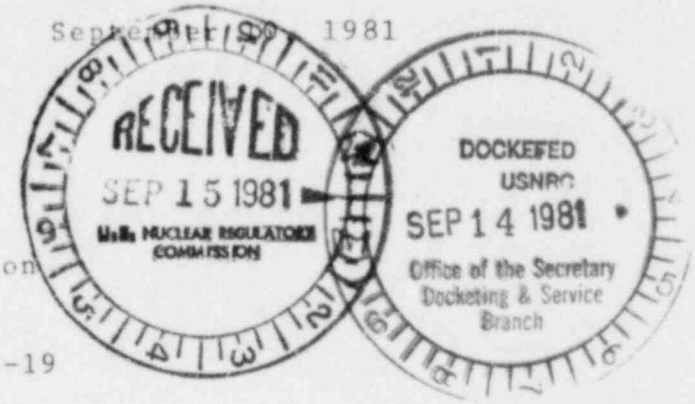
Snowhill Farm, R. D. 5
Coatesville, Pennsylvania 19320

September 10, 1981



Chairman Nunzio J. Palladino
Commissioner John F. Ahearne
Commissioner Peter A. Bradford
Commissioner Victor Gilinsky
Commissioner Thomas M. Roberts
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Re: Commission Order CLI-81-19

Dear Mr. Chairman and Commissioners:

In response to your request of August 20, 1981, the Aamodt Family intervenors pro se, submit the following comments relative to the Atomic Safety and Licensing Board partial decision on management issues.

The Aamodts find that the Board's decision is so faulted that any decision that the Commission would base upon it could result in jeopardy to the health and safety of the public surrounding the TMI-1 plant.

The Aamodts have intervened in the hearing on the issues of training and testing of operators and management. They have pursued a contention on training and testing as well as Commission Order CLI-79-9 Items 1 (e) and 6 and the first eleven items of CLI-80-3.

Mrs. Aamodt is a graduate psychologist, having pioneered the concept of human engineering in the telephone industry, being the first psychologist hired by the Bell Telephone Laboratories of Murray Hill, New Jersey and conducted the study of all-number dialing on which AT&T based their decision to adopt all-number dialing. Mr. Aamodt is a graduate engineer with education in nuclear subjects, has held management positions since 1963, and is presently president of a manufacturing concern.

The Aamodts entered the hearing because they experienced considerable inconvenience to their personal and business lives because of concern for their family's safety during the TMI-2 accident. They made petition to intervene, reluctantly, because of other commitments. They have intervened at their own expense and without legal assistance. They have continued in the hearing because they agree with Commissioner Bradford's appraisal that intervenors offer an independent and skeptical assessment.

D503
S01

The Aamodt's intervention has been thwarted, to the detriment of the public health and safety. The Board's decision does not acknowledge Aamodt findings and argument where sensitive issues which impact on public health and safety are raised. The Board misinterprets and slanders the Aamodts. Where the Board recognizes a signifigant finding, the Board faults it for lack of argument presented by the Aamodts.

The Board leans heavily upon the NRC findings which did not fault licensee's management in a single instance, despite Licensee's failure to meet many of NRC's earlier requirements, and guidelines based on the TMI-2 accident.

1. The Board fails to explain their inconsistency in promulgating a standard for issues that would be allowed to be litigated in the hearing, that is nexus to the TMI-2 accident, and on the other hand not adopting those standards which evolved from the accident in deciding sufficiency of Licensee's training and testing program to protect the health and safety of the public.

2. For instance, the Board finds that the standards for the training program for personnel who are not licensed are those of ANSI/ANS 3.1 (1978) which preceded the accident and is being rewritten to reflect the lessons learned. The 1978 ANS is an inappropriate and meaningless standard as discussed in Aamodt Reply Findings 7-9 (served June 29). The Board Conclusion 164 ignores the Aamodt findings and argument and fails to cover any of the points set for in these findings.

3. Where the Board finds that unlicensed personnel meet TMI-2 standards, they are grossly in error. The Board cites NRC witnesses (Crocker and Allenspach) who refer to a document, NUREG-0731, not allowed on the record, and uses that testimony in a misleading way. The Board concludes (164) that the Staff NTOL inspection 50-289/80-19 concluded that the training of the plant staff met the 0731 guidelines, when the inspection only dealt with the unlicensed personnel training of Shift Technical Advisors. NUREG-0731 clearly states on page 11 that each member of the plant staff (radiation protection, fire protection, security procedures) shall be trained to meet standards of the Draft December `979 ANS, not ANS 3.1 (1978).

4. The Guidelines for management, NUREG-0731, stem from the TMI-2 experience and are the only objective criteria for management existent in NRC documents. However, these guidelines and the standards which evolved from the accident, Draft December 1979 ANS and its related Reg. Guide 1.8 (Second Proposed Revision) were not used as criteria for personnel qualifications except in isolated cases, as for instance, the Shift Technical Advisors.

5. The Board fails to note that the training of unlicensed personnel, found "weak" by NRC inspection, was to be examined in the hearing. The Board's single paragraph that discusses unlicensed personnel training reflects the omission in the record of sufficient or appropriate evidence for the Board to make a decision. The Board ignores the detractions discussed in Aamodt reply findings 19-25 (served June 29). The Board was also to conclude if the training of unlicensed personnel had been implemented and completed. The Board did not conclude. The performance of unlicensed personnel can effect the safe operation of the plant, therefore, any decision of the Commission based on this severely faulted conclusion of the Board can jeopardize the health and safety of the public.

6. Regarding the training and testing of licensed operators, the Commission is fully aware of the discovery in July of cheating on the NRC licensing examination. The Board has not concluded whether the recent NRC investigations of the cheating incident were sufficient to consider the matter resolved and has requested the parties to advise them. The Board acknowledges that the incident goes beyond the involvement of two individuals who have confessed and resigned their positions as shift supervisors. The Board in their Order dated Augus t 20 states that issues of Licensee's management integrity, the quality of its operating personnel, its ability to staff the facility adequately its training and testing program may all be effected by further investigation of the cheating. The Board indicates that the hearing may be reopened by motion of the parties or sua sponte to further the investigation. In view of the implications, in that management certified and trained the two operators who cheated, and further operators and management may be involved, the cheating incident overrides any conclusions that the Board has reached relative to management.

7. The Board based their conclusions relative to management on subjective standards and opinions, as well as job resumes. One objective measure of management which the Board incorrectly assessed was management's ability to train personnel. In viewing these programs, the Board depended on the testimony of Licensee's experts, hired and paid by Licensee, rather than definitive measures such as audits. The results on audits throughout the two years since the accident were gloomy. For instance, the manager of TMI-1, who was present at the TMI-2 accident, failed the test onTMI-2 events after accelerated training which concentrated on this subject matter. His assistant, who writes procedures, failed the test twice. The former person was used by the Licensee to testify relative to their training program and recommends operators to be certified by management. The Board's failure to recognize that the training program is a failure of management and not the individual operators has yielded the current predicament, where the Board has issued a partial decision finding management competent, yet is considering reopening the hearing to find if management is involved and whether there will be enough operators to restart the plant.

8. The Board conclusions also fail to acknowledge a document referenced in the Commission's August 9 order, which document clearly specifies what the Commission meant by augmentation of the training of operators. The Aamodt Reply findings (served July 20) attempt to bring this document to the Board's attention, however unsuccessfully. The document is a report, dated June 28, 1979, of a meeting between the NRC and Licensee management in which the Licensee agreed to train 40 operators in college level subjects in fluid flow, heat transfer and Thermodynamics. Not only does the Board choose to ignore this document, NRC adopted a stance opposed to it and disparaged Aamodt testimony relative to the level of the TMI Training Department courses, framing findings which have appealed to the Board.

9. The Board refers throughout their conclusions to a six shift rotation, however there is not a shred of evidence that Licensee can meet such a commitment, in fact, the evidence is to the contrary. The Board admits in their August 20 order re cheating that sufficient personnel to mann shifts is now an open item, however the Board concludes that Licensee has resources to operate Unit 1. The Board finds five shifts an acceptable rotation, and imposes a licensed condition,

however the present number of candidate shift supervisors has been reduced to four since the resignations of those caught cheating.

10. The Board concludes, in the absence of sufficient numbers of licensed SROs, to fill the position of Shift Foreman with a licensed RO who has trained for the SRO license and failed the examination. After reading the Aamodt findings, the Board (573) faults the Aamodts for not bringing this important consequence to the attention of the hearing, rather than by moving to correct it. Frankly, the Aamodts are appalled that the Board and others, who professed extensive knowledge in human factors, did not note the obvious screening that testing affords.

11. The Board, although conceding to some overtime policy, and acknowledging throughout the hearing that adequacy of training could not be divorced from operational considerations, refused to allow the Aamodts to bring these consideration before them. The Board concludes that NRC criteria and guidance on overtime policies need only be born "in mind" and accepts whatever is current NRC criteria and guidance as a licensed condition in the event of gross shortage of licensed operators. This is despite the marginal showing of the operators on audits.

12. The Board allowed the record on management issues to be opened two months after it was closed and again about 10 days later to allow two agreements between the Commonwealth adn Licensee to be entered as exhibits in the hearing. The Board indicates that the agreements could have been reply findings, however entering them as exhibits has saved the Board time in not having to adjudicate 35 pages of very technical and complex discussions. Board conclusions 532, 535. The Board fails to note that the Aamodt findings paralleled the Commorwealth findings in common areas, as noted by the NRC in their reply findings. However the Aamodts lack legal expertise in advancing arguments, therefore similar findings of the Aamodts did not present the Board any problem. The Commonwealth's and the Aamodt's findings were grounded in the record, however the sufficiency implied by the Commonwealth-Licensee agreement and the lack of clout of Aamodt Family as intervenors has allowed the Commonwealth and Licensee to make the final judgement, and not the Board. The Board notes that they studied the Commonwealth findings,

however the Board does not print its review. The Board repeatedly misinterprets the Aamodts objections to the Commonwealth-Licensee agreement as unsubstantive. Board conclusions 538-555.

13. The Board attempts to put down Aamodt findings through inuendoes in their conclusions 531 and 537. The Board assumes that the Aamodts were attempting to delay the hearing when they requested extensions because they were short of time, and that the Aamodts possess a certain meanness which prefers to deny the Licensee a chance. This distasteful comment on the part of the Board reflects the prejudice with which the Aamodt findings and reply findings were addressed. It is a sad occasion when the public is invited to participate and then maligned. The Aamodts noted that the Commonwealth received similar treatment when they posed questions which put the Licensee to test, and the obvious glee of the Chairman when the Licensee-Commonwealth agreement was entered was unmistakeable from the comments made on the record.

14. Although the Board defends their position in allowing evidence (Commonwealth-Licensee agreement) on the record without the test of cross-questioning, their own conclusions speak otherwise. For instance the failure of the parties to recognize the possiblity of a Shift Foreman being eminently unqualified as discussed above in 10. And in Board conclusion 555, their recognition that the agreements contained statements which were not agreements. The sloppiness with which these agreements were put on the record versus the stringent requirements placed on other evidence (including the Rogovin Report which failed to make the record), should cause the Commission to take a second look. As pointed out in the Aamodt reply findings served June 20, the agreements are, in some cases, less than NRC requirements promulgated at the beginning of the hearing

15. The Board finds the training program for management (Commonwealth-Licensee agreement) to be sufficient to cover the findings of the Commonwealth and the Aamodts that assert that plant management is not familiar with the TMI-1 plant. Although the Board recognizes that the only redeeming virtue of the program is that is will consume 36 hours, the Board has made it a licensed condition and assumes (from meeting management personnel) that their time will be well-spent, rather than finding that the deficiency will be

remedied. Board conclusions 552-3.

16. The Board refuses to consider the requirement of a simulator examination for TMI-1 operators in general, despite the October, 1981 requirement by NRC for all licensing examinations. It is difficult to understand the Board's defense against simulator examinations in view of the questionable demonstration of operators' capabilities, supporting a plan by NRC to slip the examinations through prior to the time of the simulator requirement. To put the blame on Mrs. Aamodt because she did not press for such examinations seems to shameful to mention since it is the Board, and not Mrs. Aamodt, who was charged with finding sufficiency. The matter was brought to the Board's attention on two occasions: Commonwealth questioning of Mrs. Aamodt and their subsequent finding, and a question of the NRC by he Aamodts when the Commonwealth-Licensee agreement was entered. The Board indicates that the Commission Order CLI-79-8 Item 1(e) may have meant that augmentation of training on the simulator needs to be demonstrated, and that a contention requiring simulator testing prior to restart would have been accepted if filed, therefore it is clearly negligent to let the matter drop due to oversight.

17. The Board frequently notes that the Aamodts raised an important point, however the Board faults the issue for lack of argument. The Aamodts did not intend to do more than present the findings of the record and allow the Board to decide. The 14 pages of Aamodt findings were simply a restatement of the record, not a word of argument. The Aamodts assumed that the Board did not want to be persuaded, but rather would yield to the weight of evidence. When the Aamodts replied in detail in over 80 pages of evidence and argument, the Board was no more receptive.

In summary, the Aamodts contend that the partial initial decision on management issues is seriously flawed to the detriment of the health and safety of the public surrounding TMI-1 . The Aamodts are prepared to present oral arguments in support of this position along the general lines discussed herein.

Respectfully submitted,

Norman O. Aamodt

Marjorie M. Aamodt