March 9, 1981

Ivan W. Smith, Esq., Chairman
Administrative Judge
Atomic Safety and Licensing Board
25 North Court Street
Harrisburg, PA 17105

Dr. Linda W. Little
Administrative Judge
Atomic Safety and
Licensing Board
25 North Court Street
Harrisburg, PA 17105

Dr. Walter H. Jordan
Administrative Judge
Atomic Safety and Licensing Board
25 North Court Street
Harrisburg, PA 17105

In the Matter of
Metropolitan Edison Company, et al.
(Three Mile Island Nuclear Station, Unit 1)
Docket No. 50-289
(Restart)

Dear Judges:

On February 18, 1981, Norman C. Moseley of the Office of Inspection and Enforcement testified about NUREG-0760, "Investigation Into Information Flow During the Accident at Three Mile Island" (Staff Exh. 5; see Tr. 13,023-78). In connection with that matter I am enclosing, for the information of the Board and parties, a copy of the January 30, 1981 letter from Congressman Udall to Chairman Ahearne (referenced on Tr. 13,052-54), as well as the responses of the individual Commissioners to that letter dated February 13, 20, and 24, 1981. Also enclosed is a copy of a memorandum from Carlyle Michelson of the Office for Analysis and Evaluation of Operational Data to William Dircks dated February 20, 1981 in which he states his impressions of the investigations into the flow of information concerning the TMI-2 accident. As the memorandum indicates, Mr. Michelson did not conduct an independent investigation of this matter, but merely reviewed NUREG-0760 and had a staff member review the NRC Special Inquiry Group report.

It is my understanding that the Staff and Licensee now expect to fill up the weeks of March 16 and 23, 1981 with design modification testimony. Apparently the session related to management capability will then commence around March 31, 1981. Based on that assumption, the Staff now intends to

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file its testimony on the remaining management capability issues on or before the week of March 16, 1981.

Sincerely,

Daniel T. Swanson
Counsel for NRC Staff

Enclosure: As Stated

cc w/enclosures: Service List

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COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

January 30, 1981

To: Vic St
359-84
Fm: Fred
OCA

The Honorable John Ahearne
Chairman, Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. Chairman:

I am concerned that the recently completed NRC staff investigation into reporting of information during the accident at Three Mile Island does not provide adequate support for its conclusions concerning possible intentional withholding of information and the truthfulness of statements made during the course of the various investigations into the accident. Since it is unclear as to the extent to which the Commission has endorsed the conclusions of the NRC staff report, I would appreciate a statement of the Commission's position, including the views of individual Commissioners, with regard to intentional withholding of information and truthfulness of statements made to the TMI investigators.

Sincerely,

Mo Udall

MORRIS K. UDALL
Chairman

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UNITED STATES
CLEAR REGULATORY COMMISSI
WASHINGTON, D. C. 20555

CHAIRMAN

February 13, 1981

The Honorable Morris K. Udall
Chairman
Committee on Interior and Insular Affairs
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This is in response to your January 30, 1981 letter regarding the NRC's recently completed investigation into reporting of information during the accident at Three Mile Island.

As you know, on January 27, 1981, the Director of the NRC's Office of Inspection and Enforcement issued a Notice of Violation to the Metropolitan Edison Company after completion of its investigation into the flow of information on March 28, 1979 during the accident at Three Mile Island. The Director's action was based upon relevant information developed in a series of earlier reports, including the NRC Special Inquiry Group's report, the Presidential Commission report, the report published by I&E as NUREG-0600, testimony and depositions taken during the Senate Subcommittee on Nuclear Regulation investigation, and testimony before the House Interior Subcommittee on Energy and the Environment, as well as depositions and interviews conducted as part of the most recent investigation. The enforcement action, a copy of which is enclosed, was issued following a presentation to the Commission and reflects the position of the majority of the Commission. My views and those of Commissioner Gilinsky are attached. Commissioner Bradford and Commissioner Hendrie will forward their views next week.

Sincerely,

John F. Ahearne

Enclosures

cc: Rep. Manuel Lujan

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

January 27, 1981

Docket No. 50-320
EA-81-17

Metropolitan Edison Company
ATTN: Mr. R. C. Arnold
Senior Vice President
260 Cherry Hill Road
Parsippany, NJ 07054

Gentlemen:

On April 1, 1980, the Office of Inspection and Enforcement (IE) resumed its investigation into the flow of information on March 28, 1979 surrounding the accident which occurred at your Three Mile Island Unit 2 facility (TMI-2). That effort has now been completed and a copy of the report (NUREG-0760) is enclosed for your use.

Two items of noncompliance identified during this investigation are set forth in Appendix A. These items relate to the failure of the licensee to implement an adequate system to obtain, evaluate and communicate information within the onsite organization and between the onsite and responsible offsite agencies.

It is the responsibility of each licensee to ensure that information is adequately transmitted to management personnel during normal, as well as emergency, conditions. Each licensee is responsible that procedures provide for and are implemented to assure that information and interpretation of it are immediately available to plant managers as well as responsible offsite agencies during emergency conditions.

Our decision to take enforcement action based on the findings of this investigation reflects the judgment that Metropolitan Edison Company as a licensee has a unique and direct responsibility for protecting the health and safety of the public during an emergency. While other entities play a significant role in responding to an emergency situation, it is the licensee who must effectively gather data and analyze the incident for its own emergency response, as well as those of supporting local, state and federal agencies, to be effective. It is in this particular area that on the day of the TMI-2 accident, there was a clear failure in Metropolitan Edison Company's response.

The attached Notice of Violation specifies the items of noncompliance involved. Because of statutory limits in effect at the time of the accident, no further civil penalties are proposed. Since your corrective actions will be assessed by the NRC Staff in conjunction with the issues related to restart of your TMI-1 facility, no response to the Notice of Violation is required. A copy of this letter and our investigation report will be forwarded to the Atomic Safety and Licensing Board for use in that proceeding. Should you wish to respond to my office with respect to the identified items of noncompliance, your comments will certainly be considered.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosures will be placed in the NRC's Public Document Room.

Sincerely,

Victor Stello, Jr.
Director
Office of Inspection and Enforcement

Enclosures:
1. Appendix A - Notice of Violation
2. Investigation Report - NUREG-0760

APPENDIX A
NOTICE OF VIOLATION

Metropolitan Edison Company
Three Mile Island Unit 2

Docket No. 50-320
EA-81-17

A. Operation of the Three Mile Island Unit 2 facility is authorized by License No. DPR-73 which requires that the facility be operated in accordance with its Technical Specifications and the Rules and Regulations of the Nuclear Regulatory Commission. Section IV. 10 CFR 50, Appendix E, "Content of Emergency Plans," requires that emergency plans shall contain, but not necessarily be limited to:

"A. The organization for coping with radiation emergencies, in which specific authorities, responsibilities, and duties are defined and assigned..."

Section 6.8.1, Three Mile Island Unit 2 Technical Specifications, requires that written procedures be established, implemented and maintained covering Emergency Plan implementation.

The Radiation Emergency Plan for Three Mile Island, Section 3.2.1, "Responsibilities and Duties," defines the responsibilities and duties of plant personnel assigned to the emergency organization. Under the terms of this section, the Station Superintendent, or Shift Supervisor will, upon being notified of any emergency,

" ...b. Obtain necessary information to properly evaluate the situation."

Contrary to the above requirements, on March 28, 1979, following the trip of Unit 2 and the subsequent degradation of plant conditions, examples of instances where information was not obtained and evaluated by responsible individuals, include:

1. Information concerning the extended period during which the EMOV was open and the changes in system status associated with closure of the block valve was available to plant personnel before 8 a.m., but was either not gathered or not adequately evaluated in a timely manner by responsible licensee supervisors.

2. Readings taken from the core exit thermocouples (which could indicate some temperatures in the range where the zirconium water reaction is of concern) were improperly evaluated by responsible licensee supervisors at the time they were measured.

3. The occurrence and validity of the containment pressure spike was not communicated to responsible individuals in a timely manner, nor was the information on the pressure spike properly evaluated by subordinates.

This is a violation.

Onsite supervisory personnel contributed to the above described failures in implementing the facility emergency procedures. However, in particular, the Emergency Director, in his unique position as overall coordinator, and the responsible individual for managing the emergency, failed to effectively utilize onsite and offsite resources to:

1. Obtain accurate information describing the accident and plant status;

2. Analyze acquired information to plan corrective action, and

3. Adequately notify federal and state officials.

Finally, while the Emergency Director did take prudent actions to ensure continued management of the emergency prior to leaving the site to brief the Lieutenant Governor, on balance, he should not have left the site during an ongoing accident.

B. Section 6.8 of Three Mile Island Unit 2 Technical Specifications states that written procedures shall be established, implemented and maintained covering Emergency Plan Implementation. Radiation Emergency Procecure 1670.3, which implements the Three Mile Island Unit 2 Emergency Plan, states that, in a General Emergency, it shall be the responsibility of licensee personnel "... to provide maximum assistance and information possible..." to the NRC (among others).

Contrary to the above requirement, the following are examples of issues which were not reported to the NRC or to the Commonwealth of Pennsylvania:

1. Uncertainty of core cooling and potential for degradation.

2. Pressure spike.

3. Incore thermocouple readings.

4. EMOV status during the initial phase of the accident.

Because this item was caused by the violation in Item A, it is considered to be an infraction, in this case. Under other circumstances, such a failure, in itself, would be a serious violation.

Victor Stello, Jr.
Director
Office of Inspection
and Enforcement

Dated at Bethesda, Maryland
this 27th day of January, 1981

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

OFFICE OF THE
COMMISSIONER

February 13, 1981

The Honorable Morris K. Udall
Chairman
Committee on Interior and Insular Affairs
U.S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

I am responding to your letter of January 30, 1981 on the conclusion reached by the NRC staff investigation of information reporting during the TMI accident. You asked for the views of individual Commissioners on whether information was intentionally withheld by Metropolitan Edison Company and on the truthfulness of statements made during the various subsequent investigations.

The NRC staff investigation report's conclusion that "information was not intentionally withheld" from the State or from NRC is more an assertion than a conclusion. I do not find in the report the reasoning that led the investigators to make this statement. Moreover, it is inconsistent with another of the report's conclusions that:

> "Met Ed was not fully forthcoming on March 28, 1979, in that they did not appraise the Commonwealth of Pennsylvania of either the uncertainty concerning the adequacy of core cooling or the potential for degradation of plant conditions."

To say that Met Ed was not "fully forthcoming" is to say it consciously held back significant information on the accident.

My own judgment is that Met Ed, in dealing with the State and the NRC on March 28, 1979, probably withheld information which would have made the accident appear more serious and the reactor situation more precarious. It is perhaps understandable that company officials should have tried to dampen public excitement by playing down the severity of the accident in briefing State and federal officials, but it is not excusable in view of the responsibility of government officials for public protection.

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The staff's conclusion that "none of the conflicts examined were the result of lying" is apparently based in large part on the investigators' personal impressions of the witnesses. I must base my own assessment on the written record, and I find the staff's report does not deal with the numerous inconsistencies in the testimony in a way that persuades me that none of the witnesses were lying.

As you know the NRC recently took enforcement action on the basis of the TMI investigation report. I would like to add that I do not agree with the other Commissioners' conclusion that Met Ed's failure to report accident information to the NRC and the State was caused by the failure of the Station Superintendent to "obtain necessary information to properly evaluate the situation". Nor do I agree that this should be a mitigating factor in taking enforcement action on the failure to report. The fact is that a good deal of important information was available and was not reported. The Commission should have dealt more severely with Met Ed's failure to report.

Sincerely,

Victor Gilinsky
Commissioner

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

CHAIRMAN

February 13, 1981

The Honorable Morris K. Udall
Chairman
Committee on Interior and Insular Affairs
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This is in response to your letter of January 30, 1981. The investigators who prepared the recent NRC investigation report concluded that information was not intentionally withheld from the State of Pennsylvania or the NRC on the day of the accident. This was based upon their personal review of existing information and interviews which they conducted to supplement that information. In addition, based upon his staff's participation in the investigation and his personal review of the report, the Director of the Office of Inspector and Auditor concluded there was no direct evidence to substantiate intentional withholding of information from the NRC.

In light of the information developed from that investigation, the Director of the Office of Inspection and Enforcement proposed the enforcement action he found to be appropriate. As the Commission's cover letter indicates, the enforcement action which was issued reflects the position of the majority of the Commission.

In my opinion the important lesson to be learned from this issue is that the licensee must be responsible for evaluating and responding to an accident. The licensee is the entity with detailed operational knowledge of a particular reactor. Although the NRC has a role to play and it needs adequate information in order to fulfill that role, the licensee must bear primary responsibility for evaluating and controlling plant conditions. I supported the enforcement action because I believed it properly emphasized this aspect of the information flow issue.

With regard to intentional withholding of information and truthfulness of statements made to the TMI investigators, I have found nothing which would cause me to disagree with the findings and conclusions of the NRC staff. The investigators are more familiar with the technical details of the issues and have personally interviewed many of the key individuals involved. Based upon their expertise, their personal knowledge, and my lack of any basis for disagreeing, I personally endorse their conclusions.

Sincerely,

John F. Ahearne

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