UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

In the Matter of

METROPOLITAN EDISON COMPANY

DOCKET 50-289

(Three Mile Island Nuclear
Generating Station, Unit 1)

ADDITIONAL RESPONSE OF AAMODTS TO COMMISSION'S ORDER FOR PARTIES' COMMENTS CONCERNING RESTART OF TMI-UNIT 1

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On July 5, 1984 the Commission extended the time until noon of July 26, 1984 for comments of the parties concerning restart of TMI-Init 1. On that day, prior to our knowledge of the extension of time, we had served our comments. These comments essentially said that the matter of serious health effects, notably cancer deaths six times greater than would be expected in the five year period since the accident in areas of plume direction during the initial days of the TMI-2 accident, was new relevant information of major significance which required resolution prior to any restart decision. The fact that the Licensee, alone, monitored the radiological releases for the first three days of the accident and claimed to have lost the in-plant records, from which high off-site releases were extrapolated and then denied, now places these matters, previously considered benign, with the management integrity/competency issues which remain the single most significant bar to a restart decision.

We maintain our positon as stated in our comments served July 5, 1984. The present comments are additional, partly philosophical and the remainder concerning Office of Investigations reports served since July 5, for which the extension of time for comments was provided.

COMMENTS

We recently received a copy of Congressman Bevill's letter of May 31, 1984 to Chairman Palladino with regard to a timely decision concerning restart of TMI-Unit 1. (Attachment 1)

We were particularly struck by Congressman Bevill's quote that the "inability of the NRC to reach a decision on this facility jeopardizes public confidence in the NRC ability to make credible, independent decisions."

We would note that our participation in the the TMI-1 Restart Proceeding has resulted in our coming to a similar conclusion to that of Congressman Bevill.

In addition to concurring with this criticism, we profer our perception of how the Commission can come expeditiously to a "credible" decision and restore public confidence in the NRC's ability to make "credible, independent" decisions.

The basis for our perception is twofold:

1. The Commission has not articulated an objective standard by which to judge the integrity of GPU management and

2. The NRCStaff has, from the outset of this proceeding, failed in its responsibility to bring information which impugned the integrity of GPU management into the proceeding in a timely manner.

An Objective Standard

First, the Commission appears to lack a definition of "integrity". Webster can solve this problem. Integrity is quite simply "moral soundness, honesty, uprightness." This definition provides a standard which defies equivocation.

The Commission must apply this simple standard in its position

of responsibility to the public. The Commission must simply ask whether or not GPU management, as evidenced in the operation of the TMI plants, has been morally sound, honest and upright. Any negative finding would cause the Commission to deny the GPU license to operate any nuclear facility. The most elemental assumption on which a license to use nuclear materials is granted is the trustworthiness of the applicant. For the Commission to grant a license to operate with any evidence of untrustworthiness of a licensee is a serious breach of the Commission's duties.

We submit that the record of the Restart Proceeding and the extra-record evidence examined by the Office of Investigations are replete with examples of the untrustworthiness of GPU management of the TMI facilities. We provided ten items in our filings of October 27 and November 11, 1983 which have been verified and which demonstrate the untrustworthiness of GPU management. The matters investigated since that time by OI support our position that there is abundant evidence of the untrustworthiness of GPU management. The Commission has been on notice since June of 1983 (when it received the memorandum of Tim Martin to the Commission concerning the Hartman allegations, i.e., the falsification of leak rates at Unit 2) that there was clear definitive and sufficient evidence for the Commission to come to a credible decision to deny the GPU license to operate any nuclear facility.

The second aspect of the issue is the definition of "management". Licensee has argued that "management integrity" applies only to individual management personnel. We would remind the Commission that the license to operate TMI-1 would be given to the

corporate entity, not any handful of individuals. Dishonesty and disception on the part ofkey management personnel is pure and simple evidence that the corporate entity lack integrity. That the corporate entity purged itself of some individuals and shifted others to coal plants or TMI-2 cleanup activities, only after these individuals' activities became a matter of public record, is further evidence of GPU's own lack of integrity. The retention of these demonstrably dishonest personnel, including the instructor Husted, Chairman Dieckamp and Vice-president of Nuclear Assurance Robert Long (who the Licensing Board asserted did not recognize his own failures) is additional compelling evidence of a corporate entity which not only lacks integrity but exhibits a character that is recalcitrant.

The Inadequacy of a Subjective Standard

To this point the proceeding has floundered on the question of 'how much lack of integrity is too much? The Commission has offered no definitive guidance. Rather, by denying the relevance of the leak rate falsification conspiracy at Unit 2, which was the direct cause of the escalation of the TMI-2 accident and met the Commission's own unique standard for litigation (nexus to the accident), the Commission has demonstrated an unwillingness to decide the issue of restart on the basis of management integrity and the most relevant information concerning GPU's lack of it.

No matter how the Commission slices the extensive, deliberate and significant TMI-2 leak rate falsifications, it will not be able to successfully support any decision to separate the misoperation of Unit 2 (the cause of the accident and the untold suffering of the public in the area) from the management of TMI or the restart decision. (We discuss this further below.)

Nor can the Commission's failure to provide an objective standard excuse management for the widespread cheating on company exams -- collaboration which the Commission ordered to end in November 1980 (Memorandum to Collins; Collins to Hukill) and which Robert Long, supposedly Director of Training, assured the Licensing Board in February 1981 had ceased, but which continued until the Licensee was compelled in 1982 to face the testimony of operators. What was then, and later, revealed was a history of deliberate deception concerning the training and certification of operators for licensing. The Commission and Staff have not faced this history. The Commission lept on a single instance (the cheating and miscertification of Jim Floyd). This is but another example of the Commission's uneven regulation and fuzzy standards.

NRC's investigators have identified the cause of Jim Floyd's and other individuals' compromises: "Licensee management failed to establish an environment where everyone knew that compliance with procedures and license conditions was a condition of employment." (Martin, Hartman Allegation Investigation Summary, June 3, 1983, page 9) Although this conclusion regarded the leak rate falsifications, it applies universally to the TMI operation. Remember Operator "OO"'s statement that cheating was commonplace and accepted at TMI and Hukill's lack of surprise or followup! The Staff investigators found that it was operators who protested the leak rate

falsifications -- despite the environment -- but were required to participate in the deception and misoperation of the faulty TMI-2 plant. (Id., page 6: "At least three interviewed Operators believed shift supervision expected them to continue trying to get acceptable computer leak rate test results until one was received," Page 7: "..at least four held some opinion that as a last resort, it was expected.")

The Commission should halt the witch-hunt among the comparatively innocent which is an uncleverly designed ruse to protect the criminal GPU and its corporate officers and managers. The Commission is in business of granting and denying licenses to corporations. It is not the role of the Commission to provide mechanisms for the mitigation of corporate deficiencies.

Should the Commission Await the Hearing of the Remanded Issues?

The Appeal Board remanded three issues (operator training, the Unit 1 leak rate falsifications and the Dieckamp mailgram) to the Licensing Board by Order ALAB 772.

The failure to have fully resolved these issues, at this late date, must be shared by the NRC Staff and the Licensee. Despite these dismal failures to provide credible record evidence in the five years devoted to the Restart Proceeding, the Appeal Board has graciously provided these parties the additional opportunity to meet their burden within the lenient NRC system before the sympathetic Licensing Board. We have little faith in the likelihood of a fair decision by the Licensing Board. However, it will afford the Commission an opportunity to decide for itself, from the record of cross-examination by the intervenors, whether the Licensee and Staff

evidence is solid enough to support a Commission decision for restart.

For the Commission to conclude, on the basis of extra-record material, that the training of operators is now adequate, would be short-sighted. From our extensive acquaintance over the past five years with the issue of operator training, we can assure the Commission that the recent report of the reconsitituted OARP committee is mere pap. The loophole this distinguished committee has left, in now giving unanimous approval of Licensee's training program, is that their observations were limited by the time they presently had available to examine the training program!

The Licensing Board, in a recent order, has, without adequate explanation, deferred the hearing of the Unit 1 leak rate falsification matter despite the Appeal Board order and recognition by all parties of the importance of this matter to the Commission's restart decision. Perhaps, in light of the evidence already developed by OI, it is no wonder that the Licensing Board would want to delay in view of the board's strongly evident past sympathies for nearly all Licensee's inadequacies and deceptions.

We found, from a limited reading of the OI depositions that significance evidence that seriously questions the integrity of key plant and corporate management personnel jumps from the pages. With little effort, we found the following responses of Dieckamp, Hukill, Ross and Shipman that were clearly incredible.

Dieckamp, after suggesting in 1980 (following Hartman's allegations on Station WOR) that the company contract to investigate the alleged falsification of leak rates at Unit 2, claimed that he never bothered to read the Faegre-Benson report of September 1980 until March of 1983 (when he provided it to the Department of Justice). Incredible! (OI Investigation, Volume 9, Exhibit 101, pages 168-170)

Hukill, who claimed during the "Cheating Hearing" that he interviewed the operators about any and all knowledge or involvement in any kind of cheating, stated to OI that when the operators tended "to bring ..up" the topic of falsification of leak rates, he told them not to do so. Hukill stated, "I intentionally tell them that I think that is private business and not something that I should be into." (Id., Exhibit 103, page 8) Incredible!

Mike Ross, supervisor of operations at Unit 1, credited by the Licensing Board and corporate management as having the most comprehensive knowledge of the Unit 1 plant, disclaimed <u>any</u> knowledge of the loop seal which facilitated falsification of leak rates at Unit 1 until it was discovered by NRC's Dr. Chung in 1983. Ross claimed ignorance despite (1) the identification of the identical physical compromise at Unit 2 by Faegre-Benson in 1980, (2) an inspection at Unit 1 subsequently for a loop seal and (3) maintenance work request documents which indicated relevant problems and awareness of other plant staff. (Id. Exhibit 107, pages 81-85; Exhibits 11-15; Volume 1, page 24) Incredible! A mere former operator was aware of the existence of the loop seal in the pre-accident period and knew of its significance for

leak rate surveillance tests (Id., Exhibit 33, page 53).

Ross claimed no knowledge whatsoever of leak rate falsification at Unit 2 prior to the accident, however Shipman, Ross's right -hand man, declared, "but even back then when you violated the Tech Specs that's a big deal, and everybody knows about it. Everybodyin the management train would know about it, and there would be discussions on whether the unit should be shut down..." (Id., Exhibit 109, page 25) Isn't it incredible that Ross as the supervisor of Unit 1, co-licensed on Unit 2, standing watch on a regular basis at Unit 2 to retain his license, in daily contact with the supervisor of Unit 2 and sharing shift supervisors with Unit 2, denied any knowledge of leak rate falsifications at Unit prior to the accident?

Ross and Shipman both claimed that they were unaware in the pre-accident period that an addition of hydrogen in the make-up tank would affect leak rate tests (Exhibit 107, page 61; Exhibit 107, page 47) although seven of twelve pre-accident licensed operators and one of the six pre-accident unlicensed operators interviewed were aware of the hydrogen addition effect (Volume 1, page 19).

Obviously, Ross and Shipman provided OI with incredible testimony under oath and are unfit, because of this fact by itself, to hold their positions of great responsibility at Unit 1.

If the Commission does not wish to await a delayed hearing of the Unit 1 leak rate falsification matter, it can examine the direct evidence in the nine volumes developed by OI. (The OI presentation to to the Commission in April of this year did not fairly represent the evidence deduced.) OI accepted the exculpating evidence of incredible denials and failed to come fully to grips with clearly inculpating evidence of company documents, operators testimony and Dr. Chung's investigation.

Without awaiting the Licensing Board's hearing, the Commission could support OI's reinterview of Ross and others with polygraph tests. The Licensing Board considered Ross the most important management person in terms of public health and safety, and the Commission cannot make a decision in favor of restart with the matter of Ross's integrity clearly challengeable.

In conclusion, the Commission should await the hearing of the training issue, however the matter of Ross's and others culpability concerning leak rate falsification could be settled from the evidence already available and polygraph tests.

The Commission Stay of the Hearing of the Matter of Falsification of Leak Rates at Unit 2

On October 7, 1983 the Commission stayed the hearing ordered by the Appeal Board (ALAB 738) in response to our motion of April 16, 1983. On January 27, 1984 the Commission tentatively voted to excise this matter from its restart decision. The intervenor organization TMIA motioned for a lift of the stay, however the Commission has issued no response.

As we have stated in our filings before the Commission from April 16, 1983 forward, the Leak rate falsification at Unit 2 was directly related to the escalation of the incident on the non-nuclear side of the plant to a lost-of-coolant accident with over 60% core damage. The Restart Proceeding ordered by the Commission was to hear all issues with a nexus to the TMI-2 accident. The Commission is on thin ice in proceeding toward a restart decision without a hearing of the leak rate falsifications at Unit 2.

The Commission should note that although the Staff has continued to deny that the falsifications of leak rates was causal to the accident, their investigators concur with our analysis (April 16, 1983) that the operators were desensitized to the high temperatures and volumes of water pouring into the sump at the time of the accident -- which were due to the loss of core inventory -- because these conditions, due to a leaking PORV, had existed throughout the entire operating history of Unit 2. See Investigation Evaluation of Remaining Allegations Relating to Harold Hartman, June 22, 1984, page 9:

> Interviews with a TMI-2 shift supervisor and operating personnel disclosed that the operators had become "desensitized" to plant operating procedures related to block valve closure because of actual plant operations with higher tailpipe temperatures.

> This condition was also identified during the NUREG 0600 investigation which concluded that this condition was a significant factor contributing to the severity of the accident. Acceptance of this condition by operating personnel resulted in their not being able to recall the requirement to close the block valve to the pressurizer ("desensitized") and to terminate the loss of coolant.

The NRC Staff would also attempt to contine the deception concerning the responsibility for the falsification of leak rates at Unit 2 despite the conclusions of their investigators. The investigators clearly find management responsible. See Id., pages 9 and 10:

> The Keaton investigation disclosed that closure of the block valve would have assisted in identifying where leakage was occurring by the process of elimination. However, the management decided to continue operations and not close the block valve.
> OI believes that the issue concerning an alleged request to shutdown Unit 2 to address problems with leakage had been explored sufficiently for the purpose of arriving at an informed assessment...Despite...the fact that no determination was made as to the specific leak location, it does not appear unreasonable that inquiries or contacts would have been made with other off site personnel concerned with plant conditions.
>
> (emphasis added)

The interview of Chuck Mell by the United States Senate Subcommittee Staff* on the TMI accident described the procedure used to get permission to shutdown the plant. A call is made to the dispatcher at MET ED corporate offices to obtain permission. The consideration is how the outage can be scheduled so that other plants can carry the extra load. Robert Long had ultimate responsibility for generation at the time of the accident. That Robert Long was the person responsible for not shutting down Unit 2 despite evidence that plant personnel requested shutdown is a matter that should be of prime consideration by the Commission.

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* on August 27, 1979 (included at the end of the Investigative Evaluation, June 22, 198

The Commission must exhibit some curiosity concerning Long whohas been in the position of responsibility in three matters which have raised the question of management integrity (Keeping TMI-2 on Line, the Keaton Report of the Sequence of Accident Events, Training of operators after the accident)

Since 1981, after questioning Long extensively in the Restart Hearing, we have publicly stated our sincere doubts concerning the authenticity of the assignment of Long to sensitive issues. We believe that Long never functioned as Director of Training, but merely provided Licensee with a glib witness for the hearing. Why would Long have been removed from his directorship of training at the time when the Board identified deficiencies that needed to be addressed, leaving that position unfilled for some time. If Long was really responsible for the deficiencies in training, as the Board stated, why would Licensee have promoted Long to director of nuclear assurance? The Licensing Board wondered why Long apparently did not recognize that he had failed in his responsibilities to assure an adequate training program. Long's attitude is only understandable by accepting our assertion that Long had no real responsibility for training, being simply a front man -- a position that he may have been willing to take to try to prevent discovery of his culpability concerning the Unit 2 accident.

In our April 16, 1983 filing, we discussed the problems we experienced with the testimony of operators in the "cheating hearing" and the parallel problem alleged to have caused the Department of Justice to seek dismissal of Licensee's attorneys. WE assert that it is the influence and interfernce of Licensee's attorneys that have and would make further investigation of the Hartman matter difficult. We heartily disagree with OI's assertion that further investigation of the TMI-2 leak rate falsifications and other Hartman allegations would be fruitless. (Investigative Evaluation, June 22, 1984, page

10) We also take exception to the Staff's assertion that "Without the benefit of the grand jury material, there is little likelihood of achieving more investigative results than the Department of Justice effort." OI implies that NRC would have to do a better job than DOJ for an NRC investigation to be worth the effort. Such an implication is an outrage. Hasn't OI read the statement of David Dart Queen, the federal attorney, to Judge Rambo upon settlement of the case? We cannot cite references because our copy is misplaced, however we clearly recall Queen's vigorous objection to any implications (forwarded by Licensee's attorney) that DOJ did not have the goods to prove all indictments. Queen explained that DOJ's settlement was a reasonable settlement of the criminal aspect of the leak rate falsification -- DOJ having excerpted a gigantic fine (to be used to benefit the public in emergency planning) in relation to what would have been levied by the court -- and giving earlier access of the NRC to the operators for NRC's own investigation. Queen expressed his strong opinion that the NRC investigation and responsibilities in the matter far exceeded those of DOJ, NRC having the responsibility for public health and safety in relation to the TMI operation.

The OI assertion also implies that NRC was denied the DOJ materials. While we are aware of Licensee's request through the court, we have no knowledge that NRC made a genuine effort to obtain for itself the DOJ materials.

NRC cannot, however, use the the imagined or actual lack of cooperation of another agency as an excuse for not doing its own work. That a full resolution of the Hartman allegations are an obligation of the NRC within the framework of the Restart Proceeding

was clearly stated in a letter from Chairman Palladino to Attorney General William French Smith (April 11, 1983) Palladino stated:

> The Hartman allegations touch upon the competence and integrity of TMI management, perhaps the most significant issue the Commission must address in deciding whether to allow restart of TMI-1. We are rapidly approaching the point where failure to resolve these allegations may delay that decision.
> (emphasis added)

The NRC must have considerable materials of its own concerning the Hartman allegations than those provided in the scant file served on us last week. We find that this withholding and the Commission performance and attitude concerning the Hartman allegations to be matters of great concern. If the Commission should continue in its tentative position (of January 27, 1984) to exclude the Hartman allegations from the restart decision, we would consider legal challenge. We consider the NRC's history of hiding the Hartman matter from public scrutiny to be a regulatory disgrace and an obstacle to public assurance of safe operation of Unit 1.

NRC Policing of Restart

The NRC Staff proposed restart prior to the resolution of all management integrity/competency issues with NRC inspectors on all shifts(November/December 1983). This proposal is doubly faulted. (1) What assurance is there that the NRC inspectors have any more competency or integrity than the Licensee or its personnel? (2) Where, as a practical matter and legally, would responsibility lie? Would continual surviellance be a condition of the license or would the license be granted jointly to the NRC Staff and GPU?

How does the public have assurance from the history of NRC inspection at TMI? Why were the high temperatures and leaking PORV at TMI-2 missed thoughout its operation?How did the NRC Staff fail to enforce the strict refurbishing of the polar crane in the cleanup operation at Unit 2 last year until after whistleblowers, at great personal sacrifice,brought the matter to public attention? Why did the NRC fail to followup on what corrective actions were taken by the Licensee concerning leak rate measurements after NRC inspectors discovered procedural violations in October 1978? Why did the NRC Staff deliberately lie, under oath, in their Safety Evaulation Report in 1981 which was entered into the record of the Restart Proceeding? (The lie was the misrepresentation of evidence NRC had concerning Unit 1 leak rate falsification.) Did the NRC collaborate with GPU personnel in "losing" filters and other inplant radiation data from the initial days of the accident? A former employee has claimed, in documents in our possession, that the NRC was a party to deception of the public concerning radiation releases.

Any attempt by the Commission in their restart decision to lean on NRC policing of Unit 1 is surely subject to successful challenge.

Disclaimer

We have not had sufficient time to discuss all material provided by the NRC concerning the OI investigations of management issues. The Commission's schedule for the parties was unrealistic and illegal. We do not have all relevant information nor do we have any way to pursue questions which have developed in examining the material we do have. The NRC rules of practice and procedure state that the NRC make available all materials of matters of interest to a party (with the exception of possible security violations) and that the NRC Staff not be allowed the resolution of matters of safety even after a hearing has ended.

We put the Commission on notice that it is the Commission which, if it makes a decision to proceed without a full hearing of all open issues, has the grave responsibility to fully review and fully face up to all the material that has been generated concerning GPU.

The NRC has failed, to the point of nearly total disgrace in its obligations to the public and to us as parties. The NRC has caused unnecessary expenditure of public and private resources by failing to act openly and forthrightly to pursue the most significant issue known to the Commission since 1979 -- the leak rate falsifications at Unit 2. It was left up to us to pull this issue out into the open by our motion of April 16, 1983 (and when we did, the NRC Staff practiced further deception to make it appear that they did).

We have learned. When, on June 21, 1984, we raised the issue of cancer deaths six to eight times in excess of those expected in areas of plume direction in the early days of the accident, we identified our concern publicly to avoid the manipulation accorded the Hartman matter. As we expected, the Staff, with its position of "low releases" and "no harm to the public", has asked the Commission to deny our motion for an investigation of the "lost" radiation records from the initial days of the accident, when only the Licensee was monitoring. Will the Commission follow suit and thumb its nose at a fatally injured public living on ground contaminated by radioactive particulates from the core of Unit 2, with farmers unable to pursue the livelihood of growing clover seed, swathed in krypton gas and whose health is further threaten by the restart of a deteriorated plant by inexperienced operators and incompetent and corrupt management? If the Commission seeks to cover the Staff's past, by denying our motions, we warn the Commission that it will have made a fatal mistake.

The Commission has supreme responsibility -- not to see how the parties and public can be hood-winked or cajoled -- but to be just and forthright.

We add that we view our participation in the Restart Proceeding at the invitation of the Commission as a deliberate abuse of citizens by a federal agency in view of the recently released transcripts of closed Commission meetings. Can the Commission provide a credible explanation for its solicitation of our participation, including extensive comments invited concerning the Hartman allegations in 1983? We hope to find it in the Commission's decision concerning restart.

Conclusions

We find, as we did prior to the OI investigations, that the only valid Commission decision is a DENIAL of the GPU license to operate TMI-1. We believe that there exists sufficient evidence on the record of the Restart Proceeding, notably from the hearing of cheating of operators on tests, to support a Commission decision that GPU lacks the managerial trustworthiness to operate a nuclear plant. Any evidence of untrustworthiness is too much in the operation of a nuclear facility where the public heath and safety is clearly at jeopardy. The Commission can find more than ample extra-record evidence from the OI investigations which would support any challenge by the Licensee of a denial.

The only alternative to a denial of the license is for the Commission to allow the full and fair hearing of all open issues, most notably the matter of health effects which have been most reasonably caused by Licensee's deception concerning radioactive releases, prior to its decision.

Immediate denial of the license would better serve the public's interest since denial can be the only final result from a full resolution of all issues.

Respectfully submitted,

Marjorie M. Aamodt

Norman O. Aamodt

July 26, 1984

Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

May 31, 1984

Honorable Nunzio J. Palladino
Chairman
Nuclear Regulatory Commission
Washington, DC 20555

Dear Mr. Chairman:

During our recent hearings, we made clear our interest in a timely decision by the NRC on restart of the undamaged TMI-1 plant.

As stated in the Committee Report:

> "Over five years have passed since the accident at Three Mile Island and yet the NRC has not been able to reach a decision on the restart of the unaffected TMI-1 plant. The inability of the NRC to reach a decision on this facility jeopardizes public confidence in the NRC ability to make credible independent decisions. The NRC has indicated that all litigation and decisions on the restart of TMI-1 will be completed by June 1984. The Committee expects the NRC to maintain this schedule."

I am aware of the recent Atomic Safety and Licensing Appeal Board decision remanding several issues to the ASLB to complete the hearing record. However, it is my understanding that the Commission itself is not limited to the hearing record in the Restart proceeding and that the Commission already has information on each of the issues remanded by the Appeal Board adequate to enable the Commission to reach a restart decision without awaiting those hearings.

Please advise promptly whether the Commission still intends to pursue its immediate effectiveness determination regarding the TMI-1 Restart and the related steam generator issue on the tentative schedule announced last month.

Sincerely,

Tom Bevill

Tom Bevill, Chairman
Subcommittee on Energy