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

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MEMORANDUM FOR: William J. Dircks
Executive Director for Operations

FROM: Carlyle Michelson, Director
Office for Analysis and Evaluation
of Operational Data

SUBJECT: INVESTIGATIONS INTO INFORMATION FLOW CONCERNING THE TMI ACCIDENT

References: (1) January 17, 1981 memorandum for the NRC Commissioners from V. Stello, Jr., transmitting a draft copy of "IE Investigation Into Information Flow During the Accident at Three Mile Island."

(2) Draft copy of the U.S. House of Representatives Committee on Interior and Insular Affairs' report, "Reporting of Information Concerning the Accident at Three Mile Island."

This is in response to your request for a statement of my personal views concerning the referenced reports. First, I would like to state that my views are based, in part, upon considerable previous exposure to many aspects of the accident (including the general subject area of the referenced reports) while serving as a consultant to the the ACRS. I examined numerous documents and listened to extensive relevant testimony as a full-time consultant to several ACRS subcommittees during the three months immediately following the accident, and part-time thereafter until joining the NRC. I still have a personal interest in, and appreciation for, this subject area.

Since the referenced reports were extensive and my time was limited, I requested a member of my staff, Hal Ornstein, who had reviewed the reports in some detail previously, to give me an informal briefing statement. Hal served on the NRC Special Inquiry Group for over six months and had considerable knowledge of the events that took place at the plant during the accident, and the actions of Met Ed, NRC and B&W personnel.

Based on my previous views and experience, a brief examination of the subject reports, and the views of Hal Ornstein as expressed in his briefing statement, my present views concerning this situation are best summarized as follows:

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1. There has not been, and is not now, any reasonable basis, other than circumstantial, for concluding that one or more members of the Met Ed staff in responsible charge of the plant during the accident purposefully issued untrue statements or withheld information with the intent to deceive or mislead the NRC or the State of Pennsylvania regarding the severity of the accident.

2. On this basis, I must conclude that the person or persons in responsible charge were either unaware of or did not understand the numerous indications of impending or onsetting core damage and final gross degradation.

   They did not put together the significance of numerous tell-tale symptoms, each of which in itself was a sign of significant core degradation, which, when taken concurrently, revealed an uncontestable picture of significant damage to the core that was placing the plant in a configuration beyond those which had been analyzed, and had the potential for further degradation with significant impact upon the public health and safety. These symptoms included:

   a. High in-core thermocouple temperatures (obtained using direct millivolt readings because the plant data logging and recording equipment could not handle temperatures above 700°F).

   b. Extremely high containment building radiation levels.

   c. A containment building pressure spike at 1:50 pm and the subsequent initiation of the containment sprays (pressure was registered on two independent containment pressure recorders in plain view of the control room occupants at the time of the "thud").

   d. High hot leg temperatures, 730°F (loop A) and 780°F (loop B), verifying the presence of superheated steam and an uncovered core.

   e. Overexposure of the Met Ed staff who took samples of primary system coolant (intense radioactivity associated with the samples should have been a clear indication of significant core degradation).

3. Since the reports clearly indicate that several Met Ed staff members were aware of these indications, I must conclude that such information was either not made known to, or not understood by, the person(s) in responsible charge of the accident response.

   It is not apparent from the reports that the person in charge attempted to assure himself that all critical information was being received for his consideration, as would be the behavior of a prudent manager in a similar situation where there were uncontestable signs that the situation was exceeding all expectations without apparent reason.

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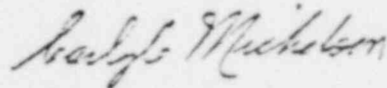
At this point, I must conclude that one of two situations prevailed: either there was a serious lack of attention on the part of the person in responsible charge to heed a fully visible and compelling need to find out what was happening by searching or asking every available source in the ample time available; or the needed information was, indeed, being received but not understood or communicated to other organizations (such as the NRC) for their consideration. In either case, I would judge that the person or persons in charge did not function responsibly or act in a manner commensurate with the needs of the situation and should not again become placed in a similar situation in a nuclear power plant.

If the needed information was being received at the time of the accident but this receipt was later denied, then a question of perjury and the willful withholding of information exists.

4. It appears to me that in some areas the IE investigation report does not go far enough, and in other areas the conclusions and recommendations do not appear to be fully supported by the facts. The recommended enforcement actions do not appear to be consistent with the facts revealed by the investigation. The House Interior Committee report is much more comprehensive and does not appear to suffer from similar shortcomings.



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