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COMMONWEALTH OF PENNSYLVANIA OFFICE OF THE GOVERNOR HARRISBURG

THE GOVERNOR

November 20, 1981

Dr. Nunzio J. Palladino Chairman U. S. Nuclear Regulatory Commission Washington, DC 20555



Dear Mr. Chairman:

It is my understanding that the Nuclear Regulatory Commission is nearing a decision on whether the undamaged Unit 1 generating station on Three Mile Island should be returned to active service.

As you are aware, I have been involved in an effort to address a serious and lingering health and safety concern on Three Mile Island.

That concern has to do with the dangerous levels of radiation that continue to contaminate the crippled Unit 2 facility, and with the need for a clear consensus and financial commitment for the safe, timely and total removal of that contamination.

On July 9, I advanced a national cost-sharing proposal for achieving the cleanup of TMI-2, a proposal which presently appears to be our best hope for removing what the entire spectrum of scientific and technical experts agrees to be a genuine health and safety hazard.

At the time, I was concerned about the possibility that Unit 1 might be reactivated without regard to resolving a "crisis of commitment" to funding the cleanup of Unit 2. I do not believe these two questions should be considered separately.

Because the cleanup funding task requires the use of revenue that would be realized from a newly-active Unit 1, I have announced my intention to support restart of the undamaged facility only if two conditions are met:

- Development of a consensus for a realistic plan for Unit 2 decontamination.
- (2) Receipt of adequate assurances that Unit 1 can be operated safely.

B112030305 B11120 PDR ADOCK 05000289 PDR PDR Both of these conditions reflect my paramount concern for the health and safety of the people who live within the shadow of Three Mile Island, as well as the environmental integrity of the area. Considerable progress has been made to date toward building the kind of consensus and financial commitments we need in order to deal with the Unit 2 hazard.

The other condition can only be met, however, by the NRC itself. Your agency has the exclusive jurisdiction over all questions regarding the safe operation of this, or any other, nuclear power plant in the country.

It would be foolish of me, as a layman, to attempt to substitute my judgment for yours on this matter.

However, I continue to believe it to be in the public interest for the NRC to fully address the views of a variety of sources on matters of such obvious importance to public health and safety.

It is in that spirit that I am forwarding for your review correspondence I have recieved from the Union of Concerned Scientists (UCS) and from U.S. Rep. Morris K. Udall, chairman of the House Committee on Interior and Insular Affairs. You will note that these letters raise several technical and procedural questions concerning the safety of a Unit 1 restart.

I urge you to conduct a careful and objective review of these concerns. If there are, in fact, any Unit 1 safety questions that have yet to be satisfactorily addressed, I suggest that now is the time for the NRC to address them.

I would appreciate a written response from you or your staff reflecting NRC's view of the various points raised by UCS and Rep. Udall.

Dick Tho Governor

Attachment

NINETY-SEVENTH CONGRESS

MORRIS K. UDALL ARIZ., CHAIRMAN

ADNATHAN B. BINGHAM, N.T. JONATHAN B. BINGHAM, N.T. JONA F. BEIBERLING, OMIO DAN MARRIOTT, UTAH ANTONIO BORJA WORD PAT, GUAM JAMES WEAVER, OREG. GEORGE MILLER, CALIF, JAMES J. FLORIC, N.J. MILLER, CHARLES PARMATAN, JR., CALIF ODJOLAS K. BERRETUTER, NEBA. JON HINBON, MISS. MILLER, EMART, IND. DAVID O B. MARTIN, N.T. LASTY CRAIG. IDAMO SEDRGE MILLER, CALIF. JAMES J. PLORIC. N.J. PHILIP R. SHARP. IND. EDWARD J. MARKEY, MASS. BALTASAR CORRADA, P.R. AUSTIN J. MURPHY PA. MICK JOE RAMALL II. W. VA. BRUCE F. VENTO, MINN. JERRY MUCHARY. LA. RAT KOGOYSEK, COLO. PAT WILLIAME, MONT. DALE E. KILDEE, MICH. TONY COLLING, CALIF. BEVERLY S. SYRON, MD. NON DE LUGO, VI. BAMUEL SEJDENSON, CONN.

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COMMITTEE ON INTERIOR AND INSULAR AFFAIRS

U.S. HOUSE OF REPRESENTATIVES WASHINGTON, D.C. 20515 NOV 30 P2:33 ENERAL COUNSEL ere

ASSOCIA'E STAFF D'RECTON AND COUNSE. LEE MC ELVAIN

CHARLES CONKLIN

STANLEY SCON LLE

STAFF DIRECTOR

REPUBLICAN COUNSEL

July 23, 1981

Honorable Richard Thornburgh Governor of Pennsylvania State Capitol Harrisburg, Pennsylvania 17120

Dear Governor Thornburgh:

This regards the strategy for funding the cleanup of Three Mile Island Unit 2 that you proposed on July 9, 1981. I appreciate your thoughtful recommendations on this matter as well as your commitment to working for a solution to this difficult problem.

As Chairman of the Committee in the House with primary jurisdiction over the Nuclear Regulatory Commission (NRC) and the regulation of the commercial nuclear industry, I have been deeply involved in inquiries into various aspects of the Three Mile Island accident. I have also actively participated in the ongoing national debate over where responsibility should lie for funding the cleanup of TMI-2 and any future reactor accidents. On May 4 and 5 of this year, the Subcommittee on Energy and the Environment held hearings on the financial implications of the TMI accident; your proposed strategy for funding the cleanup is a welcome addition to the record the Subcommittee has compiled on this matter.

I would like to share with you some thoughts regarding the portion of your July 9 statement wherein you state that "contingent upon adequate safety assurances" from the NRC, you are prepared to support a decision to restart TMI Unit 1. This statement is consistent with my own position on the restart of Unit 1. In my view, the conditions established by NRC as prerequisites to any decision by the Commission to allow Unit 1 to go back on line have not been fulfilled. I infer from the Office of Policy and Planning report appended to your statement that you agree with my assessment that Unit 1 is not physically ready to operate. In particular, that report says that you would urge the postponement of restart of TMI-1 until:

The Babcock and Wilcox reactor design flaws which may have contributed to the accident in Unit 2 have been fully discovered and corrected in Unit 1. (Report on the Cleanup of Three Mile Island, prepared by the Governor's Office of Policy and Planning, page 7.)

In view of your position on this matter and in light of GPU's urging in the strongest terms that TMI-1 be permitted to resume operation, it is noteworthy to find continuing resistance by GPU to requirements instituted for purposes of correcting deficiencies revealed by inquiries into the accident. Among such deficiencies was the lack of instruments that would permit control room personnel to readily detect that water was being lost from the primary cooling system and that the system was approaching a condition of inadequate core cooling (ICC). Had there been a device, for example, to indicate water level above the core, the TMI operators would likely have continued to pump water into the system rather than taking actions that led to a loss of coolant over a period lasting more than two hours.

A constant theme that runs through the reports prepared in the wake of the accident is one noting the lack of instrumentation that would permit the TMI-2 operators to readily determine that a loss of coolant accident had occurred. A report of the staff of the President' Commission on the Accident at Three Mile Island states that instruments for detection of inadequate cooling would have helped the operators.¹ The Report of the Senate Special Investigation states that a design weakness was, "The lack of instrumentation to measure water level in the reactor vessel directly."² The report of the MRC's Special Inquiry Group states that, "The plant did not have instrumentation showing the level of reactor coolant in the main reactor vessel."

The need for water level instrumentation was stressed as early as April 7, 1979 in a letter to Chairman Hendrie from NRC's Advisory Committee on Reactor Safeguards (ACRS):

The Committee believes that the analyses recommended above will demonstrate, as has the accident at Three Mile Island, that additional information regarding the status of the system will be needed in order for the plant operator to follow the course of an accident and thus be able to respond in an appropriate manner.

¹The President's Commission on the Accident at Three Mile Island, Report of the Technical Assessment Task Force, Vol. I, p. 37.

²Nuclear Accident and Recovery at Three Mile Island, p. 10.

3NRC Special Inquiry Group, Vol. I, p. 126

As a minimum, and in the interim, it would be prudent to consider expeditiously the provision of instrumentation that will provide an unambiguous indication of the level of fluid in the reactor vessel. Early consideration should be given also to providing remotely controlled means for venting high points in the reactor system as practical.

The latest version of NRC's TMI Action Plan contained requirements (Item II.F.2) for instrumentation to provide indications of inadequate core cooling. This instrumentation was to be described in a report submitted by January 1, 1981 and to be installed by January 1, 1982. Subsequent to the imposition of these requirements, the ACRS in a June 9 letter to the NRC Executive Director raised questions as to whether the implementation dates were premature in light of unanswered questions as to whether the proposed ICC instrumentation was actually needed, as to the conditions under which it would be used, and as to whether ICC instrumentation might actually mislead the operators.

On July 14, after hearing from NRC and GPU officials, the ACRS concluded that ICC instrumentation should be installed, and that the NRC and GPU "should act promptly to establish a basis for selecting a suitable monitoring system" taking into account the reservations expressed by the ACRS in its June 9 letter.

At the meeting leading to the July 14 ACRS letter, NRC staff reported to the ACRS that the staff would be willing to recommend allowing TMI-1 to operate without additional ICC instrumentation providing they obtained "evidence of reasonable progress" toward the installation of such instrumentation. The staff reported to the ACRS, however, that there had been no such demonstration of "reasonable progress" toward the installation of ICC instrumentation, and that "... up to this point (July 10, 1981) at least this applicant has taken the position that they don't ... essentially, to be blunt, that they don't need a (ICC instrumentation) system and they're not going to install ona. And this is in spite of a staff indication ... at least a year and a half ago, that that position was totally unacceptable."

GPU has presented various explanations for its failure to proceed with ICC instrumentation. They have, in effect, told the ACRS that they did not perceive what this instrumentation would add to that which already existed and they have suggested that currently available water level instrumentation designs were inadequate. While in the eyes of the NRC staff GPU has not made sufficient progress toward fulfilling the requirement for ICC instrumentation, the staff has noted that commitments have been made to install ICC instrumentation at some 27 plants. NRC staff, in fact, reported to the ACRS that GPU has been among the least responsive utilities on this matter, and that GPU has failed to provide the NRC evidence of having conducted an in-depth study of available equipment and that furthermore they have not indicated why such equipment would not be appropriate for TMI-1.

In sum, the picture that emerges is one wherein GPU has resisted implementing a requirement based upon a widely held engineering judgement which, while not unanimous, holds that ICC instrumentation would make a significant contribution to safety. The NRC staff is in this case demonstrating a commendable commitment to compensate for unanticipated defects in pressurized water reactor systems. The reluctance of GPU to meet the NRC requirement, to say nothing of its failure to go the extra mile, suggests that the current TMI management, as did its predecessor, holds that the plant systems as they exist are adequate to cope with anticipated events; they appear to believe that unanticipated events simply will not occur. This is of course the same line of thinking that led to GPU's present predicament.

The record of the ACRS meetings on TMI-1 restart contains additional information on the readiness of TMI-1 which is not adequately summarized in the ACRS letter of July 14 to Chairman Palladino. The record indicates, in fact, that less progress has been made toward satisfying the Commission's post-TMI requirements than is implied by the ACRS letter. I commend this record to your attention for the light it sheds on the situation.

Sincerely,

Chairman



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October 19, 1981

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Honorable Richard Thornburgh Governor Commonwealth of Pennsylvania Harrisburg, PA 17120

Dear Governor Thornburgh:

In a statement you issued on July 9, 1981, you indicated a willingness to support the restart of the Three Mile Island Unit 1 nuclear plant as a possible means of partially financing the cleanup of the damaged Unit 2. In your statement, you made your support for Unit 1 restart "contingent upon adequate safety assurances."

UCS has serious reservations about the safety of restarting TMI-1 as proposed by the GPU Nuclear Corporation and the Nuclear Regulatory Commission Staff. These reservations stem from UCS's participation in the NPC hearings on restart of Unit 1, as well as our continuing review of the implementation of the "lessons learned" from the TMI-2 accident. Our concerns may be broadly expressed as follows:

1) After identifying many of the safety issues raised by the TMI-2 accident, NRC has largely focused its attention and resources on quick, cheap fixes. These fixes have generally ignored the more serious problems revealed by the accident.

2) As a result of restrictions in the scope of the TMI-1 restart proceeding before NRC's Atomic Safety and Licensing Board, important questions about the safety of restarting TMI-1 were not considered in the NRC hearings.

3) GFU's position -- that TMI-1 should be allowed to restart unless it poses unique safety problems -reduces NRC's standard of safety to the lowest common denominator.

4) NRC has repeatedly extended its own deadlines for implementing the TMI-2 "lessons learned" requirements at TMI-1 and other nuclear powerplants after continued pressure from the nuclear industry.

5) Commitments made by the NRC Staff and GPU Nuclear during the hearing process have since been retracted or

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substantially modified. Some of these commitments involve hardware improvements or plant staffing level upgradings which are directly related to the causes of the TMI-2 accident.

1) NEC's Emphasis on Quick Fixes

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UCS has drawn from its participation in the TMI-1 restart hearings a straight firm conviction that "adequate safety assurances" have not been provided by UC, either the NRC Staff or GPU Nuclear. If TMI-1 is restarted as presently proposed, it will be without adequate assurance that another accident more severe than the TMI-2 accident cannot occur at TMI-1. Many factors contribute to this conclusion, but they can perhaps be summarized by the general observation that the initial impetus for serious reform in the immediate aftermath of the TMI-2 accident has been supplanted by a retreat to "business as usual."

While "business as usual" might arguably be an appropriate posture if the NRC and the nuclear industry had learned and applied the lessons from the TMI-2 accident, the unfortunate fact is that in many important respects they have not. Nuclear industry spokespersons frequently claim that all of the significant safety problems associated with the TMI-2 accident have been solved. This is patently untrue. Although the NRC's so-called "Action Plan" does a relatively good job of identifying these safety problems, NRC's progress toward resolving them has been glacial at best.

In determining the priority assigned to implementing Action Plan items, the NRC used a 210-point rating system. Only 100 points were based on safety significance. The majority of the points were assigned for such factors as cost (both to NRC and the industry), the time required to solve the problem, and whether the item involved hardware modifications or improvements in the man-machine interface. This approach has directed the NRC's attention to quick cheap fixes, rather than problems with high safety significance which involve more complex technical questions and require more time and expense to resolve. (A copy of the NRC's priority ranking system is enclosed for your reference.)

Today, two and onc-half years after the TMI-2 accident, some of the most serious safety issues (identified by all independent investigations of the accident) have not even begun to be addressed in a meaningful way. In March 1981, NRC listed three new generic safety issues that stem directly from the TMI-2 accident. NRC does not plan to resolve these issues until April, 1964. Based on NRC's past record, we have good reason to expect that schedule to be extended by many years. NRC is continuing its practice of classifying safety problems as generic as a way to effectively postpone decisions on difficult technical questions. The hydrogen control and degraded core issues are two prime examples. While the NRC has spent literally thousands of man-hours finding ways to speed up the approval of new operating licenses, it is unwilling to adopt the same standards of expedition in setting deadlines to resolve these and many other important safety problems that plague currently operating reactors.

2) The Issues Ignored in the Restart Hearings

A decision authorizing restart of TMI-1 by the Atomic Safety and Licensing Board and the Commission itself would not constitute a full endorsement of the safety of that unit. We say this because the scope of the restart hearings was legally restricted in a way that allowed the Board to consider only the precise sequence of events that occurred at TMI-2 or very close analogs. In essence, the Commission quite deliberately refused to look at other safety issues not directly involved in the TMI-2 accident.

This contrasts sharply with the current requirements for a reactor to receive a construction permit, an operating license, or an upgrading from provisional to full-term license. In each case, NRC rules require the utility and the NRC Staff to demonstrate publicly that each of the so-called "generic unresolved safety problems" has been resolved on a plant-specific basis or that compensatory safety measures have been adopted. This review has never been done for TMI-1, because it was criginally licensed before the generic unresolved safety problems were publicly disclosed.

In the TMI-1 restart hearings, the Commission's refusal to look at safety issues beyond those directly involved in the TMI-2 accident amounts. in UCD's view, to deciding that safety problems will only be dealt with after they have caused an accident, if then. While NRC may have the legal right to limit its proceedings in this way, such restrictions cannot be justified on technical or common sense grounds.

One issue conceded by all parties to be directly involved in the TMI-2 accident was effectively barred from the hearing. This is the issue of hydrogen gas control. During the TMI-2 accident, large amounts of explosive hydrogen gas were generated when the reactor core became heavily damaged and partially melted. The amount of hydrogen generated during the accident was 6 to 10 times larger than the maximum credible amount recified in NRC regulations. As a result, a hydrogen explosion occurred during the accident.

While that explosion did not breach the containment, no one yet knows whether the explosion damaged other equipment important to safety. Neither the NRC nor GPU Nuclear has even examined the safety equipment inside TMI-1--a much older plant than TMI-2--to determine whether a hydrogen explosion would compromise the safety of that plant. GPU's only response to the hydrogen control issue has been to install a hydrogen recombiner in TMI-1 that is incapable of coping with the amount of hydrogen actually generated during the TMI-2 accident.

UCS had sought a fuller inquiry into the hydrogen issue. However, before the restart hearing, the Commission (by a 2-2 vote) refused to waive its existing hydrogen control regulation. This pre-TMI-2 regulation bases the design of hydrogen control systems on the assumption that the maximum amount of hydrogen generated will be only 1/6 to 1/10th the amount that was actually generated during the accident. In a later decision, two NRC Commissioners bluntly explained the effect of the Commission's ruling:

The Board [in this case] found 'relying on the TMI-1 roling] that, in view of new instructions to reactor operators and other improvements, ar event which actually occurred two years ago was no longer 'credible', and that, therefore, there was no need to pursue possible remedial steps. It is a finding that could only have been made by a group schooled in the arcane subtleties of nuclear regulation. No ordinary person is capable of such foolishness. After the TMI experience, this review of the 'credibility' of an accident involving hydrogen has been a waste of the parties', the Board's, and the Commission's time. It can only contribute to public cynicism about nuclear regulation and the role of public hearings in the decisionmaking process. Duke Power Cc. (William B. McGuire Nuclear Station, Units 1 and 2), Order (June 29, 1981), Separate Views of Commissioners Gilinsky and Bradford, slip opinion at 10.

We believe it is especially ironic to apply such tortured reasoning to TMI itself.

Another issue that was severely restricted in the restart proceedings is the question of whether the equipment needed to safely shut down the rlant in an accident has been qualified to survive the accident environment. The NRC Staff's testimony was limited to the ability of the equipment to survive a small break loss-of-coolant accident of much smaller dimension than the TMI-2 accident on the remarkable grounds that an accident as severe as TMI-2 cannot happen again! Nor did the NRC ever review for the restart proceedings the ability of safety-related equipment to survive other types of serious accidents, such as main steam line and high-energy line breaks.

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This is far from a theoretical problem. Because of these limitations on the scope of the hearings, UCS was prevented from presenting evidence to the Licensing Board that many safety-related components in TMI-1 have not been qualified to survive serious accidents. The NRC Staff and GPU Nuclear precised to address these questions by July 1982, but not in a way that allows open hearings or public participation. Nor is there any reason to expect the July 1982 date to be a firm one. A large number of utilities have already applied for a 13-month blanket extension, which the NRC Staff public sects perfectly willing to grant. We have little doubt but that, after the public attention that accompanied the restart hearings is over. GFU will line up with the other utilities if it finds it inconvenient to adhere to the July 1982 "deadline."

3) The Lowest Common Demoninator is not the Appropriate Standard of Safety

There are a large number of other issues that were covered during the restart hearings in which UCS believes that the company and the NRC have proposed to compromise safety in order to get TMI-1 back on line and to keep other reactors in operation. Because the Licensing Board has not yet issued a decision on design issues, we cannot say whether it will accept the company's and the NRC Staff's positions. It is therefore premature to

discuss these issues in detail; however, if you or your staff would like to be briefed on them, we would be pleased t do so.

A few examples of these issues are: whether the relief valve (PORV) which caused the TMI-2 accident should be classified as a component important to safety and required to meet strict standards of design and construction; whether the method of supplying electric power to the pressurizer heaters jeopardizes the power source for all in-plant safety systems, thereby making TMI-1 more dangerous than it was before the TMI-2 accident; and whether the reactor operators must be provided with positive indication when valves in safety systems are not in their correct positions (the TMI-2 operators were unaware that two emergency feedwater valves were closed). In each case, GPU and the NRC Staff argued against the imposition of stricter requirements. (UCS recently moved to reopen the hearing on some of these design issues because the NRC Staff failed to disclose that some Staff members recommended that certain stricter safety measures advocated by UCS be adopted, contrary to the Staff's testimony during the hearing.)

UCS has been astonished at the attitude consistently exhibited by GPU Nuclear throughout the restart hearings. GPU has time and again responded to safety issues by taking the position that if any other plants are operating with similar problems, TMI-1 should likewise be permitted to operate. This reduces the standard of public protection to the lowest common denominator--a "standard" dictated by considerations of expediency and accidents of history. It substitutes for reasoned judgment the proposition that the worst shall set the pace for all. On the contrary, GPU Nuclear should, we believe, exhibit the strongest commitment to leadership in safety after its experience at TMI-2.

4) NRC's "Deadlines" are Infinitely Flexible

Another consistent. very troubling pattern emerged during the TMI-1 restart hearings: NRC's so-called "deadlines" for achieving compliance with TMI-2-related requirements are not true deadlines, but instead are infinitely flexible. Virtually all of the deadlines have already been extended. Many requirements originally had implementation deadlines of January 1980 or January 1981. In successive issuances, the NRC has postponed these deadlines to July 1981, and beyond in some cases. For example, the deadline to upgrade the emergency feedwater system to meet NRC's requirements for systems important to safety was originally January 1981, was extended to July 1981, and is being considered now for an additional delay.

The NRC Staff announced during the restart hearing that all deadlines occurring after June 30, 1981 are subject to reconsideration. These deadlines cannot in any Jense be called firm. Thus we have no basis for believing that any promises of future action by specific dates will be kept. NRC's history clearly demonstrates that the convenience of the licensees will take precedence over strict enforcement of safety requirements, including those requirements that stem directly from the TMI=2 accident.

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5) GPU's Commitments Have Been Withdrawn

Nor can GPU Nuclear's commitments be relied upon. For example, during the TMI-2 accident noncondensible gas and steam accumulated in the reactor coolant system, blocking the circulation of water needed to cool the core. Circulation of coolant was established only by the use of the reactor coolant pumps, which are not considered important to safety and therefore need not meet NRC's requirements to ensure the reliability of safety systems. In order to provide a reliable method of removing noncondensible gas and steam, GPU originally "committed" to installing new vents for this purpose at TMI-1 before it restarts. However, GPU has since abandoned this commitment. When TMI-1 restarts (assuming the Licensing Board so rules) it will be in essentially the same condition as TMI-2 was during the accident. The vents will not be installed until many months in the future.

In concluding, we must emphasize that the specific issues mentioned here are only a very few examples of the safety problems that remain unresolved at TMI-1. As you recognized when you asked UCS to provide an independent technical evaluation of the krypton venting, these questions are complex and become entangled with economic and political considerations. We advised you then that the venting would not pose a significant radiological health hazard to the public. This time our conclusion is the opposite: restart of TMI-1 in the condition proposed by GPU Nuclear and the NRC Staff would not provide adequate assurance of safety to the people who live around it.

NRC's decisions are strongly influenced by its regulatory history and its extreme reluctance to take any action that might suggest to the public that currently operating reactors are less than safe. Thus, each time NRC examines the safety of a particular plant, its response is colored by considerations of how its action might highlight past mistakes or req ire changes in other plants. Your jurisdiction is much clearer: you must consider only the interests of your constituents. UCS firmly believes that restart of TMI-1 as currently proposed is not in their interest.

One more point deserves your attention. Your cost-sharing proposal for the cleanup of Unit 2 appeared to rely on the restart of Unit 1 as the basis for raising almost one-third of the remaining cleanup costs. We agree with you that the cleanup of Unit 2 is necessary and should not be delayed. We also believe that your cost-sharing proposal represents the most promising approach developed thus far toward breaking the cleanup funding logjam. While, as you have pointed out, the two issues --cleanup of Unit 2 and restart of Unit 1-- are interrelated, we hope you will not link them so tightly that the result is two, rather than one, unsafe nuclear plants at Three Hile Island.

Sincerely.

Huy W Kendall

Henry W. Kendall Chairman Board of Directors

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Robert D. Pollard Nuclear Safety Engineer

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Ellyn R. Weiss General Counsel

Enclosure

TABLE B.1 THE ACTION PLAN PRIORITY REALING SYSTEM

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1.	Safety Significance	
	High	100
	Medium	50
	Low	0
11.	Type of Improvement	
	Improves the human element	20
	Fixes the hardware	10
111.	Utilization of Resources	
	A. Project is ongoing, and resources would be wasted if stopped	20
	Project has not yet been initiated	10
	B. Staff resource requirement: Total - \$50K = 1 my	
	Small (< 2 my)	20
	Medium (> 2 < 10 my)	10
	Large (> 10 my)	0
	C. Industry resource requirement: Total per unit over 40-yr	
	life - 1 my = \$50K	
	Small (< \$1.0M)	20
	Large (> \$1.0M)	0
IV.	Timing of Improvement (i.e., how quickly will the expected benefit begin to be realized after initiation of task)	
	Short-term (within one year)	30
	Near-term (within two years)	20
	Long-term (within three years)	10
	Extended beyond three years	0