



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

February 22, 1980

The Honorable Alan Simpson
Subcommittee on Nuclear Regulation
Committee on Environment and Public Works
United States Senate
Washington, D.C. 20510

Dear Senator Simpson:

This responds to your letter of February 5, 1980 that requests information on the notification activities and followup work that was performed following transient events that occurred on June 13, 1975 at the Oconee Unit 3 nuclear facility, on September 24, 1977 at the Davis-Bessie nuclear facility and four events resulting in actuation of the high pressure injection system at Three Mile Island Unit 2. A response to the additional questions regarding the condensate polishing system at TMI-2 is also provided.

In summary, the six events were included in monthly reports which were sent to licensees for information purposes but no action requirements or requests were made by the NRC. The NRC reviewed the six events individually and each was assessed not to be of the severity requiring specific notifications to be licensees or a report to Congress as an "Abnormal Occurrence." Detailed information on the notifications is presented in Section I, III, IV, V, VI, VII and VIII of Enclosure No. 1. The Special Inquiry Group Report (p. 98) and the Report of the President's Commission (p. 66) also contain information on these matters.

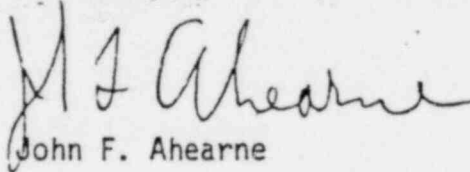
The followup effort for the six events included a routine Licensee Event Report (LER) evaluation of each event by the Office of Inspection and Enforcement (IE) and limited reviews by the Office of Nuclear Reactor Regulation (NRR) on some of the events. Detailed information on the followup effort is presented in Sections II, III, IV, V, VI, VII and VIII of Enclosure No. 1.

In response to your question about actions taken to reduce actuation of High Pressure Injection; the TMI-2 licensee submitted a request for a technical specification revision that would increase operational flexibility and reduce the number of actuations of High Pressure Injection (HPI). This request was reviewed by NRR and the request was granted. Details of this change are given in Section IX of Enclosure No. 1.

The NRC was not informed of the chronic problems with the condensate polisher system because NRC regulations did not require any reports on events on this system; one event was mentioned in the licensee's monthly report, only as an explanation for a plant outage. Details are given in Section X of Enclosure No. 1.

As a result of the TMI-2 accident and related studies, the Commission recognizes that substantial improvement and expansion of the NRC's operating experience assessment programs were required. Therefore, the Commission has initiated several organizational changes, including establishing the Office for Analysis and Evaluation of Operational Data. The clear mandate of the Commission's expanded and strengthened program is to provide high confidence that the immediate and longer-term safety concerns inherent in operating experience are properly identified and effectively fed back to the NRC regulatory activities, to reactor operators, and to licensee and vendor organizations. We would be pleased to provide additional information if you desire.

Sincerely,



John F. Ahearne

Enclosures:
As stated

ENCLOSURE NO. 1

(A listing of references is provided at the end of this Enclosure.)

I. General Statement of Providing Information to Licensees at the Time of the Events in Question.

Several methods for providing information to licensees on operating events were in existence when the transients in question occurred. The method used in any particular case was determined by the significance of the event, the necessity for a response, and the NRC office identifying the concern. At the time of these six events, the methods employed by the Office of Inspection and Enforcement (IE) of communicating the details of significant operating events to licensee holders were the IE Circular and the IE Bulletin. The format of the Circular and the Bulletin provides a description of circumstances and recommends licensee action or requires licensee response to questions or recommended actions. The IE Bulletin is used to transmit information to, and obtain information from, licensees regarding matters of safety, safeguards or environmental significance. Bulletins may also be used to obtain from licensees specific actions on a one time basis, e.g. special inspections, surveys or checks for the purpose of determining whether certain events/conditions may have generic applicability. In order to respond to Bulletins, licensees may take actions over a period of time. However, Bulletins are not intended to substitute for new or revised license conditions or requirements. Responses are required for all Bulletins, but the allotted time for response may vary depending upon the significance. The responsible IE Division or Executive Officer assesses the degree or urgency and establishes an appropriate response time. A Circular is used to transmit information to licensees or permit holders when the information is of safety, safeguards or environmental interest but replies from licensees are not necessary for IE to assess the significance of the matter. A Circular does not involve a specific response to the NRC but, rather, informs the licensees or permit holder. A Circular is issued when it is desired to get the information to licensees or permit holders in a period of generally less than 30 days. There is no record that the preparation of either a Circular or a Bulletin was considered as a result of any of the six events described. The Office of Nuclear Reactor Regulation issues Generic Letters to licensees and both offices may issue Orders to licensees, but there is no record of any Generic Letters or Orders associated with these events. Monthly reports prepared by NRC, Operating Unit Status Report NUREG 0020 (Grey Book), are provided to each holder of an operating licensee; these contain a brief statement of reportable events during that month. Each of the six events described in your request was identified in issues of NUREG 0020. A second NRC publication, Current Events - Power Reactors, available to licensees on request, contains selected events to provide information on operating experience in a timely manner. Two of the six events were described in issues of Current Events - Power Reactors. A monthly computer listing of Licensee Event Report (LERs) is prepared; five of the six events were included in this listing. Therefore, in response to your questions on notification of appropriate utilities of the six events, notification was made to all utilities with operating

licenses through the distribution of NUREG 0020 Operating Unit Status Report. It should be noted however, the amount of information on LERs is limited to a brief statement that the event had occurred. Based on our perception that the events were not generic nor outside the envelope of analyzed events, no additional communication was felt to be necessary.

II. General Statement of Followup work for LERs.

There is a routine followup effort performed by Regional personnel that is defined in the inspection procedures 90712 "In Office Review of Event Reports"(1), and 92700, "Licensee Event Followup" (2). Each LER is reviewed and the results of that review are documented in an IE Inspection Report. In addition, there is a screening review of LERs for generic concerns performed in IE Headquarters. Therefore, each of the events had some followup work, but the extent of the review was limited to the perception of the individual reviewer and his judgment as to the importance of the event. The description of the specific reviews are provided in the following Sections of this Enclosure.

III. Oconee Unit 3 Event - June 13, 1975

A discussion of this event was included in "Current Events - Power Reactors" for Aug./Sept. 1975 (3).

In addition, this event was included in the Safety-Related Occurrences section of "Nuclear Safety" magazine, (4) dated January - February 1976. This magazine was available to all interested parties for a fee from the Nuclear Safety Information Center, Oak Ridge. The event was described in two monthly computer listings that were prepared on August 8, 1975 (5) and October 23, 1975 (6).

A Listing of this event was included in the NUREG 0020 "Operating Unit Status Report" for August 1975 and reported as: "Excessive cooldown rate and reactor coolant system blowdown."

The Inspection and Enforcement (IE) Region II Office reviewed this event with the licensee during a routine inspection on July 29-31, 1975 (7). It was concluded that the Licensee's report (8) did not fully describe, analyze and evaluate safety implications and outline all corrective actions. This was because the Licensee's report primarily addressed the excessive cooldown rate of 101° F in one hour. It failed to address the entire reactor system blowdown and the safety implications of the incident. Duke Power then provided the additional information (9) which satisfied the Region II Office. The perception of the safety significance was such that no further action was taken by Inspection and Enforcement.

IV. Davis-Besse Event September 24, 1977.

Information was made available to the utilities in two forms. Information relating to the Davis-Besse event was documented in "Current Events - Power Reactors" (10) for the period September 1 through October 31, 1977, that was published during December 1977.

The Davis-Besse event was reported in NUREG 0020, Volume 1, No. 3, which was distributed during November 1977 and stated: "Loss of reactor coolant system pressure due to the failure of the pressurizer power operated relief valve." The licensee made a public announcement about the event. This event was included in the monthly computer listing that was issued in December 1977 (11).

NRC follow up effort for the September 24, 1977 Davis-Besse event is discussed in detail in Volume II, Part I pages 209-267 of the Special Inquiry Group Report to the Commission on Three Mile Island. As discussed in this report, the licensee reported details of the event to the NRC's Region III Office of Inspection and Enforcement (IE) by telephone at 0845 on Sunday, September 25, 1977. Because the reactor was in a safe condition, it was decided to send an inspector to the site on Monday, September 26, 1977. The immediate and subsequent inspection effort, documented in Inspection Report No. 50-346/77-32 (12), involved two inspectors who made a determination that no generic issues were involved because (i) the valve that failed was designed by one manufacturer while the valves in other Babcock and Wilcox facilities were supplied by a different manufacturer; (ii) the valve failed because of a missing relay; (iii) the auxiliary feed pump governor malfunctioned (unique design); and (iv) the event was initiated by an added system of unique design, the Steam Feedwater Rupture Control System.

The subject Davis-Besse transient event was considered by Division of Operating Reactors (DOR) staff before TMI-2 event to the extent of identifying potential problem areas and considering whether the event should be designated as an "Abnormal Occurrence." Such a designation requires reporting of the event to Congress under the provisions of Section 208 of the Energy Reorganization Act of 1974. The DOR review to determine whether this was an "Abnormal Occurrence" concluded that, since this was not a significant event resulting in fuel damage, it did not constitute an "Abnormal Occurrence." The potential problem areas identified for further study were:

- a. The water hammer and/or excessive pipe vibration during the transient.
- b. How the Steam Feedwater Rupture Control Systems (SFRCS) in the secondary system affects the control of the primary system.
- c. The fuel and clad conditions during the event since boiling occurred in the core. One DOR staff member considered this to be a small break LOCA.
- d. Safety features of B&W PWR's which were not the same as those in the Westinghouse PWR's (i.e., Westinghouse design trips reactor upon loss of main feedwater and turbine trip while B&W design does not).

Details associated with this event were also reviewed by other personnel in the Office of Nuclear Reactor Regulation (NRR) and the Headquarters Office of Inspection and Enforcement (Special Inquiry Group Report Volume 2 Part 1 pages 213-215). A note (14) to IE Headquarters from NRR outlined four areas of interest that should have been addressed in the Licensee's report (15), but there is no record that this note was forwarded to the Regional personnel who were performing the review; however, it is possible that the information was forwarded in a telephone call from IE Headquarters to the Region (Special Inquiry Group Report Volume 2 Part 1 page 0215). No significant action resulted from this effort. During the power ascension testing phase, an NRC inspector identified concerns that were related to the September 24, 1977 event (Special Inquiry Group Report Volume 2 Part 1 pages 0231 - 0244). These concerns were documented by the inspector and received further review by NRR and IE staffs. Based on a review of this information and additional information requested of the licensee, NRR Division of Operating Reactors concluded that, because no fuel damage would occur if the operator actions were not taken, no unreviewed safety question was involved and no licensing action was required. However, the inspector raised new issues which required further inspection effort by inspectors not actively involved in earlier review (17). This effort required further review by IE and NRR staff personnel (18).

This effort did not appear to satisfy the inspector. Therefore, he requested a meeting and met with Commissioners Ahearne and Bradford and members of their staffs on March 21, 1979 (Special Inquiry Group Report Volume 2, Part 1 page 0242).

V. TMI Unit 2 Event - March 29, 1978

A discussion of this event was included in NUREG 0020 (Grey Book, June 1978). The text states: "Vital Bus 2-1V became deenergized during emergency safeguards [ES] test due to fuse blown on bus power supply transfer."

"Computer Listings of Licensee Event Reports Sorted by Facility" (September 1978), also reported the event. (19) The text states in part, "No adverse safety concerns, reactor tripped, ECCS functioned as designed..."

The Inspection and Enforcement Region I staff reviewed this event with the licensee during routine inspections. Onsite inspection of this event was performed during the period of March 30 - April 6, 1978 (20). During the inspection it was determined that the licensee was taking corrective action to prevent the loss of electrical power that caused the event and that further, the licensee was planning to provide position indication to detect the status of the EMOV solenoid. The Inspection Report also noted that a special report on the ES actuation (HPI) would be submitted. As a result of a review at the Region I Office, a memorandum was submitted to IE Headquarters which requested further safety analysis (see below, IE Headquarters discussion) (21). During an inspection that took place on May 3-10, 1978, further review of the event took place (22). The review of LER 50-320/78-21 (23) was completed during this inspection. On August 23, 1978, the Special Report on ECCS Actuation of March 29, 1978, was closed out after a review in the Regional Office (24). Details of the licensee's evaluations of the March 29, 1978, event were apparently informally provided to the Licensing Project Manager (25).

IE Headquarters reviewed the Region I memorandum that requested further analysis of the event (previously referenced). The reply noted that no further analysis was necessary (26). LERs were also reviewed as a matter of course but no IE Headquarters action was taken on the LERs pertaining to this event.

See Section VI regarding the NRC views on the severity of this event.

VI. TMI - Unit 2 Event - April 23, 1978

This event was reported in "LER Monthly Output Sorted by Facility" (July 1978) (27). The text noted that safety injection was initiated. The text stated in part: "calculations and radiochemistry show that the core remained covered at all times and no release of radioactive material resulted. Combination of relief valves failing to reseal and continuing to feed steam generators resulted in rapid depressurization and cooldown. RVS (relief valves) will be tested." There is further reference to the design of the relief valves.

The event was also reported in NUREG 0020 (Grey Book, June 1978). The text states: "Reactor trip followed by RCS depressurization and sodium hydroxide injection due to steam generator safety valves not properly resealing."

IE Inspectors reviewed the licensee's corrective measures concerning the emergency safeguards (ES) actuation which accompanied the event during an inspection on May 3-10, 1978 (28). Details of the occurrence, including the event description, the cause, and the related consequences, were reported in a Met Ed Letter to Region I which enclosed LERs 78-33/IT and 78-31/IT. The inspector reviewed these documents and B&W Analyses and had no further questions (29).

The Inspection Report noted that the licensee's corrective action and ES actuation/injection report would be reviewed during a subsequent routine inspection. On or about June 5, 1978, the project inspector informally sent the Licensing Project Manager a copy of Met Ed's special report on the April 23, 1978 event (see below for NRR response) (25). On August 23, 1978, the Special Report on ECCS Actuation of April 23, 1978 was closed out after a review in the Regional Office (30). Followup on relief valve testing continued until September 7, 1978 (31).

IE Headquarters was not involved with this event.

The Office of Nuclear Reactor Regulation (NRR), Licensing Project Manager (LPM) received a copy of a special report for the April 23, 1978, event (32). In addition, he received another copy of a report prepared by Met Ed concerning the event which had been sent to him informally by the project inspector (33); no action by NRR was requested with this informal transmittal.

On July 5, 1978, the LPM sent this report to the Chief, Reactor Systems Branch, noting "If you feel we should do more, please let me know" (34). The Chief, Reactor Systems Branch, then assigned the review to a Section Chief in the Branch. The report was returned to the LPM with no comments.

For both the March 29 and April 23 events the dominant concern of Met Ed, IE and NRR appears to have been the injection of chlorides with sodium hydroxide into the RCS (34a). This concern was apparently discussed between the LPM and a Region I Section Chief. The concern is further discussed in a memorandum from the LPM to the technical review staff (35). Item 1 of License Amendment 4 to the TMI-2 license was issued to address avoidance of injection of sodium

hydroxide into the reactor coolant system during inadvertent actuations of the ECCS, such as the events in question (36).

No quantitative assessment of the severity of each event was performed by the NRC. The ECCS actuations of March 29, 1978, and April 23, 1978, were considered severe by the regional personnel, due to the magnitude and extent of the accompanying transients. The regional personnel further felt that the November 7, 1978, and December 2, 1978 events were of short duration and less severe. However, they felt that each ECCS actuation was significant in that they were required for safe operation. For each non-loss-of-coolant accident condition, the ECCS actuation was necessary to maintain or restore subcooling of the reactor coolant system. The licensee's corrective actions were reviewed and found acceptable. No additional actions were contemplated by the NRC that would reduce the number of HPI actuations.

VII. TMI Unit 2 Event - November 7, 1978

NUREG 0020 (Grey Book, March 1979) reported on this event. The text stated "ECCS actuation on November 7, 1978."

IE inspectors reviewed the licensee's corrective measures concerning an emergency safeguards (ES) actuation which occurred during this event on November 7-17, 1978 (37). On April 17, 1979, the Special Report on ECCS Actuation Which Occurred on November 7, 1978, was closed out based on a review in the Regional Office (38).

Neither IE Headquarters nor NRR were involved with this event.

The NRC's views on the severity of this event were discussed in Section VI.

VIII. TMI Unit 2 Event - December 2, 1978

"LER Monthly Report Sorted By Facility" reported on the event (39). The text states, in part: "A reactor trip occurred followed by safety injection actuation due to over feeding the steam generators. Since safety feature systems functioned as designed, this event did not affect the health and safety of the public. This event occurred due to the main feedwater regulating valve being pinned open. Procedures have been revised to preclude recurrences."

NUREG 0020 (Grey Book, April 1979) also reported the event. The text states: "ECCS actuation due to reactor trip caused by over feeding the steam generators."

On April 17, 1969, the Special Report on ECCS Actuation Which Occurred on December 2, 1978, was closed out by IE inspectors based on a review in the Regional Office (38).

Neither IE Headquarters nor NRR were involved with this event.

The NRC's views on the severity of this event were discussed in Section VI.

IX. Actions Taken To Limit Number of High Pressure Injections (HPI)

On July 7, 1978, the licensee requested a Technical Specification change to allow greater operating flexibility and to allow a greater margin from operating conditions to HPI actuation so that a rapid depressurization will not unnecessarily actuate HPI as frequently as would occur with less margin (40). This request was reviewed in the SER accompanying the license amendment and approved on August 17, 1978 (41). The change included raising the low pressure reactor trip setpoint 100 psi and raising the point at which HPI could be bypassed by 100 psi.

X. Condensate Polishing System Problems.

A review of our records shows that, with one isolated exception, the condensate polishing system problems experienced at TMI-2 were not reported to the NRC. The October 19, 1977 incident, in which water was noted in the service and instrument air systems, was first identified by the review of a plant log book during the NRC Office of Inspection and Enforcement investigation of the accident. (42) Additional review of the problem is documented in the Special Inquiry Group Report Volume 2 Part 2, pages 211-216.

A second incident, occurring on May 12, 1978, and in which water was introduced into these air systems, was also identified during the IE investigation by a review of the plant logs. A facility shutdown from power, which was caused by the closure of the condensate polisher outlet valves on November 3, 1978, was reported in the routine monthly operating report for November 1978. However, this incident was unrelated to the water intrusion problems, being caused by a technician mistakenly opening the control power supply breaker to the condensate polisher control panel.

None of these incidents was required to be reported under NRC regulations. The October 19, 1977 incident occurred during plant construction. When the holder of a construction permit finds deficiencies in design and construction which, if left uncorrected, could adversely affect safety, the permit holder is required under 10 CFR 50.55(e) to report such deficiencies to the Commission. However, the occurrence of water in a pressurized air supply system at this time was not considered by the licensee to fall within this reporting requirement. The May 12, 1978 water intrusion occurred during an extended plant outage when the systems involved were not needed for reactor operation. The cause is believed to have been the failure of the operator to close an air valve on one condensate polisher unit before it was returned to service. In any case, problems related to the condensate-feedwater system were not considered by the licensee to be reportable because the plant is designed to safely sustain a loss of normal feedwater. The consequences of a loss of normal feedwater are analyzed and shown to be acceptable in the Plant Safety Analysis Report (Section 15.1.8). The November 3, 1978 closure of the condensate polisher outlet valves resulted in such a loss of feedwater. In this case the plant automatically shutdown without any adverse effects. The incident was reported only as an explanation for the plant outage.

REFERENCES

Proc-90712

- (1) IE Inspection Procedure 90712 - "Inoffice Review of Event Reports" (Reference Attached)
- (2) IE Inspection Procedure 92700 "Licensee Event Followup" (Reference Attached)
- (3) Current Events - Power Reactors, August - September 1975, Page 3. (Reference Attached)
- (4) Nuclear Safety, Vol. 17, No. 1, January - February 1976. Selected Safety-Related Occurrences Reported in September and October 1975. Page 106. Published by the Nuclear Safety Information Center. (Reference Attached)
- (5) Monthly Computer Listing of LERs August 8, 1975 (Reference Attached)
- (6) Monthly Computer Listing of LERs October 23, 1975 (Reference Attached)
- (7) USNRC, IE Inspection Report Nos. 50-269/75-9, 50-270/75-10 and 50-287/75-10 forwarded to the licensee on August 27, 1975. (Reference Attached)
- (8) Abnormal Occurrence Report A0-287/75-7 dated June 27, 1975. (Reference Attached)
- (9) Letter W. O. Parker, Duke Power Corporation, to N. C. Moseley, Director Region II, dated August 8, 1975. (Reference Attached)
- (10) Current Events - Power Reactors, 1 September - 31 October, 1977 Pages 2-4 (Reference Attached)
- (11) Monthly Computer Listings of LERs, December 9, 1977 (Reference Attached)
- (12) USNRC IE Inspection Report No. 50-346/77-32 November 22, 1977 (Reference Attached)
- (13) Transcript Notes from the Davis-Besse 1 Project Manager's Daily Telephone Log for December 13, 1978 (Reference Attached)
- (14) Note to Karl V. Seyfrit, Assistant Director, Division of Reactor Operations Inspection, IE "Davis-Besse 1 Abnormal Occurrence (9/24/77), October 20, 1977 (Reference Attached)
- (15) Licensee's Event Report NP-32-77-16, October 7, 1977 Supplement November 14, 1977 (Reference Attached)
- (16) Office of Nuclear Reactor Regulation (week ending December 29, 1978) (Reference Attached)
- (17) Special Inquiry Group Report: Volume 2, Part 1 (Draft). Page 237 (Reference Not Attached)
- (18) Id at pages 238-241 (Reference Not Attached)

REFERENCES

- (19) Letter I.A. Kirk, USNRC to Those on Attached List, Subject: Computer Listings of Licensee Event Reports Sorted by Facility, dated September 28, 1978. (Reference Attached)
- (20) USNRC, IE Inspection Report 50-320/78-15, Paragraph 4, dated April 24, 1978. (Reference Attached)
- (21) Letter D.M. Sternberg, USNRC Region I, to K.V. Seyfrit, IE Headquarters, Subject: Three Mile Island 2 - Pressurizer Relief Valve Control System, dated March 31, 1978. (Reference Attached)
- (22) USNRC, IE Inspection Report 50-320/78-17, Paragraph 4 and 5, dated May 31 1978 (Reference Attached)
- (23) Licensee Event Report 50-320/78-21, May 1, 1978 (Reference Attached)
- (24) USNRC, IE Inspection Report 50-320/78-24, Paragraph 10, dated October 3, 1978 (Reference Attached)
- (25) Telefax, D. Haverkamp, Region I to J.S. Creswell, IE Headquarters dated February 13, 1980 (Reference Attached)
- (26) Memorandum from K.V. Seyfrit, IE Headquarters, to E.J. Brunner, IE Region I Subject: Three Mile Island Unit No. 2 - Pressurizer Relief Valve, dated May 3, 1978 (Reference Attached)
- (27) Letter from I. A. Kirk, USNRC to Those on Attached List, Subject: Computer Listing of Licensee Event Reports Sorted by Facility, dated July 5, 1978
- (28) USNRC, IE Inspection Report 50-320/78-17, Paragraph 8, dated May 31, 1978 (Reference Attached as Part of Reference 22)
- (29) USNRC, IE Inspection Report 50-320/78-24, Paragraphs 3, 6, 7, and 10, dated October 3, 1978 (Reference Attached as Part of Reference 24)
- (30) USNRC, IE Inspection Report 50-320/78-24, Paragraph 10 dated October 3, 1978 (Reference Attached as Part of Reference 24)
- (31) USNRC, IE Inspection Report 50-320/78-28, Paragraph 2, 5, and 6, dated September 21, 1978 (Reference Attached)
- (32) USNRC, Distribution for Incoming Material, dated August 4, 1978 (Reference Attached)
- (33) Metropolitan Edison, "Reactor Trip/ES Incident of April 23, 1978" dated May 4, 1978 (Reference Attached)
- (34) USNRC, Memo Route Slip, from H. Silver to T. Novak, dated July 5, 1978 (Reference Attached)

REFERENCES

- (34a) Memorandum from H. Silver, NRR to W. Gammill, NRR, Subject: Preliminary Response to 2/5/80 Letter from Senators Hart and Simpson, dated February 12, 1980.
- (35) Memorandum from S. A. Varga, NRR, to Distribution, Subject: Inadvertent ECCS Actuation and NaOH and Chloride Injection TMI-2, dated May 1, 1978 (Reference Attached)
- (36) Letter from S. A. Varga, USNRC to J. G. Herbein, Met Ed, Subject: Three Mile Island Nuclear Station, Unit 2 - Issuance of Amendment to Facility Operating License, dated May 19, 1978 (Reference Attached)
- (37) USNRC, IE Inspection Report 50-320/78-33, Paragraph 4, dated November 30, 1978 (Reference Attached)
- (38) USNRC, IE Inspection Report 50-320/79-07, Paragraph 6, dated April 20, 1979. (Reference Attached)
- (39) Letter from E. L. Boyle, USNRC, to Those on Attached List, Subject: LER Monthly Report, dated June 4, 1979
- (40) Letter from J. G. Herbein, Met Ed to S. A. Varga, USNRC, Subject: Technical Specification Change Request No. 014, dated July 7, 1978 (Reference Attached)
- (41) Letter from S. A. Varga, to J. Herbein, Met Ed, Subject: Three Mile Island Nuclear Station, Unit 2 - Issuance of Amendment to Facility Operating License (Reference Attached)
- (42) NUREG 0600, Investigation Into the March 28, 1979 Three Mile Island Accident by Office of Inspection and Enforcement, August, 1979 page I - 4 - 2 (Reference not Attached)