UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

In the Matter of:

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

COMMONWEALTH OF PENNSYLVANIA'S SUPPLEMENTAL COMMENTS
ON THE IMMEDIATE EFFECTIVENESS OF
PARTIAL INITIAL DECISIONS REGARDING MANAGEMENT ISSUES

This document is submitted in response to the Commission's May 23, 1983 Order soliciting comments on the May 24, 1983 Commission briefing. Since the Commonwealth believes that the open issues raised by the Staff in the May 24 briefing and in the May 19, 1983 memorandum from William J. Dircks to the Commission have a direct bearing on the restart management issues currently pending before the Atomic Safety and Licensing Appeal Board, these comments are respectfully submitted as supplemental immediate effectiveness comments for the Commission's consideration. The Commonwealth urges herein that the Commission defer consideration of the immediate effectiveness of the Licensing Board's management decisions pending a complete review by the Appeal Board of the open issues raised by the Staff.

On August 20, 1982, the Commonwealth filed comments regarding the immediate effectiveness of the ASLB Partial Initial Decision (PID) on operator cheating issues (Reopened Proceeding) (dated July 27, 1982). These comments argued that the integrity of those responsible for the operation of TMI-1 was critical to plant safety, and that individuals with a demonstrated lack of integrity should not be permitted to operate

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the plant. The Commonwealth's comments also argued that a decision on restart must be predicated upon reasonable assurances regarding the adequacy of GPU's operator training program. Issues raised recently by the Staff renew these concerns and pose additional uncertainties regarding the ability of GPU to operate TMI-1 safely. Most importantly, the Staff states that it "can draw no conclusion regarding management integrity at this time." The Commonwealth's argument that integrity is critical to plant safety is particularly compelling with respect to the Licensee's top management officials, who have the ultimate responsibility in the GPU organization for ensuring that public health and safety is protected. The Commonwealth will not support the restart of TMI-1 until it receives adequate assurances from the Commission that the management of GPU Nuclear Corporation is willing and able to operate the plant in a safe and competent manner. The public deserves no less.

The nexus of the five issues raised by the Staff to matters that are currently pending in the restart proceeding is addressed below.

1. The veracity of the Hartman allegations. The PID on management issues addressed the Hartman leak rate allegations briefly, at ¶¶504-505. Based on the limited information available to the Board in Supplements to the Staff's Restart Evaluation Report, the Board concluded that there was "no basis to conclude that restart should not be permitted until the DOJ investigation is complete." Id. ¶505. However, the Staff Restart Evaluation Report only stated, that it had identified "a number of apparent problems related to procedure adherence." Id. ¶504, quoting Staff Ex. 13 (Restart Evaluation Report, Supplement 2), at 9-10. In fact, as reported to the Commission in the

May 24, 1983 briefing, the Staff had concluded by April of 1980 that Licensee's personnel had falsified leak rate data prior to the TMI-2 accident. Tr. 13-16 (Martin). The significance of potential evidence regarding the intentional falsification of safety-related test data is far greater than "apparent problems related to procedure adherence," as reported by the Staff in the Restart Evaluation Report and relied upon by the Licensing Board in the PID. There is also reason to question the Staff's conclusion, as quoted and relied upon by the Licensing Board, that "there appears to be no direct connection with the Unit 2 accident." Id. ¶504. First, falsification of test data by Licensee personnel goes directly to the issue of management integrity, which as argued above, is critical to plant safety. Second, it is apparent from the GPU v. B & W court proceeding that at least B&W's attorneys felt that the leak rate falsification issue provided evidence that the TMI-2 accident resulted, in part, from GPU management deficiencies. Third, the leak rate issue is relevant to GPU's maintenance practices, which were litigated before the ASLB. The general issue of GPU's failure to correct plant safety-related maintenance problems was addressed squarely in the Restart Proceeding. The Licensing Board's decision on these issues was clearly based on incomplete evidence. The Staff's treatment of the Hartman evidence may have materially affected the Licensing Board's decision in the case. Therefore, the PID should not be made immediately effective until these issues are resolved.

2. Statements on the record of the GPU v. B&W court proceeding. Although the Staff's references to the B&W transcript are somewhat vague, it is clear that at least part of the information under review by the Staff is relevant to issues in the Restart Proceeding. Page 2, note 1 of the Dircks memorandum indicates that the Staff is reviewing information relevant to the integrity of Licensee's program for the

requalification of licensed operators. The adequacy of Licensee's operator training and retraining programs was addressed in the original management PID (¶¶163-276), the April 28, 1982 Report of the Special Master (¶¶238-251) and the July 27, 1982 PID (Reopened Proceeding (¶¶2321-47)). The new information alluded to by the Staff is clearly relevant to these decisions, and to the overall question of whether there is reasonable assurance that GPU's licensed operators are adequately trained to operate TMI-1 safely. Until these questions are adequately resolved, neither the August 27, 1981, nor the July 27, 1982 PID should become immediately effective.

3. The Parks and King allegations. Short-term order item 6 of the Commission's August 9, 1979 Order and Notice of Hearing required the Licensee to "demonstrate his managerial capability and resources to operate Unit 1 while maintaining Unit 2 in a safe configuration and carrying out the planned decontamination and/or restoration activities..." Thus, the management competence and integrity of the Licensee to operate Unit 1 safely are clearly linked in the Restart Proceeding to management capabilities at Unit 2. The issues raised in the polar crane affidavits, in turn, plainly challenge both the management integrity and competence of the Licensee to conduct the Unit 2 clean-up. The following broad allegations in the Parks and Gischel affidavits are particularly disturbing:

> "I am submitting this statement to express my personal knowledge and concerns that the management of Three Mile Island-Unit 2 (TMI) has sacrificed its own system of safety-related checks and balances for TMI cleanup activities in order to meet unrealistic time schedules and in the process equipment has been modified and snap judgments made without proper engineering

> analysis, quality assurance (QA) steps have intentionally been skipped and totally circumvented, rules and documents have been changed after the fact to justify QA violations, and those who have defended the normal system of nuclear industry checks and balances have faced pressure, intimidation and retaliation which stripped them of the authority to function as viable members of the management team. I am among those who have suffered this fate. Quality Assurance violations include many other issues of which I am aware but do not have personal knowledge."

(Parks).

> "Based on my observations, I believe that the TMI-2 accident was due to a "people" problem that must have begun before the accident, and still exists... The present mentality at the Island emphasizes shortcuts, expediency and disdain for professional standards."

(Gischel).

Although the issues raised in the Parks and Gischel affidavits relate solely to TMI-2, the generic management issues are precisely the same as those raised in the Restart Proceeding. In the Restart Proceeding, GPU argued that deficiencies in its Quality Assurance/Quality Control procedures and attitudes have been corrected through the use of new management structures and procedures. Evidence that these new procedures may not have worked at TMI-2 is certainly pertinent to a determination of whether or not the procedures are working and will work at TMI-1 in the event of a restart. Substantial plant modifications have been made to support restart, all of which require the application of QA/QC procedures.

The polar crane allegations are relevant to the Restart Proceeding for a number of additional issues. The Commission clearly linked GPU's

management capabilities and resources to operate Unit 1 safely to their capability and resources to conduct the decontamination at Unit 2. GPU's primary response to this criteria was an acknowledgement that it lacked sufficient technical capabilities and resources to conduct the Unit 2 decontamination simultaneously with a safe restart of Unit 1. To meet this deficiency, GPU argued that it had employed the significant technical resources of Bechtel. The recent evidence regarding Unit 2 indicates that the Bechtel-GPU interface is far from adequate and calls into question GPU's arguments in the context of the Restart Proceeding. Moreover, the new evidence tends to indicate that GPU is devoting superior talent and resources to its restart management than to its cleanup management. This is inconsistent with the Commonwealth's position that a safe and expeditious cleanup at Unit 2 is paramount, and that Unit 1 restart should be permitted only if consistent with this primary goal.

Second, it is important to note that there are significant common management links between TMI-1 and TMI-2. Both organizations report directly to the Office of the President of GPU Nuclear Corporation (Robert Arnold). Both the Parks and Gischel affidavits allege that Mr. Arnold and other members of his office were directly involved in the allegedly improper management activities, including alleged management harassment and intimidation of dissenters within the company. Moreover, the technical allegations raised in the affidavits relate primarily to quality assurance and quality control. Again, QA/QC deficiencies were a significant issue in the Restart Proceeding. GPU's evidentiary response was that it had centralized its technical and engineering QA/QC resources above the levels of individual plant management. Groups such as the General Office Review Board (GORB) and the Division of Nuclear

Assurance, both of which bear the fundamental QA/QC review responsibilities within the corporation, function independent of the onsite Unit 1 and Unit 2 organizations and are supposed to regulate QA/QC at both units. Breakdowns in QA/QC procedures at Unit 2 are therefore related to potential deficiencies at Unit 1. (There are many other examples of technical resources common to both units and which have an indirect responsibility for quality assurance, such as the Division of Technical Services in the GPU Nuclear Corporation.)

Third, GPU presented evidence during the Restart Proceeding that quality assurance deficiencies would be remedied by new onsite procedures. Although different personnel may serve these functions at Unit 1 and Unit 2, evidence of breakdowns in the procedures at Unit 2 indicate that GPU's new management structure has not necessarily resolved management difficulties at the Island. One example is the Plant Operations Review Committee (PORC), which is intended to serve as a day-to-day quality assurance review committee at the Island. The effectiveness of the Unit 2 PORC was challenged strongly in the Parks affidavit. Another example is the "ombudsman" procedure, which was established to ensure that concerned company employees have an opportunity to resolve safety-related problems without fears of reprisals or intimidation by company management. It is evident that the ombudsman procedure did not work, or was not allowed to work, at Unit 2.

The Commonwealth does not wish to imply that any firm conclusions can be drawn at this time on the basis of the affidavits. The motives of the individuals bringing the charges and the veracity of their allegations have not been challenged. Nor has GPU been given a proper opportunity to rebut these claims. However, the issues raised have

extremely important potential ramifications regarding the overall management integrity and competence of GPU Nuclear Corporation. These issues should be fully aired prior to restart. The Licensing Board's management PID cannot be given immediate effectiveness under these circumstances.

4. Concerns raised by the BETA and RHR reports. A large number of issues and open questions in the GPU consultants' reports relate to issues before the Appeal Board, and contradict or qualify many of the conclusions reached in the management PID. Although it would be impossible to catalog the nexus between each item in these reports to the Restart Proceeding at this time, deferral of the Commission's immediate effectiveness decision on the management PID is warranted pending an in-depth review of these issues by the Staff, the parties, and the Appeal Board. The Commonwealth is particularly concerned with allegations in the BETA report regarding plant maintenance, quality assurance, and operator training, all of which are critical to plant safety.

5. Failure to Notify the Commission or Appeal Board of Relevant and Material Information. The Commonwealth is perhaps most concerned by the Staff's allegation regarding the Licensee's failure to promptly notify the NRC of potentially relevant and material information. It is a fundamental principle of NRC regulatory policy that Licensee's have an affirmative duty to come forward with all

potentially relevant information. Duke Power Co. (William B. McGuire Nuclear Station, Units 1 & 2), ALAB-143, 6 AEC 623 (1973); Georgia Power Co. (Alvin W. Vogtle Nuclear Plant, Units 1 & 2), ALAB-291, 2 NRC 404, 408 (1975); Duke Power Co. (Catawba Nuclear Station, Units 1 & 2), ALAB-355, 4 NRC 397, 406 at n.26 (1976); Consumers Power Co. (Midland Plant, Units 1 & 2), CLI-74-3, 7 NRC 7, 11 (1974); Petition for Emergency and Remedial Action, CLI-78-6, 7 NRC 400, 418 (1978); Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), CLI-76-22, 4 NRC 480 (1976), aff'd sub. nom. Virginia Electric and Power Co. v. Nuclear Regulatory Commission, 571 F.2d 1289 (4th Cir. 1978). A potential failure by Licensee's upper management to comply with this fundamental principle of NRC law and policy would bear grave consequences in terms of Licensee's management integrity. Again, this issue warrants a complete investigation prior to any final decision on the immediate effectiveness of the Licensing Board's management PID.

CONCLUSION

For the foregoing reasons, the Commonwealth urges the Commission not to grant immediate effectiveness to the Licensing Board's management PIDs until the five issues raised in the May 24, 1983 Commission briefing and the May 19, 1983 Dircks Memorandum are fully investigated, on the record of the Restart Proceeding.

Respectfully submitted,

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Dated: June 2, 1983

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NUCLEAR REGULATORY COMMISSION

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CERTIFICATE OF SERVICE

I hereby certify that copies of the Commonwealth's letter to the Secretary of the Commission, with attachments, were served on the persons on the attached service list this 2nd day of June, 1983. Persons identified by an asterisk were served by Federal Express. All other persons were served by deposit in the U. S. Mail, first class, postage prepaid.

Robert W. Adler

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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of:

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

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