the Staff explained that this conclusion "does not imply a judgement as to whether any of the material addressed in the report is 'relevant and material' to the matters addressed in the TMI-1 Restart Proceeding....The BETA and RHR reports do...contain information which is 'material and relevant.'" Further, it does not mean that "the separate matter of the timing of the licensee's provision of these reports to the adjudicatory bodies in the TMI-1 restart proceeding may not raise a significant regulatory concern."

Yet Licensee's management perception that these reports were not safety significant is frequently presented as one excuse for their failure to report these documents. For example, current GPUN President Philip Clark stated in his OI testimony,

> ... in terms of the substance of what was in the reports, I don't think I ever had any concern that there was substance in there that went to safety, the knowledge of which would impede restart.

Exhibit 2, p. 31. See, also, id., p. 35 ("Even having reread them, we didn't see them as safety issues"); p. 45 ("We never saw it or thought about it as a safety issue, or something that needed to be reported").

10/ TMIA has expressed disgareement with the Staff's determination that the documents are not safety significant. See, TMIA's May 23, 1983 Motion to Reopen the Record.

GPU President Herman Dieckamp told OI, "the reports themselves were not material with respect to safety. Exhibit 21, pp. 16-17. See also, p. 25-26. Ironically, Dieckamp had earlier told OI in the same interview, regarding the BETA report,

> "[c]ertainly, if the organization is ineffective, that is a safety matter. But we didn't think of it that way. We rather thought of it as just cost effectiveness. Frankly, it never occurred to me that this was a matter that would be of interest to the NRC.

Id., p. 13.

3. Relevant and Material

Licensee was also unwaivering in its position that these reports contain no information which would require that they be reported to the NRC. Henry Hukill, Vice-President and Director of TMI-1, stated in testimony to OI, "...in my mind the reports did not contain anything that I thought was of vital interest to the NRC or anything that would be of material interest to the NRC out of these reports." Exhibit 11, p. 18. As to the BETA report, Hukill stated, "I didn't feel that was a material issue for the NRC." Id., p. 19. Dieckamp told OI that prior to May, 1983, he was aware of no consideration of any need to or obligation to officially give those reports to the Commission or to the Boards. Exhibit 21, p. 6.

When asked if the reports had potential to reopen restart hearings, current GPUN Vice President for Nuclear Assurance, Robert Long, told OI, "Not to my mind. After having read both reports, it didn't seem to me that we really even considered

that...." Exhibit 19, p. 21.[11/] And Hukill stated,

> ".. the more important issue was that I read those reports to contain nothing of material significance to things that were discussed in the hearings or gone over in the hearings, and subconsciously I saw no reason to report these to the NRC or anything else.

Exhibit 11, p. 42. This statement seems to be in contradiction to management's stated purpose for hiring RHR. See, p. , infra. See, also, Clark, ("I just don't think we saw that as a licensing -- either of those -- as a licensing kind of document.") Exhibit 2, p. 19.

Another criteria often presented by members of management was the "new information" standard. Then GPUN President Arnold told OI,

> ...In this case, the report [BETA] was not containing, to the best of my knowledge and my reading of it afterwards did not indicate to me it was containing, any new information. So, I didn't really think of the report in and of itself as being something that is reportable. To me, the issue of reportability comes up with regard to new information.
>
> ...[T]here was no information provided to me which I thought was of the nature that required reporting either to the NRC or reporting to the Atomic Safety and Licensing Board.

Exhibit 1, p. 18.

In OI's investigation, Licensee management often expressed this view as to both RHR and BETA. Regarding RHR, Arnold stated, "I don't think there was anything in the way of information, didn't think at the time there was information developed by RHR that was new in terms of the nature of the information, or of any substantial increment of insight into issues beyond what was

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11/ But see, pp.39-42, infra.

already available from what the ASLB and the NRC knew on items which we had obligation to report to them." Exhibit 1, p. 24.

In Hukill's opinion, "The RHR report... indicated pretty thoroughly that the vast majority of our operators' viewpoint toward safety was a positive, that the issues that they had were more of an internal nature and an organizational nature that we needed to work on." Exhibit 11, p. 19. Hukill also remarked,

> "My feeling at that time was very strong that there had not been anything of a material nature that we needed to take immediate action on...I was pleased basically with what Dr. D'Arcy found. He found in my understanding of his discussions with me, that our operators' veiwpoint toward safety was good, was positive, was strong, that they had a good feeling about their own management...
>
> He did bring up some of the specific items that were bothering them. Some of them...had problems with pay, and as I mentioned, personal problems, and other things. And I discussed these with Dr. Long, but to me the items he brought up were not of material nature that I thought that we should...go out and tell the NRC right now that I've got a problem over here.

Exhibit 11, p. 35. And further,

> In the RHR report, they didn't tell me anything that I didn't know, or anything of significance that I didn't know. I knew that the operators had the problems that they indicated. I knew or I felt that the operators' attitude toward safety was good. And there just never appeared to me to be anything in those reports that was of significant material that I ought to turn over to Mr. Conte.

Id., p. 53. See also, Long, Exhibit 19, p. 25 ("...They really hadn't identified any problems that we didn't already know about."); Dieckamp, Exhibit 21, p. 22 ("...we felt that the reports did not introduce new material that was truly different than what had been characterized in the hearing....").

Dieckamp told OI that there was "[n]othing in the reports which "grossly undercuts -- significantly undercuts, or would change the conclusion that had previously been made." Exhibit 21, p. 26. But once the Staff learned of the reports, Licensee clearly understood the position of senior Staff relative to whether there was new information in the reports which could "undercut" the ASLB decision. Then GPU President Arnold recounted a May 9, 1984 discussion in Bethesda with members of the NRC Staff, BETA, and RHR concerning the reportability of these documents. Arnold told OI,

> My recollection is that the discussion was principally as to whether there was information in those two reports which undercut the ASLB record which supported the ASLB decision. I clearly felt there wasn't...one or two, at least, of the NRC's staff expressed concern that there was.

Exhibit 1, p. 37. Similarly, GPU Attorney Ernest Blake recalled,

> ...the discussion was the importance of the information, the significance of the information, the difference between, for example, what was reflected in the BETA report from what Mr. Wegner's preceding testimony had been in the restart proceeding, those sorts of questions that would reflect on the importance, the significance of the reports from a legal standing, their materiality.

Moreover, Licensee's position that for the purposes of reportability requirements the reports contained no new information, is simply incredible. According to Long, "the RHR Study was intended to look at issues raised by the Milhollen (sic) Report, other kinds of feedback we had had about training, and about the operators, and we decided we wanted to try to get a better base of information.12/ See also, Arnold, Exhibit 1, p. 21 ("We were surprised at some of the things we had learned out of the cheating incident. We recognized that a lot of those problems were contributed to, as a minimum, by the perceptions

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12/ The "Milhollin Report" is the "Report of the Special Master" ("SMR") who presided over the "cheating" hearings, dated April 28, 1984. Among Milhollin's findings were:

-- The fact that the training program failed to teach Mr. H such a simple and important concept [i.e.] relative position of heat source and heat sink for natural circulation to occur] is quite remarkable. SMR ¶242.

-- the ...testimony of G and H reveals very poor instuction. SMR ¶ 245.

-- many of the questions on the quizzes were unrelated to the candidates's ability to operate the reactor. This encouraged memorization and diminshed the operators' respect for the training program. SMR ¶251.

-- ... the operators' opinion of the examination may be right. The examination may not in fact measure their ability to operate the reactor safely. SMR ¶287.

-- In light of the number of persons who were compromised, and their positions on the operations staff, I conclude that the overall level of integrity of the op erations staff has been shown to be inadequate. SMR ¶325.

-- The Licensee's training and testing program was poorly administered, weak in content, ineffective in its method of instruction, and not an adequate response to the Commission's order of August 9, 1979. SMR ¶338.

and attitudes of operators."); Clark expressed the same general feeling,

> ...as a result of the cheating incident on the NRC exams and the licensing board hearing, we looked at the record of that and recognized that one of the elements in that was kind of an element...lack of respect for the licensing exam process. It was an attitude kind of problem. And as we reflected on that we decided that we ought to make some effort to see whether there were other attitudes amongst the people, and we focused on the licensed operators, whether there were other attitudes which....we would want to change or correct, and whether it was a morale problem.

Clark, Exhibit 2, p. 7.

The RHR report, which grew out of the Milhollin decision and the cheating incident, revealed that the operators still had substantial criticism of the training program. 13/. While Milhollin chose to attach more blame to management, RHR's findings as to the quality of the training program were quite similar to Milhollin's, 14/, and therefore generally not

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13/ RHR reported:

> -- only 60% of those who responded agreed that the content of the last exams was job relevant and only 1/3 agreed that the oral portion of the exam tested how one would act in an emergency.
>
> -- most considered the training department is not oriented to the needs of the operators.
>
> -- there is... strong agreement that there is not enough training on plant conditions.
>
> -- operacors complained of a lack of convergence between training, testing, and ability to operate the plant. Three out of four denied that training prepared them for what they actually do....what is taught in training is different from what they experience in the plant.

14/ Compare footnotes 13 and 14, supra.

surprising in light of the somewhat astonishing testimony during the "cheating" hearings regarding the poor quality of post-accident training. See PID, ¶2321 et seq.

However, during the "cheating" hearings, Licensee denied event the most serious wrongdoing particularly as later characterized by Judge Milhollin, 15/, presented disingenous testimony concerning cheating and other wrongdoing,16/, and on the basis of findings by Milhollin, was scolded by the Licensing Board for misrepresenting the quality of the training department. PID ¶2321 et seq. Now it appears Licensee accepts the

Further, Licensee has argued strongly against the validity of the more critical RHR findings. See, Licensee's Response to TMIA's Motion to Reopen the Record, dated June 7, 1983. But for purposes of defining their reporting requirements, and promoting their "good management practices," Licensee accepts the

15/ See, SMR ¶ 329, where Milhollin finds, "... the Licensee did not admit at the hearing that the poor testing conditions, and the operators' uncertainty whether they were expected to do their own work, might explain the similar answers on the weekly quizzes. The Licensee took the position that cooperation on the weekly quizzes was "cheating," and then denied cheating had occurred. This made it necessary to pull evidence of cooperation out of the operators on the witness stand....In effect, Licensee litigation strategy was to maintain the credibility of its training program by characterizing the cooperation on the weekly quizzes as "cheating" when the operators did not regard it as such at the time it happened....I conclude that the cooperation on the weekly quizzes was caused directly by the conditions under which the quizzes were given, and that the Licensee was responsible for those conditions and whatever cheating occurred."

16/ e.g., SMR ¶215, regarding management response to cheating.

legitimacy of Milhollin's findings, and humbly acknowleges the serious problems which RHR confirms, and tells the Commission that it will now set out to respond to them. For example, Long told OI,

> The reports were done at our request to make ourselves better. Once we had them in our hands, we began to set some priorities on how we should respond. We assigned responsibilites to people to respond and take action on those issues that we had identified as priority concerns.

Exhibit 19, p. 24. He further stated,

> Certainly, it was very significant to us that the operators identified training as still not being something they were very comfortable with. As I said, we already and clues to that, and we understo a lot of the reasons for that.....So, there were lots of things that gave us genuine concern.

Id.. p. 26-27. When asked if the areas discussed were considered to be no surprise, no new information, Long replied, "I think that is correct in the case of both reports, yes." Id. p. 27. See, also, id., p. 25; ("...They really hadn't identified any problems that we didn't already know about.") ("I don't think there is very much positive in either report. We weren't looking for positives. We were looking for identification of problem areas.")

Dieckamp also told OI,

> Now, if you have got something where the report had come up and said: This condition, or this assumption, is so and so, and that is clearly at odds with the foundation position in the hearing, then I think one would have no choice but to recognize that that was relevant. But if it is just added information, with a different set of words or adjectives, like in the case of RHR's, the reflections of operator attitudes without an ability to really clearly, yet correlate those with

> operator performance, I don't see the materiality in the sense of Board notification.

Dieckamp, Exhibit 21, p. 26. See also, Id., p. 7-8; SMR ¶189 ("management did not need to ask why the cheating [of O and W] occurred; management knew that it was caused by the operators' disrespect for the NRC examination.") Thus, Licensee has either misrepresented its positions to the Licensing and Appeal Board, or to OI. In either case, it indicates a serious integrity problem.

As a collorary to Licensee's "no new information" argument discussed, supra, Licensee indicates that since the consultant reports acutally presented a "positive" view of management, there was no need to clutter up the Board with volumes of this material. Hukill states in Exhibit 11, p. 49 "I felt they would be a plus to the NRC decision on restart." Dieckamp states in Exhibit 21, p. 23 "..you don't want to be obscuring the process by unloading just volumes of material on people."

Yet by its own admission, Licensee states, "we have gone way overboard on the INPO, in terms of submitting what we get from INPO, to INPO's considerable unease." Clark, Exhibit 2, p. 25. In fact, every "positive" report Licensee has recieved concerning any restart issue, some of which involve volumes of material, has been served on the Board, the Commission, and the parties. Even as to other information they have not necessarily considered positive, Clark answers in response to question whether the material in the BETA and RHR reports was immaterial

to the Board, "Frankly, yes, but we recognize the other opinion, and we have been sending stuff in. Exhibit 2, p. 35. (emphasis added).

Reporting requirements aside, there was a definite feeling among members of senior GPU management that the documents not be made public. Deickamp told OI that he was contacted by then GPUN President Arnold, and "because of our concerns about making these reports public I indicated to Bob, or somehow in the conversation with Bob, we reached a feeling that would it not be acceptable or adequate for the inspectors, or their supervision at Region I, to simply have the opportunity to review those reports in whatever depth they wished, but to not retain copies. I did participate in the Company's suggestion that that be the manner in which they were handled." Exhibit 21, p. 10.

With regard to BETA, Licensee states that these concerns were motivated by legitimate considerations. Clark told OI,

> Now, a couple of things in each of those reports that made them internally sensitive. The BETA thing had recommendations to reduce staff. Obviously, circulating that kind of report to everybody in the Company was going to cause a lot of speculation.

Exhibit 2, p. 18-19. However, this rationale, even if it could be a legitimate excuse for withholding documents from the NRC, is not credible. Arnold stated, "... we did advise BETA at the beginning of the effort that their report would, undoubtedly, be public record and they would very likely be called to testify at PUC proceedings on their work effort. Exhibit 1, p. 28.

Regarding RHR, there was the concern expressed that "we had promised the operators confidentiality of the information." Clark, Exhibit 2, p. 19. See, also, Dieckamp, Exhibit 21, p. 12. Again, even if a legitimate basis to withhold documents, the operator's views were obtained on a confidential basis. No names were revealed. Moreover, many of the more "negative" findings concerned management, who of course was entirely privy to the information obtained by RHR.

Stripped of the rhetoric and excuses, the real motivation behind Licensee's decision to withhold these documents appears to be obvious concern with the negative nature of the reports. In fact, Licensee was concerned that the reports were sufficiently negative that 1). the Appeal Board may have found cause to reopen the record, thus delaying or preventing restart, or 2). serious adverse publicity would have resulted upon the documents' release. When questioned whether the reports could have adversely impacted on the larger issue of management competency and integrity, GPU counsel Ernie Blake told OI,

> "I think no, in the way in which I understand your question. But I think yes in terms of what the poential impact could be of the reports. Yes in terms of somebody, important somebodies like commissioners, the appeal board or licensing board, taking a view different from ours about the significance, the importance of the material in those reports and that leading to more hearings, more discussion, more testimony or other evidence on it.

Exhibit 20, p. 40. 17/

17/ D.L. Caphton of Region I, indicated that Region I personnel expressed similar fears. Region I, it should be noted, has never found cause to disagree with Licensee position on witholding of these documents. In ¶6 of a February 13, 1984 memo, Caphton, (footnote continued on next page),

Licensee's atttude is perhaps most best described in Exhibit 18, which is a Report of Interview with Jack R. Goldberg, ELD Attorney. As reported by OI in this interview report, Goldberg participated in a May 3, 1983 conference call with Region I, NRR, and ELD people. He remebered that while discussing the two consultant reports, one of the conferees, possibly from Region I, stated, "these reports are really damaging, if they get out there will be a lot of trouble."18/

A day or two later, in a conference call with NRR, Goldberg requested a copy of BETA and RHR, but was told he could not have copies of the reports since the Licensee had made only eight copies and had requested no further distribution of the reports outside of the inspection team. According to OI, "Goldberg indicated that he was outraged by this dictate from GPUN and demanded the documents be provided to him for review." Id., p. 3. After speaking several days later to GPU Counsel Blake, he was provided with a copy.

But in later telephone conversation with Blake and GPU Counsel Trowbridge, OI reports that Goldberg "remembered that the

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(footnote continued) stated, "many of the authors' perceptions, if taken out of the context, would appear derogatory in nature toward TMI. This was very clear to all NRC personnel dealing with the reports." Exhibit 14, Attachment.

18/ This is confiremed by Hugh Thompson, Director Division of Human Factor Safety, who also participated in the conversation. Thompson said that there was a concensus among the inspectors that GPUN did not want the documents released to the public, noting that a Region I inspector, whose name he could not recall, stated that one of the licensee's personnel had told him "Boy, we don't want this to go public."

GPUN attorneys' response was that they were not aware of the reports and secondly that they were not sure if the material in the reports were relevant and material." Id.[19/] Later on, Goldberg was told by Blake and Trowbridge, that after perusing both documents, they felt that the information within the reports were neither relevant or material and that GPUN was not obligated to provide the information to either the Commission or the Appeal Board.

On May 9, 1984, Goldberg met with Licensee, BETA, RHR consultants, and NRC Staff. He recalled that Harold Denton, Director of NRR urged GPUN to provide the two reports to the Commission and the Appeal Board based on the reports potential impact on a restart decision. He recalled Bob Arnold objected to the release of the reports maintaining that the reports were neither material or relevant, asserting that if GPUN gave the reports to the Appeal Board, the Appeal Board would misinterpret the reports and take them out of context. Arnold continued to maintain that GPUN was not obligated to provide the reports.

Blake then told Goldberg that the company would release the reports, but not until they got letters from the consultants concerning the "significance of the reports to the areas of

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19/ However, Blake says that after Hukill provided reports to NRC, he believes he had conversations with at least Arnold, maybe Hukill and Clark, not having seen the reports until then, i.e. sometime before the Goldberg conversation. Exhibit 20, p. 8. Also, Long states at Exhibit 19, p. 14, "I would imagine that I sent Ernie [Blake] a copy of this March 15th final report for information purposes.

management integrity and competence." Not until this was done were the reports released.

Other evidence also indictates that the company had inappropriate motives for withholding the reports. For example, when asked whether he had any particular concern with the public disclosure of these reports once they had, in fact, been turned it over to the NRC, Hukill replied,

> I personally didn't, no. You know, I can be honest that nothing that comes out of Three Mile Island and gets into the newspaper, it turns out negative. It's very seldom, if ever, that you see anything positive in the local newspaper about Three Mile Island. Once they were out, I knew the newspapers would blow them up, but that had never entered my mind before the fact. I knew once they were out that we would get probably negative publicity, but I didn't think it would be major.

Exhibit 11, p. 51: (emphasis added).

Long told OI, "[t]hat wasn't what came into our minds as: Gee, if somebody sees this, are they going to have a negative reaction." Exhibit 19, p. 35. Yet several minutes earlier, he told OI,

> Certainly, all of us at GPU have learned that anything that appears to be negative that gets into the public domain is likely to have an adverse effect on peoples reaction to us, so I am sure any of us who would look at either of those two reports would say, Golly, if this particular individual or this group reads that, won't they have fun.

Exhibit 19, p. 28-29. And immediately after, he stated,

> There was certainly a concern on the part of Bill Gifford's communications people and others of us that giving these reports to the public would certainly result in lots of inquiries. There were enough negative kind of things in them that people would want to know more about and ask questions about. I don't characterize that as fear. I characterize that as

> anticipating what is going to happen realistically from issuing reports of the nature of these two.

Id. p. 36. See, also, Arnold, Exhibit 1, p. 36, (" ... our experience through the restart proceeding is every new piece of information made public was seized on by somebody with an interpretation that was adverse to us, and it was cause for further investigation and I think in a sense we are sitting here today dealing with one such example.").

Moreover, the threat of eventual release by the Staff was the only reason Licensee finally turned these documents over to the Commission. Indeed, according to Hugh Thompson, Director Division of Human Factor Safety, only after GPUN was threatened with Commission action to force the Licensee to provide the reports, did GPUN finally provide the report formally to the NRC and to the Board. Exhibit 18, p. 2. Moreover, Licensee admits that if they had to do it all over again, they would have released the documents, but only to avoid the embarrassing situation they caused for themselves. Hukill told OI, "[i]f I had known what was going to come, that we were going to have this as a major issue on restart, and that we were going to have a major investigation, I would have given them those reports before they ever got to me." Exhibit 11, p. 44. Dieckamp stated,

> It was a matter of: 'Okay, if that is the wa y it is, that is the way it is'....I don't think our judgement about their materiality or relevance was changed. It was simply a recognition that there was a fait accompli.

There is every indication that Licensee not only still does not understand the criteria and its responsibilities for reporting critical information to the Commission, but will continue to chose to deliberately withhold such information if adverse publicity, or action by the Commission, could result.

Hukill explained

> I'm not a lawyer; I don't know whether this stuff should have been reported. Knowing what I know now, I guarantee I would have handed it to -- I would have called Ernie Blake and said: submit this. Things that cross my desk now I have an entirely different look at, no matter who has written them or who has done what. I question: should we report them?

Exhibit 11, p. 45. See also, p. 43. But Hukill's new assurances in light of this incident are questionable. His OI interviews seemed more like efforts to protect himself rather then truly facing up to his responsibilities as Unit 1 Director. For example, he stated,

> ...I am relatively new to the utility industry and not totally familiar with all of the rules and regulations of submittal of information and hearings type things, and frankly, had counted on our licensing people and our lawyers to be the people who would foward this type stuff that was required. It had always been done in the past.

Exhibit 11, p. 19.

There is nothing to suggest this incident will serve to deter further misconduct in the area of reporting responsibilties. Not only did Licensee acquire no additional insight into reporting responsibilties as a result of this incident, but they clearly believe their original position was correct and give every indication that when faced with similar situations, they will do it again. GPU Counsel Blake stated,

"[o]ur position remains the same. Exhibit 20, p. 35. When asked if he considered the reports' findings material, Long stated, "I did not before May, and as I looked at them after May, I still do not." Exhibit 19, p. 23. See, also, Arnold, Exhibit 1, p. 40 ("I didn't then and I don't now consider them material to the restart procedure."). Thus, the "solution to the problem" proposed by Licensee and discussed by OI, supra, i.e., a new internal document "review" procedure, is certainly meaningless in light of Licensee's continuing and fundamental misperception of what its reporting responsibilities are.

In defense of his client, GPU's Counsel is skilled at defining the key legal jargon, but provides no support that management can be trusted to fulfill its legal responsibilties. 19/ Blake explains that the documents had some potential effect on restart, but that management still did not consider them important or significant. Exhibit 20, p. 42.

Moreover, save Bob Arnold, the very same people responsible for this prior misconduct remain responsible. The evidence supports that other licensing individuals, whose involvement OI dismisses, were at least part of the decision making process also. Clark stated, "the licensing people you know are one of the people most aware and concious of the reportability requirement. Exhibit 2, p. 35. In Clarks opinion, at least Jack Wetmore ("I

19/ See, OI's exchange with Blake, at Exhibit 20, p. 43. ("Q. So in your mind, you can differentiate between the potential but still the quesiton of materiality or the significance? A. Yes.")

think he would have been involved.") id., p. 38, and C.W. Smythe("...he just must have been invovled.") id., p. 40, were likely involved. With regard to Wetmore's boss Jack Thorpe, Clark told OI, "I think less likely than Wetmore. Wetmore would have reported to Thorpe. Whether he would have chosen to take the discussion to the Thorpe level, I don't know. The other possibility is as the thing got to be an issue, it is po ssible that Hu kill or Arnold, for example, would have called Thorpe and said you are our licensing manager, what do you think.

Hukill confirmed this. When asked whether any of those individuals have been involved in the issuance of the reports to the NRC, Hukill replied: Yes, I'm certain all three of them were. I take that back; I'm not certain of anything that happened in early '83. There was so much going on here. Exhibit 11, p. 39. However, he also stated, "[Smythe] is the one I count on to advise me as to what to do in these situations and in our dealing wwith the NRC. He is really my coordinatior in our relations with the NRC." Exhibit 11, p. 40. Further, "I'm certain -- or feel certain that once I told Courtney Smythe about it that he would have reported it up the chain of command." Id.
Exhibit 20, Ernie:

OI, however, manages to eliminate these individuals from consideration with one swift stroke. See, Exhibit 23. Certainly, in light of these statements by Clark and Hukill, there is no reliable evidence presented that might lead an objective decision maker to place confidence in the "categorical denials" described in Exhibit 23. Further, OI also failed to even interview GPU Chairman of the Board William Kuhns on his involvement. See, Blake, Exhibit 20, p. 37, indicating he may have interfaced with Kuhns on this issue. OI's failure to do a thorough, objective review of this issue is evident in the

leading questions which typified its investigative style. See, e.g., Attachments.

By demonstrating improper motives for Licensee's withholding of the BETA and RHR reports, and by proving that Licensee failed to provide the BETA and RHR reports until threatened release by the Commission, this investigation evidences serious defects in Licensee's integrity. By failing to correct its obvious misperceptions as to what information is material, Licensee hoped either that the Commission would overlook this, or would simply take no action in response to it. In either case, this indicates a serious integrity problem and stands as an extremely bad example from top management to subordinates as to what its legal responsibilities are. The record must be reopened on this issue.

Respectfully submitted,

Three Mile Island ALert, Inc.

By Joanne Doroshow
Louise Bradford

May 23, 1984

ATTACHMENTS

EXHIBIT 19

TESTIMONY OF ROBERT L. LONG

to identify the problems, and notify usually first thing the on-site inspectors, and then proceed from there if notification is required.

Q Was there any particular fear regarding these two reports going public? Did you have any overriding concern to the thought that if this information became public we were going to have particular problems as a result of that?

A I don't think I would describe it as fear. There was certainly a concern on the part of Bill Gifford's communications people and others of us that giving these reports to the public would certainly result in lots of inquiries. There were enough negative kind of things in them that people would want to know more about and ask questions about.

I don't characterize that as fear. I characterize that as anticipating what is going to happen realistically from issuing reports of the nature of these two.

DIRECT EXAMINATION

BY MR. CHRISTOPHER:

Q And that is given the fact that you had already made the determination that the information would not have affected a licensing decision, and was not material. In other words, once a decision had in some fashion been reached, either consciously or unconsciously, that there

was nothing, 'material, new, and relevant' that would require it to be reported to the Board.

And to go one step further, why should we put this information out to open a pandora's box of questions.

A Yes.

DIRECT EXAMINATION

BY MR. LETTS:

Q By your response to that, do I understand, in fact, Bill Gifford's communication section was involved in the issue regarding release of the BETA and RHR Reports?

A Bill Gifford is always informed of material which is going to be made available to the public, because the first telephone calls come into his division.

DIRECT EXAMINATION

BY MR. CHRISTOPHER:

Q I think you mentioned earlier that you thought Mr. Gifford wasn't involved. Were you speaking about the early on review?

A Review in terms of the decision whether or not to give it to the NRC inspectors when they were on site, or to give it to the public. I am not aware that Bill was involved in that decision. Once that decision is made, Mr. Gifford's organization needs to know about it, because they get all the questions.

Q So it was more or less after the fact?

EXHIBIT 11

TESTIMONY OF HENRY D. HUKILL

to all of us after this all happened and said that we all have to be aware of our requirements to keep the Board informed of any material that is relevant and material to the hearings, and that we should be looking at all material with that in mind; and anything we come across that we think could be relevant material, we should submit to Licensing for further evaluation.

So the evaluation still isn't in my hands, although I do have the responsibility to be on the lookout for it, and I have alerted my staff to this.

BY MR. CHRISTOPHER:

Q Are you saying that the review -- let's say it would get to your attorneys as a very final review and approval of whether it should go, and as an initial cut on whether something should be going to the Board?

A I really don't know how they do it.

Q There is an argument that can be made here, that the only reason these reports finally went to Ernie Blake of Shaw-Pittman was for him to come up with a fancy legal argument after the fact as to why they shouldn't have been, to justify why they weren't taken to the Board.

A No, I don't think that is true at all.

Q I was just getting into this process of review for potential Board notification. Whether it is initiated from your office or someone else's, it goes to your Licensing

we ought to improve on them, but we have always got room for improvement; and I presented them as a plus, not as a negative. As a plus. I had no problem with them.

I did not give Don Caphton the reports at first. I just mentioned them to him, and he asked me for them. I think he took them with him that night to read. So I didn't have any objection to him reading them.

There are things in there that say, you know, we ought to improve our efficiency here or we ought to improve our efficiency there. In the RHR report there are some things that say -- some personnel matters that we could do better in the personnel handling of our operators, and better organization.

So management competence, yes; they talk about management competence.

Management integrity, I don't think that is brought up at all, not as I view it.

BY MR. CHRISTOPHER:

Q Management competence, not in the sense that it should be a factor that the Board should be made aware of, not in that sense?

A No, not at all.

Q Only because any research project that you get reflects on how you do things?

A Just like any report I get, just like a QA audit

that I get internally that tells me -- you know, recommends that you look at these three areas and look for improvement in these programs. And that's how I viewed those reports.

BY MR. LETTS:

Q And you stated earlier that you had no particular concern with the public disclosure on these reports once you had, in fact, turned it over to the NRC?

A I personally didn't, no. You know, I can be honest that anything that comes out of Three Mile Island and gets into the newspaper, it turns out negative. It's very seldom, if ever, that you see anything positive in the local newspaper about Three Mile Island. Once they were out, I knew the newspapers would blow them up, but that had never entered my mind before the fact. I knew once they were out that we would get probably negative publicity, but I didn't think it would be major.

Q And you stated that once you had turned the reports over finally to Region and Rick Keimig within the NRC Region I, your basic involvement with the issuance of those reports ceased. There was, in fact, a meeting on May 9, 1983 in Bethesda at which time Bob Arnold and Ernie Blake representing GPU attended a meeting with NRC officials and representatives from both BETA and RHR. At that meeting there seemed to be reluctance on the part of Bob Arnold, speaking for GPU, to release the materials to the Board for

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING APPEAL BOARD

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

CERTIFICATE OF SERVICE

I hereby certify the copies of the attached TMIA MOTION TO REOPEN THE RECORD ON TRAINING IRREGULARITIES AND THE REPORTABILITY OF THE BETA AND RHR REPORTS were served this 23rd day of May, 1984, by deposit first class in the U.S. Mails, or hand delivered that day, where possible.

Joanne Doroshow

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