UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION


BEFORE THE COMMISSION

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| In the Matter of<br><br>METROPOLITAN EDISON COMPANY<br><br>(Three Mile Island Nuclear Station, Unit 1) | ) | Docket No. 50-289<br>(Restart) |

MEMORANDUM IN SUPPORT OF REQUEST FOR STAY PENDING ADMINISTRATIVE REVIEW

## I. Introduction

TMIA requests the Commission to order a stay of the immediate effectiveness of the Atomic Safety and Licensing Board's (ASLB) partial initial decision on management issues which supports restart of TMI-1 under certain limited conditions. TMIA makes this request in order to secure for itself and other parties concerned with the critically important management issues a meaningful review before the Atomic Safety and Licensing Appeal Board, and to protect the public from immediate and unnecessary health and safety risks.

## II. Chronology and Background

On March 28, 1979, whil TMI-1 was in a power ascension mode after completing a refueling outage, TMI-2 experienced an accident. TMI-1 was immediately shut down and on July 2, 1979, the Commission issued an Order directing that TMI-1 be maintained in a shut down position, lacking reasonable assurance that TMI-1 could be operated without endangering the health and safety of the public. The

Commission further determined that the public interest would be served by conducting a hearing on the restart of TMI-1.

In its Order and Notice of Hearing dated August 9, 1979, CLI-79-8, 10 NRC 141 (1979), the Commission appointed the ASLB to conduct the hearing on TMI-1 restart. In this Order, the NRC staff identified safety concerns to be resolved prior to the restart of TMI-1, resulting from, inter alia, questions about management capabilities and technical resources of Met. Ed. Based on these concerns, the Commission's Director of Nuclear Reactor Regulation (NRR) recommended that certain "short term actions" be required of the Licensee to resolve the Commission's concerns and to permit a finding of reasonable assurance that the facility could safely resume operation. Included among these actions was that

> "The Licensee shall demonstrate its managerial capability and resources to operate Unit-1 while maintaining Unit-2 in a safe configuration and carrying out planned decontamination and/or restoration activities. Issues to be addressed include the adequacy of groups providing safety review and operational advice, the management and technical capability and training of operations staff, the adequacy of the operational Quality Assurance Program and the facility procedures and the capability of important support organizations such as Health Physics and Plant Maintenance."

In the subsequent ASLB proceeding, intervenors placed several management issues into contention. But in addition, the Commission itself mandated that the Board examine 13 specific issues relating to management competence. Order of March 6, 1980, CLI-80-5.

TMIA was admitted to the hearing to pursue two contentions--one dealing with faulty maintenance practices at TMI-1 and one dealing with the Licensee's financial qualifications. Not until

the Order of March 23, 1981, CLI-81-3 did the Commission remove all litigation of the financial contention from the ASLB hearing.

The hearing itself began in October, 1980, at which time TMIA was represented by attorneys. Counsel for TMIA made frequent requests for assistance in the form of technical help, but was denied such assistance. Transcripts were delivered to TMIA until early December, 1980, at which time the Commission ordered that free transcript delivery immediately cease. TMIA was unable to afford transcripts thereafter. In January, 1981, TMIA counsel was forced to withdraw from the proceedings due to the inability of TMIA to financially support them. At that time, a volunteer member of TMIA, with no legal, scientific or engineering background, with no previous involvement in the hearing or pre-hearing process, and recognizably unfamiliar with the hearing issues, took over as TMIA representative. She continued to represent TMIA for the remaining six months of the hearing, and prepared proposed findings of fact and conclusions of law on management issues.

## III. Standards for Assessment of Stay Request

Under its most recent rules, the Commission shall order a stay "if it determines that it is in the public's interest to do so, based on a consideration of the gravity of the substantive issue, a likelihood that it has been resolved incorrectly below, the degree to which correct resolution of the issue will be prejudiced by operation pending review, and other relevant public interest factors." 10 CFR Section 2.764, 46 FED.REG. 28627 (May 28, 1981). In assessing

each of these criteria, the Commission may emphasize the criterion which it views as the most important in balancing the equities and serving the interest of justice, particularly in light of the peculiar circumstances of each case.

Virginia Petroleum Jobbers Association v. F.P.C., 259 F.2d 921 (D.C. Cir., 1958). Under this rule, a stay is particularly appropriate in this case.

Certainly, the gravity of the substantive issue, that is whether management is competent to operate Unit-1 safely, has been long recognized by this Commission. Doubt concerning management capabilities, as first expressed in the Commission's August 9, 1979 Order, has since been reinforced by virtually every independent investigation examining the TMI-2 accident, including NUREG-0600, NUREG-0760, the Report of the NRC's Special Inquiry Group (Rogovin), the Report of the President's Commission on the Accident at Three Mile Island (Kemeny), as well as the U. S. House of Representatives (Udall) and U. S. Senate (Hart) Reports. Each of these reports conclude that management decisions had a definite role in the course of the accident, as well as conditions which eventually led up to it. As the Court noted in United Church of Christ v. F.C.C., 359 F.2d 994 (D.C. Cir., 1966), when past performance is in conflict with the public interest, a very heavy burden rests on the applicant for renewal of a license to show how renewal can be reconciled with the public interest. Certainly, management's past performance at TMI was certainly not consistent

with the public interest, and whether management is now capable of running TMI-1 in a safe manner is an issue of grave importance entitled to the closest scrutiny.

The Board's decision below is fraught with deficiencies and errors, including a lack of reasoned basis for many conclusions drawn, a failure to adequately discuss evidence on major issues, and adoption of Staff and Licensee conclusions without support on extremely serious issues, particularly those mandated for consideration by the Commission in its March 6, 1981 Order. Board actions during the hearing amounted to arbitrary and capricious conduct, clear abuse of discretion, and were contrary to law. There is thus a strong probability that the Board's decision will not withstand appellate scrutiny. Helvering v. Taylor, 293 U. S. 507 (1935), Federal Radio Commission v. Nelson Brothers Bond and Mortgage Company, 289 U. S. 266 (1933); Northern P.R. Company v. Department of Public Works, 268 U.S. 39 (1925); Louisville and Nashville Ry.Co. v. Finn, 235 U.S. 601 (1915); Chicago R.I. and P.Railway Co. U.S., 274 U.S. 29 (1927). We will discuss these errors below.

Correct resolutions of these issues will be severely prejudiced by operation of the plant pending review. Without a stay of this decision, the appeal process will be a time consuming and expensive exercise in futility. If this plant is permitted back on line and the requisite Pennsylvania Public Utility Commission approvals are obtained, the implicit pressure on the Appeal Board and eventually on the Courts to moot the validity of management competence issues

and order continued operation will be unavoidable. The certainty of this happening seems quite obvious, yet who could benefit from a decision which will later be shown to be wrong, but the result of which may be impossible to alter? The Commission has a responsibility not to consciously frustrate the appeal process by forcing TMIA to exhaust our administrative remedies while at the same time foreclosing any opportunity for meaningful relief.

Further, the Commission has a special duty in this case to the people surrounding this plant. Lest this Commission forget, the people in this area have already experienced the trauma of the worst commercial nuclear accident in this nation's history. The Commission must not permit operation until every effort has been expended to assure Unit-1's safe operation. We note the Commission has already broken one promise to the people in this area by virtue of its Order of August 20, 1981, CLI-81-19, refusing to immediately rule on the merits of this case. But then to allow restart on the strength of this preliminary decision places the integrity of the Commissioners and this entire process in doubt. At the very least, the public is entitled to have a reasoned decision before, not after restart.

Even more, however, the Commission has a responsibility to prevent impending irreparable injury to the public which will flow from the inevitable delay incident to the prescribed appeal board process if restart is not immediately halted. As long as a real possibility exists that current management is not

competent to run the plant safely, which can only be determined

upon proper review of this decision, the public's health and safety will be endangered. If the Commission permits this plant to reopen pending our appeals, and if another accident attributable to management incompetence should occur during that time, the Commission will have only itself to blame for the consequences, however dreadful. As the Supreme Court stated in Scripps Howard Radio, Inc. v. F.C.C., 316 U.S. 4, 9 (1942):

> No court can make time stand still. The circumstances surrounding a controversy may change irrevocably during the pending of an appeal, despite anything a Court can do. But within these limits it is reasonable that an appellate court should be able to prevent irreparable injury to the parties or the public resulting from a premature enforcement of a determination which may later be found to have been wrong.

Thus, for these reasons and for the reasons stated below, the Commission must conclude that by any standard, it is in the public's interest to stay the immediate effectiveness of this decision.

## IV. Errors in Decision Below

### A) The Decision in General

Before documenting the legal and factual errors rampant throughout this decision, we believe we should first express what appears to be the decision's most basic flaw. The Commission has, since its August 9, 1979 Order and most recently in its August 20, 1981 Order, expressed a justifiably deep concern over the management competence issue. Certainly, management policies and attitudes affect every aspect of a nuclear power plant's operation. Thus, to have properly carried out the Commission's

August 9, 1979 Order, it was incumbent upon the Board to evaluate management issues in a broad context whether those issues concern specific management contentions, or issues mandated for consideration by the Commission.

Instead, however, the Commission will note upon reading this decision the narrow, compartmentalized look which the Board has given to these issues. A recurring problem is the Board's failure to connect evidence presented during one phase of the hearing to other aspects where it is directly relevent. The Decision itself noticeably fails to connect its various parts so that an overall picture can emerge. For example, the Board first examines the new management structure at G.P.U. and evaluates the proper qualifications of each top manager within the new organization. Yet analysis of past performance of these individuals during the TMI-2 accident is completely disconnected from this section. As another example, analysis of TMIA's specific contention is placed in the middle of this decision. Because of the specificity of the allegations involved, the contention was relatively easy to attack, not withstanding the fact that certain poor past maintenance practices were admitted by the Licensee and by the Board. Yet in its glorious approval of certain top managers within the maintenance organization, the Board does not address the obvious relation between the maintenance manager's past acceptance of poor maintenance practices and their current qualifications. As still another example, the Board avoids all mention of the proposed 1979 Operation and Maintenance budget

cut discussed in the context of TMIA's contention, in its examination of financial/technical interface. Thus, we urge this Commission to examine this decision and the cited evidence in its totality, and not in the disjointed nature which the Board has treated it. We feel quite confident that the Commission will conclude that the decision betrays the Commission's and the public's concern for this most serious issue, and must certainly not permit restart on the basis of this decision.

B) Errors in TMIA Contention 5

1) Poor Past Maintenance Performance

One aspect of TMIA Contention 5 related to the deferral of safety related maintenance and repairs beyond the point established by Licensee's own procedures (see Par. 271), but the Board also considered it important to evaluate on its own whether the alleged examples of improperly deferred safety related maintenance presented by TMIA indicated a lack of attention on the part of Licensee to significant maintenance work at TMI-1 (Par. 290). The Board remarked repeatedly during the course of the hearing that the various work request exhibits were significant only to the extent they established a pattern of deferred maintenance. Tr. 3037, 3574, 3577. Obviously then, each work request that TMIA attempted to introduce was important to its contention and to the Board's evaluation not only for its own individual significance, but for its value in helping establish a pattern. Some TMIA exhibits were withdrawn, but many were rejected by the Board. See Initial Decision, Appendix A, p. B-26--B-31. As exhibits were rejected, a pattern became more

and more difficult to establish.

It is well settled that the discretion of an administrative agency must be exercised according to fair and legal considerations in accordance with principles of justice and not in an arbitrary and capricious manner. In the case of National Airlines, Inc. v. CAB, 321 F.2d 380, 383 (D.C. Cir. 1963), the Court expounded upon this principle, holding that an agency may not act arbitrarily in excluding evidence for no reason. See also NLRB v. Capitol Fish Co., 294 F.2d 868 (5th Cir., 1961).

In this case, the Board was admittedly in need of help in determining the relevance of specific work requests offered by TMIA. At Tr. 3605, Chairman Smith stated, "we've come in with one work request after another, which does not fall down clean on one side or another, and I am anticipating the need for some help." Yet rather than obtaining clearly needed assistance, the Board prejudiced TMIA's case by arbitrarily rejecting specific work requests, or admitting them for limited purposes only. At Tr. 3727, Chairman Smith stated, "the Board is not going to accept the exhibit and we're hard put really to explain why. But there has to be a couple points somewhat subjective, somewhat arbitrary." Further, at Tr. 3732, Chairman Smith stated "there are no standards that have been presented to us that we can reliably look to to see what the standard is to receive into evidence. So this is our ruling and it could very well be wrong. And we are not going to defend it anymore. And we are going to go home pretty soon." We conclude that the

Board was grossly arbitrary in rejecting relevant TMIA's exhibits offered into evidence. This is a clear abusive discretion and the Board has thus unquestionably committed a reversible error of law.

Relative to the same topic, the Board in Par. 292 states that the parties, including TMIA, initially agreed to rely upon the expert opinion of Licensee witness, Mr. Joseph Colitz, to determine whether particular maintenance activities were safety related, and that only later did TMIA disagree with his conclusions. The significance of the safety relatedness issue cannot be overemphasized, since the definition of safety relatedness went to the very heart of TMIA's contention as well as to the Board's interest in maintenance practices, and to Licensee's defense. The Board's interpretation of this paragraph is entirely misleading, and there is in fact compelling evidence on the record directly contradicting this assertion.

At Tr. 2575, TMIA counsel clearly states that Mr. Colitz is to be called only to describe systems and components in order to enlighten the Board, so that the Board could justly arrive at its own conclusions regarding safety relatedness. The basis for TMIA's objection to having Mr. Colitz define the term was evident to all parties--Licensee's witness had an obvious self interest in defining the term safety relatedness as narrowly as possible. The Board itself understood that TMIA may not have agreed with Mr. Colitz's definition of safety relatedness. Tr. 2577. Further, the Board rejected efforts by the Licensee to question Mr. Colitz on his

opinion as to safety relatedness, using TMIA's counsel's argument that to permit Licensee to elicit such testimony from TMIA's hostile witness would violate the law. Tr. 3121. Therefore, the Board's findings in Paragraph 292 are totally unsupported by the record and factually incorrect.

TMIA refutes the Board's statement in Paragraph 294 that TMIA offered no alternative means of determining safety relatedness. At Tr. 2576, TMIA's counsel stated the following:

> "And the Kemeny Commission in its findings in respect to the accident at TMI-2 concluded that there were components at the plant which were not identified as "safety related components" but which impacted upon safety related components, and because the maintenance on those components had been deferred, that the deferral was one of the precipitating causes of the accident. Now, that is a conclusion of the Kemeny Commission, and from that standpoint safety related from our viewpoint has a much broader meaning. And when we question Mr. Colitz, we intend to question him about the consequences of a particular component failing to operate correctly. That particular component itself may not be a safety related component, but if the failure of that component to operate correctly can result in a major safety problem at the plant, then we view it as safety related. That is the approach that we are going to take." Further, the Board's clear implication of bad faith on the part of TMIA is totally unwarranted and without support in the record. The Board was quite aware of TMIA's inability to afford its own expert testimony, and of its displeasure of having to rely upon Licensee's own employees to establish the importance of certain components and systems. Tr. 2576, 2583, 3661, 3804. Both TMIA and the Board found the staff unable to help. Tr. 30 , 3900. These relevant facts were improperly ignored by the Board.

Par. 296 summarily concludes that Licensee's written testimony, submitted three months after presentatior of TMIA's case, satisfactorily indicates no significant improper maintenance deferral. The Board, by merely listing TMIA exhibits and the page number in

Licensee's testimony where discussed, so completely fails to inform the reader of the factual basis for these ultimate conclusions as to violate the basic rule of administrative law that requires "the grounds upon which the administrative agency acted be clearly disclosed and adequately sustained". SEC v. Chenery Corp., 318 U.S. 80 (1943). This is particularly serious in light of the often factually unsupported explanations by Licensee throughout this written testimony.

Further, the Board concludes in Paragraph 300 that no evidence exists from which to conclude Licensee has improperly deferred safety related maintenance. Yet the Board implies the opposite in Paragraph 298 and 299. In Paragraph 298, the Board concludes that TMIA Exhibits 33 and 34, dealing with air handling filters in the machine shop ventilation system, indicates that maintenance deferral on these items constituted a potential long run safety problem. In addition, the Board's conclusion with respect to TMIA Exhibit 40, concerning a spurious alarm situation, are quite contradictory and confusing. The Board again determines without any perceivable analysis that the spurious alarm creates no significant problem. TMIA's arguments regarding potential safety problems (See TMIA's Proposed Findings #16) were not discussed. Not withstanding this fact, however, the Board concludes that "a delay of almost four years seems long in view of the fact that it should be fixed eventually." While the Board may not have used the terms "deferred maintenance," the clear implication of this

statement is certainly contradictory to the conclusion in Paragraph 300. Again, Paragraph 299's conflicting conclusions and failure to discuss TMIA's arguments violates the rule that "the grounds upon which the administrative agency acted be clearly disclosed and adequately sustained." Id. We note similar problems in the Board's analysis of TMIA Exhibit 23, at Paragraph 297, particularly a failure to address TMIA's concerns, and reliance without discussion upon the Staff conclusion that satisfactory administrative controls were in place. Thus we find the Board's treatment of these deferred maintenance issues violative of the most basic principles of administrative law.

The Board's treatment of Licensee's new system for designating priority maintenance work items is hardly sufficient to withstand appellate scrutiny. The Board's conclusion that assignment of priorities under the new system is "radically different" and that the definitions have "completely changed" is totally unsound and without factual support in the records.

Many problems associated with the old priority system are highlighted in Paragraph 285 and 286. The past system by which priorities were assigned was admittedly unreliable, but the Board scarcely compares the old with the new system to provide any basis upon which to conclude the new system is radically different. In fact, the record indicates that the two systems are hardly different at all. Under the old system, the initiator of the work request would physically assign the priority designation, meaning that he wrote his designation on the work request. See Paragraph 285. However,

the Board fails to mention that the initiator's immediate supervisor always reviewed the designation and always had the opportunity to physically change it. Tr. 2677, 3076. (The new Priority 1 definition merely writes this procedure into the definition). As Plant Maintenance Manager Mr. Shovlin explained, when the work requests reached him, he also had an opportunity to physically change the priority. However, he testified that in fact, he left 90% of the priority designations unchanged, and only 10% of these were in Mr. Shovlin's opinion incorrect. Tr. 3082 He did physically change approximately 10%. In addition, Paragraph 286 explains that maintenance work was actually assigned through "plan of the day" meetings.

Under the new system, a practically identical process is in place. Now the initiator "recommends" a priority designation, which means he physically writes his recommendation where indicated on the job ticket, but his superiors must approve the recommendation as before. The Plant Maintenance Manager or his designee now does the official "assignment", Paragraph 287, by so indicated on the job ticket form. So now, instead of crossing out a priority designation he believes improper, the Plant Maintenance Manager changes the priority by filling in another blank. Scheduling meetings are still the primary work scheduling tool. Paragraph 288. The process is virtually identical as before, with the only perceivable difference being one of form, not substance. The evidence certainly does not support the Board's conclusion that a radical change has transpired.

Regarding the new definition of priorities described in Paragraph 287, the evidence indicates that these new guidelines are still not specific enough to eliminate subjectivity as the Board implies in Paragraph 285. On this point, in fact, the record contains direct evidence that the new Priority 1 definition is still unclear to even the Plant Maintenance Manager. TMIA Exhibits 17 and 18, discussed at Tr. 3545 et. seq., concern a series of work requests dealing with excessive packing leakage on nuclear river pumps. While all dealt with the same malfunction, under the old system some were designated Priority 1A and some were not. When asked whether the new priority system would have eliminated this discrepancy, Mr. Shovlin's answer was, "I would probably indicate other than a Priority 1." (Emphasis added). We emphasize that this question was asked of the very individual whose responsibility it is to assign priorities, and who clearly understood the malfunction under discussion. The uncertainty implicit in Mr. Shovlin's statement directly supports an inference that indeed subjectivity and opinion still play a large role in designating priorities under the new system. It is well settled that a fact may be derived as a reasonable inference from other facts without the necessity for independent proof. Radio Officers Union, C.T.U. v. N.L.R.B., 347 U.S. 17 (1954). The Board ignores this evidence and its reasonable inferences. Thus, its conclusion that the new priority definitions have "completely changed" is worthless in that the record fails to disclose any significant improvement over the old system.

There is another strikingly important problem which the new priority system certainly does not solve, and which is entirely disregarded by the Board. This concerns the lack of guidelines to assist individuals completing job tickets who must determine whether malfunctions have affects on nuclear safety. Not only does the new Priority 1 definition include items which are "nuclear safety hazards," but the new job ticket, as did the old work request, requires an individual to check a box indicating whether the work will impact upon nuclear safety. No where is this issue discussed by the Board, despite TMIA's extensive treatment of this problem in its proposed findings. TMIA maintains that no where in the record is this term sufficiently defined by the Licensee to possibly meet the requirements of 10 CFR Part 50, Appendix B, and the record abounds with evidence that this is indeed a genuine problem. The Board in fact recognized the problem in Paragraphs 300 and 305 (Footnote 27), but remarkably does not pursue it. The Board seems to treat this merely as a record keeping problem. While the issue may not fit within the narrow confines of TMIA Contention 5, it certainly should be an issue of great concern to the Board, and the Board has grossly erred in not discussing it.

The Board fails to discuss other possibly faulty maintenance practices raised by TMIA in its proposed findings. For example, TMIA faults the Licensee for having no set time frame for completion of even the most serious maintenance work, Paragraph 284. While the Board ignores TMIA's concerns and seems to condone this policy,

it fails to consider that the new priority system requires the designator to make a determination as to how quickly the maintenance work must be done. Without some guidelines, such a determination does not seem possible.

Secondly, the Board conveniently avoids confronting the issue of confusion as to when in 1980 the new priority system became effective, by stating "this system has been in effect at least since October 1980", Paragraph 284. If the problem were only one of Mr. Shovlin's confusion under direct questioning, this surely reflects upon his individual competence. However, if the problem was confusion among the plant workers themselves, this reflects serious mismanagement within the maintenance department. Again the Board has arbitrarily failed to make a finding on an issue directly relevant to management competence.

Thirdly, the Board recognizes that TMIA has serious doubt whether Licensee's job ticket and new computer system will help solve Licensee's past record keeping problems. Paragraph 310. Yet not only are these concerns not discussed, but the Board seems only able to speculate that the new system will be effective. Paragraph 310. So uncertain is the Board that in Paragraph 315, it proposes that the Staff inspect and evaluate the system <u>six months after restart</u>. (Emphasis added). Problems with the new system are inevitable. Licensee's most serious past record keeping problem, i.e., inaccuracy in completing job tickets and misplacement of paper work (TMIA Proposed Findings #76 and #77) will clearly be

exacerbated. The Board ignores these points, while suggesting that the public be subjected to six months of living near an operating nuclear power plant whose past maintenance practices were poor and whose current maintenance practices are possibly worse. Even more, the Board acknowledges other problems with the new system. Yet instead of requiring Licensee to resolve these problems, the Board simply mentions them as items worth noting. Paragraph 316-319. This unexplained reluctance by the Board to require Licensee to deal with maintenance problems they have observed, is clearly not in the public's interest. Until these issues are properly confronted and the problems adequately solved, the Commission must not permit Unit-1 to restart.

Fourthly, the Board's dismissal of the estimated man-hour issue is inexcuseable. While the Board concludes the issue is unimportant, it fails to evaluate the logical impact of consistent miscalculation on staffing needs, particularly with regard to reciprocal staffing arrangements with outside contractors or other GPU companies. Tr. 13, 546. Further, the Board recognizes that estimates are inclined to be low, but does not examine why this is so. The Board's treatment of this issue is entirely inadequate.

Finally, we find the Board's reliance on the staff's "uncontradicted and unquestioned testimony" regarding auditability of 1978 maintenance records completely unsupportable. Paragraph 314. Based upon this testimony, the Board concludes that Licensee records

under the old system were auditable. Yet in the same paragraph, the Board concedes that TMIA has brought forward examples of inaccurate and incomplete maintenance records. But the Board fails to disclose on what basis they conclude that "none of the problems disclosed safety problems in the actual work." However, assuming that this is a Staff conclusion, we note the lack of any factual support in the decision to support this conclusion. "Even though a particular item of evidence is not expressly or directly contradicted, this does not prevent the trier from taking into consideration all the other relevant evidence including circumstances and surroundings that in any way might effect the weight or credibility of such evidence." Wright v. Peabody Coal Co., 225 Ind. 679, 77 N.E. 2d 116 (1965). Although the Staff's testimony may have been uncontradicted, its conclusory and unsubstantiated opinions should have been evaluated by the Board in light of other evidence indicating that safety problems were indeed apparent. Again, the Board has improperly evaluated the evidence on the record in these proceedings.

2) Proposed Cut in Maintenance Budget

We strenuously object to the Board's statement in Paragraph 321 that "the only basis asserted by TMIA for (the conclusion that GPU management emphasized maximization of profits at the expense of safety) is any inference which could be drawn from the fact that GPU considered budget cuts, and would have imposed them, but for the accident." This statement ignores TMIA's Proposed Finding #43 which supports TMIA's concern that a maintenance budget

cut was ordered while poor maintenance procedures, record keeping problems, and excessive overtime policies were in effect at TMI, thus producing strong evidence that the cuts were not approached with due regard for safety. The Board's failure to recognize, let alone address the evidence in its decision is clearly arbitrary, and thus its conclusion must be rejected on the basis of clearly contradictory evidence in the record.

3) Overtime Policies

The Board treatment of TMIA's charge that Licensee used excessive overtime in the performance of safety related maintenance lacks any reasoned analysis of the questions raised. TMIA's assertion that overtime should never be permitted at a nuclear power plant where the risk of carelessness due to fatigue is probable, Paragraph 332, is peculiarly mentioned, but never confronted by the Board. See Wingo v. Washington, 395 F.2d 633 (D.C. Cir. 1968). The Board continually emphasizes the need for some, even extensive, overtime in a nuclear power plant, but never discusses the propriety of excessive overtime which is the basis of TMIA's contention. The Board defends Licensee's position that overtime is necessary during outages, without discussing the fact that outside contractors may also be used during this time. Tr. 2688. The Board implies in Paragraph 334 that TMIA defines a very long shift as 34 or 40 hours. No where in the record does TMIA limit itself to such an extreme definition.

Further, the Board rejects the testimony of all three witnesses as unreliably subjective. In fact, much of the testimony was

consistent. All three testified that extreme cases did exist. That some people worked overtime to make extra money, that at least rumors of complaints concerning excessive overtime existed, that the longer someone worked the more fatigued they became, and that Licensee did not limit the amount of overtime which could be worked per week. Two witnesses testified that management routinely placed a letter in the file of an individual who did not work required overtime. Clearly, the Board cannot arbitrarily reject these items of evidence. West Ohio Gas Co. v. P.U.C., 294 U.S. 79 (1934), Baltimore and O.R. Co. v. U.S., 264 U.S. 258 (1923).

There were also instances where the three differed in their analysis of overtime at TMI. Mr. Reismiller, raised a number of points which neither Mr. Eberle nor Mr. McCurdy raised. Certainly the Board could have properly analyzed the credibility of each of these witnesses in its decision. In doing so, the Board could have concluded that Mr. McCurdy's testimony lacked credibility in that he is now management and in fact schedules overtime himself. Instead however the Board summarily dismissed the testimony of all three as "subjective." Not only is such wholesale dismissal clearly arbitrary, but the Board ignores many issues which Mr. Reismiller in particular seemed to raise, which were of concern to TMIA. For example, did Licensee coerce its employees into overtime by placing a letter in their files if they refused? Were guidelines exceeded, either with or without the cooperation of the employee? Were safety meetings cancelled during outages? What response did management have to union complaints?

How much notice did Licensee require for sick leave? Were people fatigued after 12 hours of work seven days a week? Such questions were never properly answered by the Board. In addition, IE Circular 80-02 establishing new guidelines clearly does not moot any of these questions as the Board alleges in Paragraph 343. If the Board chose not to believe these witnesses, it quite definitely abused its discretion in cancelling the other two scheduled witnesses, or in not conducting a sua sponte Board inquiry into the matter. Certainly the Commission cannot permit this most important safety issue to be ignored by letting this unsatisfactory decision stand.

C) Board Issue (6)--Financial/Technical Interface

The Board was instructed by the Commission to examine whether Metropolitan Edison Company would permit financial considerations to have an improper impact upon technical dec. ions. The Board relied almost exclusively upon the testimony of Mr. Herman Deickamp, President of GPU, in evaluating this issue, supported by Staff conclusions which were primarily based upon interviews with GPU management individuals. Tr. 12059. Interviews with Licensee's management personnel, and the testimony of Mr. Deickamp are rather self-serving and therefore less than reliable on this issue. (We note that the Board had a clear duty to at least permit effective cross examination of Mr. Deickamp during the hearing, but instead, the record indicates that the Board interfered with cross examination to such an extent that it was eventually cut off. See Tr. 13512-13514. This was a clear abus discretion on the part of the Board).

It was a clear error of judgement and an abusive discretion for the Board to rely exclusively upon this unreliable evidence to support its conclusion that financial considerations will have no improper impact upon technical decisions. First Girl, Inc. v. Regional Manpower Administration of U.S.D. of L., 499 F.2d 122 (7th Cir., 1974). The Board had previously heard other testimony directly relevant to this topic concerning the issue of excessive overtime--such evidence directly contradicting Mr. Deickamp's assertions that Licensee would willingly shut the plant down if financial situations warranted it, (TMIA Proposed Finding #39), and of a proposed 1979 Operation and Maintenance budget cut which would have been implemented but for the accident. (TMIA Proposed Findings #42-47). The Board should have at least examined and discussed this relevant testimony in the context of this Board question. Their failure to do so is a significant error.

In light of Mr. Deickamp's self-interest in this matter, and previous overtime and maintenance cut testimony, the Board should also have closely examined Mr. Deickamp's conclusory remarks that at GPU safety always takes precedence over economics. (Paragraph 391, 392, 393, Tr. 13497, 13498). This he supports by boasting of increased manpower and financial expenditures at GPU. However, Paragraph 398 of the decision cites statistics which could in fact support conclusions directly opposite from those the Board has drawn. The fact that manpower levels and Operation and Maintenance expenditures are high relative to the industry could merely, and quite logically mean that the Operation and Maintenance Departments are

inefficient, or that the equipment is in much greater disrepair than in most other plants. The Board does not consider this viewpoint. Further, the Board also fails to consider that diverting a large share of the budget to inhouse manpower is meaningless without some evidence that the plant would benefit from this policy. Indeed, the plant may very well benefit more by increasing B&W personnel support. Further, using the industry norm as the standard for comparison in Paragraphs 398 and 400 is useless without some evidence indicating what the industry norm is. In fact, the only evidence we have in the record indicates what the industry norm was prior to the TMI-2 accident--and it was not particularly good. Tr. 12104. With no evidence that the industry norm has improved, these comparisons are certainly unreliable to support the Board's conclusion in Paragraph 401. Thus, we find the evidence as examined by the Board on this issue inherently unreliable and irrelevant, and thus totally unsupportive of the Board's conclusion. The Board has clearly not fulfilled its obligations to the Commission in evaluating Board Issue #6.

D) Board Issue (1)--Licensee's Management Structure

By Commission mandate the Board was ordered to evaluate Licensee's corporate structure and TMI-1's plant structure to insure that Unit-1 could be operated safely. The Board's decision relies exclusively on Licensee's and Staff witnesses and concludes that Licensee's corporate structure is indeed appropriately organized. While the Board may have assumed that Licensee and Staff witnesses produced

a balanced record on this topic, Tr. 11996, we believe the Commission's mandate placed upon the Board the obligation to inquire well beyond the self-serving, rubber stamp endorsements of the Licensee and Staff witnesses. As far as Staff testimony on this issue, which the Board uses to support its findings, we found that each witness lacked even minimum management expertise to provide reliable testimony. For example, the authors of NUREG-0731 on which the new GPU management is based, admitted under direct questioning that they had had no management training and were unable to say that the new structure was the optimum for GPU. Tr. 11991, . Yet the Board dismisses this as an insignificant criticism in Paragraph 64. The Board also relies upon the endorsement of Mr. Richard Keimig, Paragraph 60, yet ignores TMIA's point that he lacks any management training or background (TMIA Reply Findings #3). Further, the Board ignores TMIA's skepticism that Mr. Donald Haverkamp, whose endorsement is cited by the Board, is either a qualified expert or an objective witness. (TMIA Reply Findings #3).

The Board also relies quite heavily on Licensee's expert witnesses to support its conclusions. The Board fails to discuss Mr. Lee's obvious objectivity and credibility problems, stemming from his prominent position in the nuclear industry and his interest in promoting nuclear power. Mr. Lee's "expert" testimony, on which the Board relies in Paragraph 56, consists merely of unsupported conclusions which under principles of administrative law should be entitled to very little weight. Market St. R. Co. v. Railroad Commission, 324 U.S. 548 (1960). The Board also relies quite

heavily on the endorsement of Mr. William Wegner of BETA, despite his noticeable lack of management training or experience. Wegner FF. Tr. 13284, Attachment 1. Further, the Board accepts Mr. Wegner's reasons for endorsing the GPU structure notwithstanding the many questions left open by his analysis. Paragraph 58. For example, the Board makes no inquiry as to why combining the technical resources of the various GPU utilities resolves problems, or what benefit there is to uniform policies between diverse plants. The Board merely accepts his and the other Licensee and Staff witness' "expert" conclusions. We are quite confident that if the Board so chosen, it could have found other experts to render a less positive endorsement of the new GPU structure. See in Delaware L. and W.R. Co. v. Hoboken, 10 N.J. 418, 91 A.2d 739 (1952).

The Board's reliance upon these people to evaluate the competence of individual managers, however, is much more problematic. We believe the Board was extremely lax in its analysis of the competence of many top management personnel. We first question the relevance of the Board's statement in Paragraph 59 that "individual members of the management organization appearing before us seemed to have a clear understanding of their responsibilities, limitations, and resources available to them." Clearly, the fact that the Board saw these people is not sufficient to prove their competence. But even if they do understand their responsibilities, past experience indicates that certain individuals may be unwilling to properly carry out their duties.

Indeed, the record is replete with evidence concerning a number of individuals endorsed by the Board in this section. For example, consider Mr. Daniel Shovlin, Plant Maintenance Manager. In discussion of TMIA Contention 5, Licensee admits that the past maintenance department under Mr. Shovlin's direction was inadequate. In its present endorsement of Mr. Shovlin, however, the Board fails to even mention his past experience or his possible role in the development of prior maintenance problems at TMI. Such first hand, direct evidence would be significantly more meaningful in evaluating his competence than a recitation of his resume (Paragraph 156), or the vague, innocuous statement by the Staff that senior management at TMI and GPU are "probably above the norm," or the similarly general endorsement by BETA under its objective standards. This criticism applies equally to each individual whom Licensee endorses between Paragraphs 116 and 162. However, our lack of familiarity with some of these individuals prevents us from comparing their past histories to their present qualifications. The Board, however, has been clearly derelict in its duty to meaningfully analyze competence of these individuals by conducting such a thorough examination.

There are, however, a number of individuals in the current GPU management structure who were involved in some way with the Unit 2 accident. Rather than merely examining their resumes, the Board clearly should have studied thoroughly their qualifications as reflected by their past performance or current ability to handle emergencies. Thus, we will so discuss their qualifications in the context of Board Issue 10.

E) Board Issue 10- Licensee's Management Response to the Unit 2 Accident

There is perhaps no other Commission Issue which has been treated so arbitrarily and capriciously by the Board than this one. We sensed an annoyance on the Board's part by having to examine the issue at all, Tr. 12,053, and the Board admittedly did not approach the issue with a firm idea of how to best pursue it. Tr. 12,053. However, the Board was mandated to examine management competency today in terms of management performance during the accident, and certainly their duty was to resolve any doubt that deficiencies in handling the accident by management or by any individual member thereof have been corrected.

The information available to the Board on this topic was not nearly as massive as that available on the other issues involved in this hearing. There were a finite number of reliable investigations available with which the Board admits to having been generally familiar. Par. 469. In addition, a number of invidual members of GPU's top management who were involved with the accident or its aftermath testified at the hearing on various issues. But many individuals who were directly involved with the accident were never called by the Board to testify.

Licensee's expert witnesses on the issue were inherently unreliable, particularly in light of the contradictory information available in the various official investigations.

Mr. Lee who was of the opinion that Licenee's management responded to the accident with "great skill and steadfast purpose" did not even arrive on the scene until fully one week after the accident was over. Par. 465. Mr. Wegner, who similarly conducted no reliable investigation into the accident, primarily blames the entire industry for the accident rather than individual performance. His impressions also contradict the conclusions of the official investigations, and thus his factually unsupported opinion thatGPU now has sufficient management and technical capabilities to permit restart is entitled to little weight. Finally, Licensee employees, Messrs. Keaton and Long, who were only involved in post-accident events, offered entirely self-serving testimony, the credibility of which the Board itself cast doubt upon.Par. 466. Thus, the evidence to support Licensee's view that management acted competently during the accident is utterly unreliable and the Board is clearly in error to rely upon any of this testimony. First Girl Inc., v. Regional Manpower Administration of U.S. D. of L., 499 F, 2d 122(7th Cir., 1974).

Thus, the Board had a responsibility to investigate this issue in light of the exhaustive NRC, Congressional, and Presidents's Commission investigations which have been produced, and also by a thorough look at those management individuals cited as incompetent by those official investigations. Further, the Board had to consider whether any of these individuals proven inadequate have remained in management positions, particularly positions where they could have an

impact upon the public's health and safety.

The Board devoted a great deal of attention to management communication problems and reporting failures during the accident, particularly with regard to whether information was withheld from State and Federal officials. NUREG-0760 concluded that while Licensee was "not fully forthcoming," information was not intentionally withheld. The Board did, however, examine other investigative reports, including the Udall report which did conclude information was intentionally withheld. (Unlike NUREG-0760, the Udall report was not admitted into evidence. despite TMIA's efforts). All the various investigations seem to agree on the following points: that those on-site were extremely confused and uncertain as to how to handle the crisis, that they misinterpreted signs and took inappropriate actions, but that they knew the situation was serious.

The Board decision first focuses on the briefing at the Lt. Governor's office at 2:30 P.M. However, we note that the Board fails to discuss the fact that in an early morning converstion with Met-Ed official Mr. George Troffer in Reading, Mr. Gary Miller, Station Superintendent and in control on-site at that time, admitted to deliberately withholding certain vital information from a State official. Staff Ex. 5, App. B at 109-2. This individual is presumably Mr. William Dorsife, a nuclear engineer with the Commonwealth. The Board however unreasonably concludes that further inquiry into Mr. Dornsife's knowledge at that time is unnecessary. Par. 476. Further, we can reasonably infer that when Mr. Jack Herbein

arrived, who was Vice-President for Generation and the first senior management official on the scene, Miller completely briefed him on this and other conversations. Herbein chose to keep Miller in charge on-site. Yet the Board ignores the serious implications of Herbein's decision at this point.

Further, the Board remarks in Par. 496 that, as most investigations conclude, Herbein made a wrong decision to remove Miller at 2:00 from the site to accompany him to the Lt. Governor's briefing. But the Board never seems to fault Herbein for this decision; either.

NUREG-0760, at 42-44, also indicates that Herbein, the principal spokesperson at the briefing, deliberately downplayed the seriousness of the accident and lied concerning offsite releases of radiation. The Board seems to skirt the second issue implying it is hearsay. Par. 475. Yet it is well settled that hearsay is admissible evidence in administative law proceedings, Willapoint Oysters, Inc. V. Ewing, 174 F. 2d 676, cert. den. 338 US 860. reh. den. 339 US 945 (1949), and the Board's wholesale dismissal of such a serious lie is totally unfounded.

As far a Mr. Herbeins's role, the Board's response is equally inexcusable. The Board blames the intervenors for not litigating the issue. The Board is completely unjustified for blaming the intervenors for not litigating this or any other issue which the Board is required to consider. (See Pr. 506). It can not hide behind the inability of unfunded intervenors to put an entire case together

(which the Board admits would require the additional testimony of ten individuals, at least, Par. 491), to develop a record on an issue which this Commission has mandated the Board to consider. The Commission should view the Board's conclusion in Par. 491 as a total abdication of its responsibility to the Commission and the public. What issue could possibly be more important than whether Licensee has placed an individual in a top nuclear safety related position, 3d in line as Emergency Support Director, who has deliberately lied,and misled State and Federal officials dur an emergency situation?

Further, the Board arbitrarily dismisses the conclusions of the various investigative reports seemingly because they differ. Par. 489. A closer examination shows that these reports are not really so different at all. Again, instead of pursuing what appears to be minor inconsistencies, the Board abdicates from its responsibilities so it needn't "speculate." However, the Board does its own speculation in Par. 477 in its analysis of whether there was indeed intentional withholding of information. The Board fails to discuss one of the most logical motives for intentional withholding- i.e. the desire by management to try to control the situation before its seriousness is discovered. This is not necessarily a malicious motive, but rather one of self protection. To conclude that they merely misunderstood the severity of the situation is to ignore the fact that they knew something serious was wrong- a conclusion which no investigation refutes.

The principal fault with the Board's decision on this issue, in fact, is thefailure to examine how individuals interpreted what exactly was going on on March 28, 1979, why things were misundersood, how they handled what was happening, why they responed inappropriately, and what was , in their mind, their primary concern. Each of the investigations which the Board has read concluded that individuals responded inappropriately to the open PORV, the hot-leg temperature, the thermocouple data, and the pressure spike. Middle level management individuals misinterpreted these signals, many of whom are still significantly involved with the operation of TMI- including Gary Miller who was primarily responsible for these inappropriate responses. See amended decision, Par. 479 It took fully 16 hours before a relatively stable cooling mode was achieved, and for the plant personnel to be certain of what was happening.

Meanwhile, top level management had become directly involved by 11:30 A.M. when Herbein arrived. Par. 480. There was confusion and uncertainty at the plant about what to do, yet Herbein elected to remain off-site, without a personal on-site inspection. (TMIA Reply Findings #27). No regulation or policy required such action on his part. Yet the Board does not choose to examine the intelligence of Herbein's decision, and never questioned him for his reasons. Certainly by the time of his arrival, the various investigations indicate that key indications of a serious

situation were known by Herbein's on-site communication link, Miller, although all signs were not properly interpreted by Miller. See NUREG-0760. In Par. 481, the Board indeed notes that Herbein was given information that high thermocouple readings were obtained. Was Herbein's decision "not to insert himself into the chain of command" really due to his own inability to understand what these key indications meant and how to respond? This is not an unreasonable inference, and the Board certainly had a duty to inquire-particularly in light of the fact that the Licensee has rewarded Herbein with the position of Vice President in charge of Nuclear Assurance, as well as the position of 3d Emergency Support Director.

The Board's treatment of management's response as it related to their competence in handling the accident, is minimal. They do cite the Rogovin Report conclusion that "the inablility of the utility's management to comprehend the severity of the accident... was a serious failure of the company's management. Par. 483. But the only other discussion can be found in Par. 468 which cites the IE conclusion that no noncompliance items remain open. This provides no factual support for the conclusion that management now has the technical competence to understand and properly cope with an accident.

Further, Licensee's choice for its 2d position in the Emergency Support Director chain of command is Mr. Phillip Clark. Mr. Clark has "no in-depth knowledge of the specific design functions of B&W pressurized water reactors." Tr. 11,520. And in light of Herbein's past performance, we believe

Licensee's decision to choose these individuals for such a critical positionan extremely serious reflection on their concern for the public's health and safety. Licensee's committment to put these individuals through a 36 hour training course is absurdly inadequate, although the Board seems to think it is sufficient. (The Board seems also to think that Herbein's chances of actually becoming the Emergency Support Director are slim. We disagree. An emergency situation is likely to last more than 24 hours and as such will require at least 2 or 3 individuals to take control at various times). We believe the Commission should find this training program totally inadequate, and a clear indication of a lack of concern by the Licensee on this most crucial issue. Clearly, on the state of this record, management is not competent to run Unit 1 safely. The inadequate treatment by the Board of this issue is clearly violative of the public interest.

IV Relief Sought

For the above-stated reasons, we request that a stay be granted to protect the public health and safety until these issues can be properly resolved through the appeal process.

We further request the Commission to exercise its option to review the merits of these particular issues, pursuant to 10 C.F.R. 2.764. We believe it will not be possible for this Commission to make a proper stay decision without examining the merits, and in light of the Commission's concern over management issues, and considering that the Commission has ample time to look at these issues before the rest of the

the ALB's initial decision is rendered in November, we submit that this is a reasonble request under the perculiar circumstances of this case.

Respectfully submitted,

Louise Bradford

Louise Bradford
TMIA

Dated: September 11, 1981