UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

CHAIRMAN

June 1, 1983

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The Honorable Morris K. Udall, Chairman
Subcommittee on Energy and the Environment
Committee on Interior and Insular Affairs
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Commission shares your view that the Babcock and Wilcox (B&W)/General Public Utilities (GPU) litigation be carefully reviewed as expressed in your February 25, 1983 letter to me.

The answers to questions 2 through 5 raised in your February 25, 1983 letter are enclosed. The answer to question 1 will be provided upon the completion of additional staff work.

Sincerely,

Original Signed By
John F. Ahearne

John F. Ahearne
Acting Chairman

Enclosures:
Responses to Questions

cc: Rep. Manuel Lujan

TO: PRC for DCS

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Certified By L. N. Underwood
6/16/83

Cleared with Cmrs' Offices by SECY C/R.
Separate views of Cmrs. Gilinsky and Asselstine included in answer to Question 3.
Ref.-CR-83-45

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DATE	~~5/16/83~~	5/16/83	5/16/83	5/16/83	~~5/17/83~~	5/ 23	5/17

QUESTION 2: When did the NRC become aware of the GPU analysis of the April 23, 1978 transient at TMI-2? What inference would the Commission make should GPU claim that this analysis did not indicate the need to revise certain of its emergency procedures?

ANSWER: PART A:

The GPU review of the April 23, 1978 transient was documented in a May 4, 1978 GPU internal report. This report was first reviewed by an NRC inspector during an inspection conducted May 3-5 and 5-10, 1978. The GPU report determined that there was steam formation in the hot leg piping but that the core remained covered. The GPU report, specifically the issue of steam formation outside the pressurizer, was analyzed by B&W. B&W, by letter dated May 5, 1978, informed GPU that the pressurizer was never emptied, that no steam bubble was drawn into the reactor coolant system from the pressurizer, and that a steam bubble did not form in the reactor coolant system outside the pressurizer during the April 23, 1978 transient. This B&W analysis was also reviewed during the NRC inspection referenced above.

PART B:

The hypothetical question concerning possible inferences cannot be answered without additional information. GPU did analyze this transient and sought input from B&W. A review of the licensee's response to the April 23, 1978 transient indicates that GPU did make changes to procedures, equipment, and training.

QUESTION 3: What does the Commission know about the emergency core cooling pumps being turned on at about 1 hour and 40 minutes into the accident and being turned off approximately 5 minutes later?

ANSWER:

The operation of high pressure injection (HPI) pumps during the morning of the TMI-2 accident was reviewed during previous investigations; e.g., Rogovin and NSAC reports. With the exception of the GPU sequence of events, the other reports reviewed that specifically addressed HPI operation at about 1 hour and 40 minutes into the accident concluded that it was not turned on in this time frame. This issue was also discussed during the B&W/GPU lawsuit. The NRC team which reviewed the trial court record concluded, on the basis of the evidence available, that HPI was not fully initiated at approximately 5:41 a.m. However, because of continued questions about this issue, such as regarding a "mystery man", the NRC's Office of Investigations is looking into this issue.

Commissioners Gilinsky and Asselstine add: We think the answer is that we really do not know whether or not the pumps in question were turned on and off.

QUESTION 4: Has the Commission received a report indicating the extent to which the pre-March 28, 1979 literature, available in the NRC Public Document Room and elsewhere, contained information that would have alerted GPU to the fact that pressurizer water level was not an accurate indication of the level of water above the reactor core? Does the Commission have information indicating the extent to which GPU fulfilled its commitment to review reports of malfunctions for the purpose of learning from experience obtained at other utilities.

ANSWER: PART A:

The Commission has reviewed several investigation reports of the TMI-2 accident. Most, if not all, addressed precursor events and/or the NRC and industry's method of evaluating experience at operating reactors prior to March 28, 1979; e.g., Rogovin and Senate reports.

PART B:

The Commission does have information indicating the extent to which GPU fulfilled its commitment to review the operating experience of other utilities. As discussed above, previous investigations examined the issue of GPU's past method for reviewing operating experience. The B&W/GPU trial court record also contains information which addresses this issue.

QUESTION 5: When did the Commission become aware that the supervisor of the Met-Ed training program had himself not passed certain operators' exams? When did the Commission become aware of an internal document prepared in early 1978 stating, "The quality of operations personnel is on a continuous downhill trend due to lack of training?

ANSWER: PART A:

The NRC was aware in December 1978 that the supervisor of training at Met-Ed had failed an NRC examination. This individual took the November 1978 NRC examination. The results of the NRC examination stating that this person failed were sent to the licensee on December 12, 1978.

PART B:

The NRC was not aware of the 1978 audit report referred to in Question 5 until the NRC staff's review of the B&W/GPU trial court record which was initiated in December 1982.

The internal document which referenced training was a TMI management audit conducted by Met-Ed personnel during January 1978. The audit team examined management effectiveness, management efficiency, productivity, and employee morale. There were thirteen areas in which findings were identified. Training in the Operations Department was found to be deficient in that too little time was available with personnel in a five-shift rotation. The licensee determined that increasing staffing to allow a six-shift rotation would solve deficiencies in training.