TERA

OCT 6 1980

Mr. Bill Gervasio
Route 3, Box 177E
Buffalo, Minnesota 55313

Dear Mr. Gervasio:

Your letter to the Nuclear Regulatory Commission was referred to me for response. I regret that this answer has been delayed. The accident and its consequences have created a substantial increase in the agency's workload, which has prevented me from responding to you as promptly as I would have liked.

Information about the accident made available to the public was confusing for a number of reasons. Some problems were attributable to the sources of information, some to the way in which information was made available to the press, and some to how the press reported the information it obtained. NRC's information was not always complete nor, in some instances, wholly accurate.

We recognize the importance of making complete and accurate information available to the public. Consequently, we have made specific plans for providing information to the public for such potentially serious accidents as occurred at Three Mile Island. These plans include making the availability of public information part of NRC's and the utilities' emergency response planning. Under this policy, the utilities must provide offsite locations for newscenters. We also plan to appoint a senior NRC official responsible for coordinating NRC information activities during an emergency. By centralizing the gathering and dissemination of NRC's information, we will provide the public with relevant and timely information.

Several human errors have been identified as contributing to the accident at Three Mile Island. Accordingly, steps have been taken to address procedure changes necessary to assist the operator on both a short- and long-term basis. Immediate changes were required at all Babcock and Wilcox facilities prior to their restart after the Commission ordered them shut down. Also, the Lessons Learned and the Bulletins and Orders Task Forces have recommended design and operating requirements implemented in the near future on all facilities in operation or under construction. Longer term modifications for all facilities are presently under consideration by the Lessons Learned Task Force.

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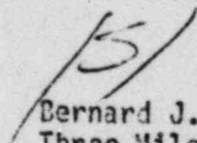
The human errors experienced at Three Mile Island stemmed in part from the incorrect interpretation of reactor coolant system instrumentation. Operator training had not previously addressed the system and operator response to the set of conditions experienced during the March 28, 1979, transient. As a result, all licensed operators at Babcock and Wilcox facilities received special training and a written examination on the transient. Additionally, these operators attended training sessions on the Babcock and Wilcox simulator to reinforce the operator response required during similar transient situations. All training was completed before operators could resume their duties during power operations. Long-term commitments on operator training and licensing are being developed by NRC's Operating Licensing Branch.

I appreciate your concerns and assure you that every effort is being made to ensure the continued protection of the health and safety of the public, not only at Three Mile Island, but also at all nuclear power plants.

Sincerely,



Bernard J. Snyder, Program Director
Three Mile Island Program Office
Office of Nuclear Reactor Regulation

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