MAR 3 1982

MEMCRANDUM FOR: Commissioner Gilinsky

FROM: Victor Stello, Jr., Deputy Executive Director
Regional Operations and Generic Requirements

SUBJECT: COMMISSIONER GILINSKY'S SEPARATE REMARKS ATTACHED TO THE MARCH 2, 1982 LETTER TO CONGRESSMAN UDALL

The discussion concerning my conclusions about withholding of information during the TMI-2 accident in your separate remarks attached to the March 2, 1982, letter to Congressman Udall are incorrect and therefore I feel obliged to provide a response for the record.

The second paragraph in your separate remarks states:

> Recently, at long last, the Staff, in the person of Mr. Stello, finally conceded that significant information about the severity of the accident had been withheld "knowingly" by the Company on the day of the accident. But, Mr. Stello added, in what can only be described as an Alice-in-Wonderland departure from the dictionary meaning of the words, this involved no "intent" or "willfulness" on the Company's part.

The first sentence says that my views regarding information flow regarding the severity of the accident has recently changed. This is incorrect. My views now and at the conclusion of our investigation, as reported in NUREG-0760, "Investigation Into Information Flow During the Accident at Three Mile Island," dated January 1981, remain unchanged. I have recently reiterated my conclusions to you in a memorandum dated January 28, 1982, which stated:

> ...the real issue is the conclusion I draw as to intentional withholding of information by the licensee. You will recall one of the issues to be examined in the IE investigation of the information flow during the accident (NUREG-0760) was whether or not information was intentionally withheld. Conclusions Number 5 and 6 state clearly that information was not intentionally withheld; i.e.,
>
> 5. Information was not intentionally withheld from the State on the day of the accident.
>
> 6. Information was not intentionally withheld from the NRC on the day of the accident.

I remain convinced that those are the proper conclusions....

OFFICE ▶							
SURNAME ▶							
DATE ▶							

The second sentence in the excerpt from your separate remarks which attributes to me a departure from the dictionary definition of words in my conclusions is equally objectionable. The departure from the usual meaning of words in the transcript of the December 21, 1981 meeting, which is the source of your comment, arose from your request to me to leave aside certain concepts in our discussion. My memorandum of January 28, 1982 points out the unusual context in which certain words were used in your questioning of me. You began a line of questioning for which you asked me to "forget about the word intent." I tried to be responsive to your questioning using that assumption. Thus, I believe the Alice-in-Wonderland departure from the dictionary meaning of words was taken at your initiative not mine.

You are, of course, free to reach any conclusion you choose regarding the flow of information during the TMI-2 accident. I assume you want me to reach independently my conclusions based on my understanding the facts. I have done so. Until such time as new facts arise, I am not prepared to change my conclusions.

Original signed by
Victor Stello

Victor Stello, Jr.
Deputy Executive Director
Regional Operations and
Generic Requirements

cc: Chairman Palladino
Commissioner Bradford
Commissioner Ahearne
Commissioner Roberts
EDO
SECY
OGC
ELD
OCA
Service List

DISTRIBUTION
Central File
PDR
DEDROGR

OFFICE	DEDROGR						
SURNAME	VStello						
DATE	3/3/82						

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

CHAIRMAN

March 2, 1982

The Honorable Morris K. Udall, Chairman
Subcommittee on Energy and the Environment
Committee on Interior and Insular Affairs
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your February 4, 1982 letter. You expressed deep dissatisfaction with our handling of the investigation of information flow during the Three Mile Island (TMI) accident.

As Chairman of the Commission, I could not help but be troubled by your letter even though I was not on board when the events in question took place. Of particular concern to me was your use of the term "inaction" with regard to this matter. Hence I felt obligated to reexamine the actions taken by the Nuclear Regulatory Commission (NRC).

From this reexamination it appears to me that considerable time and energy was expended by the NRC on this matter. Although the conclusions reached by these actions differ from your views, the use of the term "inaction" does not appear appropriate. Let me recount where it appears to me we have been and where we are today:

-- We have examined this issue several times, and devoted extensive funds, staff resources, and Commission time to this effort;

-- Not only did the Commission direct the NRC Special Inquiry Group to study this question, but, in response to your dissatisfaction, we extended the Rogovin effort to examine your issues in greater detail;

-- This matter has been investigated by our staff and by your staff;

-- The Director of IE worked closely with your staff during development of your report, to include providing rapid access to our investigation transcripts;

-- We have addressed this matter in meetings with our staff, and have had a number of communications from your staff on this matter;

-- The final conclusions of your staff investigation and of our investigation are consistent. The only place we appear to disagree with you is over the statement in your letter that the company willfully violated our reporting requirements;

-- A notice of violation was issued, which is enclosed; and

-- Both your report and our report have been referred to the Department of Justice.

We share your view that continuing dialogue on this matter no longer serves any useful purpose. We would rather turn our efforts toward implementing lessons learned from past experience to improve the flow of information.

With regard to information flow, it is vitally important that personnel at all licensee facilities be aware that we cannot tolerate reporting deficiencies, and that sanctions -- including referrals to the Department of Justice -- will be pursued as needed against such conduct. We are planning to prepare a policy statement clarifying in no uncertain terms the expectations of this agency for complete and candid communications with us at all times by all licensees. The policy statement would also emphasize our intent to deal forcefully with licensees or their personnel when these expectations are not met. The statement would be distributed to all licensees and published in the Federal Register.

In a related context, we are now considering steps that can be taken to improve our investigative program. It is clear that we must possess the capability to perform thorough and timely investigations which command the respect of knowledgeable persons inside and outside the agency. We intend that our investigations actively pursue indications of intentional violations of our regulations, and we intend that our staff be candid in discussing the conclusions of such investigations with us. I also appreciate the comments in your February 26 letter discussing our investigative activities. I will carefully consider your suggestions.

We are fully aware of your interest in the flow of information during the accident. I am personally grateful for your staff's help since my becoming Chairman of the Commission in highlighting their report to assist me in understanding the issues involved. With your continued help, we look forward to addressing the current major challenges facing nuclear regulation.

Commissioners Gilinsky and Bradford disagree with this letter. Their views are enclosed. Commissioner Ahearne's views are also enclosed.

Sincerely,

Nunzio Palladino

Nunzio J. Palladino

Enclosures:
As stated

cc: Rep. Manuel Lujan

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

February 4, 1982

The Honorable Nunzio Palladino
Chairman
United States Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Mr. Chairman:

I want to express deep dissatisfaction with the manner in which the Commission has handled one important aspect of the Three Mile Island accident. This concerns reporting failures that occurred on March 28, 1979. The initial inquiry conducted by the Office of Inspection and Enforcement (I&E) did not address the issue; the inquiry conducted by the NRC Special Inquiry Group was incomplete; and the most recent I&E investigation undertaken after my repeated urging was wholly inadequate.

You did not respond to my November 4, 1981 request for an explanation of I&E's failure to conduct a comprehensive inquiry with regard to reporting of information to State officials. Recently we have observed the sorry spectacle of high level Commission staff seeking to make a distinction between "knowingly" and "willfully" withholding information required to be reported by NRC regulations, a distinction that appears acceptable to a Commission majority.

This history does little to inspire confidence in the Commission's ability to confront situations involving an apparent willful violation of its regulations.

For my part, I do not accept your staff's tortured distinctions between "knowingly" and "willfully." Notwithstanding the fundamentally flawed character of the NRC investigations, the record is such that a fair reading of it leads to the conclusion that significant information was willfully withheld from State and Federal officials on the first day of the accident at Three Mile Island.

*7602100281

If I believed that continuation of our dialogue on this matter would lead to a satisfactory resolution, I would continue to press for a response, particularly to the question as to whether the Commission believes that persons, who acted as stated in the conclusions of the House Interior Committee staff report, did willfully violate the Commission's regulations. But given the Commission's apparent determination to avoid confronting the issue directly, I have concluded that further requests for a clear resolution are destined to result only in more obfuscation.

Finally, your inaction on this matter has done more than to raise questions about the Commission's credibility. Your response to this serious violation of NRC regulations conveys to your staff the notion that circumstances exist where the interest of the greater good dictates avoidance of findings that would force administrative actions that imply commission of a criminal act. Moreover, in permitting staff to conceal a problem with obfuscatory language and with words having meanings different from those in common usage, you set a poor example for your licensees.

Sincerely,

MORRIS K. UDALL
Chairman

NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

January 27, 1981

cket No. 50-320
-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.

Tha 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.

8102260535

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 Procedure 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

COMMISSIONER BRADFORD'S SEPARATE REMARKS

I would like to reiterate the conclusion of my February 24, 1981 letter on this matter. In particular, I believe that the committee staff view is probably correct. I see no useful distinction to be made between "knowingly" and "willingly." Both Commissioner Gilinsky and I voted unsuccessfully in October 1979 to revoke rather than suspended the TMI licensing precisely because we felt that willfulness need not be proven in view of the importance of the information that did not flow.

Nonetheless, I continue to feel that enforcement action against the individuals would fail. My conclusions are not altogether free from doubt. The investigative groundwork is inadequate to support such a proceeding. The investigators and enforcers have no heart for it. An action that failed would be worse than nothing, for that result would appear to condone a state of affairs that the Commission has already condemned in other ways.

For these reasons, I see nothing further to be gained from actions against individuals involving charges of deliberately withholding information. However, this subject is a legitimate area of concern in the TMI-restart proceeding.

COMMISSIONER GILINSKY'S SEPARATE REMARKS

I do not share the Commission's assessment of its handling of GPU's reporting failures during the Three Mile Island accident. The first NRC investigation of this question was superficial. After that, the Commission pursued this matter only at the insistence of your Committee. Each step was taken reluctantly and grudgingly. Just as the Company was too weak to level with the State and Federal authorities on the day of the accident, and too weak to confront that failure afterward, so NRC has been too weak to carry out its responsibilities. Both the Commission and the Staff have hidden behind every ambiguity to explain away any wrongdoing connected with the reporting failure. The Commission has, thus, avoided facing the implications of this failure for the finding it has to make in the TMI-1 case on the adequacy of the Company's management. At the outset of the TMI-1 hearing, the Commission refused to deal itself with the issue of the competence and integrity of the Company's management, and instead turned the matter over to a hearing board, which is inherently unsuited to deciding this type of issue. Ironically, this delegation has been the chief cause of the extraordinary prolongation of the hearing.

Recently, at long last, the Staff, in the person of Mr. Stello, finally conceded that significant information about the severity of the accident had been withheld "knowingly" by the Company on the day of the accident. But, Mr. Stello added, in what can only

be described as an Alice-in-Wonderland departure from the dictionary meaning of words, this involved no "intent" or "willfulness" on the Company's part.

If the Commission does indeed take the reporting failure seriously, it shows little sign of doing so in connection with the possible restart of TMI Unit 1. Even more serious than the reporting failure itself is the continued unwillingness or inability of the top management of the Company to face up to the wrongdoing in their ranks on the day of the accident. So far as I am concerned this disqualifies that management from operating nuclear plants in the future. I would not authorize GPU to operate a nuclear power plant until important changes have been made at the top.

Additional Comments of Commissioner Ahearne
in Response to
Congressman Udall's letter of February 4, 1982

I would have added the following to the Commission response:

"Your letter states that . . . "that record is such that a fair reading of it leads to the conclusion that significant information was willfully withheld from State and Federal officials . . . ." We did not reach that conclusion. However, if you have, it would appear appropriate for you to request the Justice Department to follow up on your conclusions."

In addition, I cannot allow Commissioner Gilinsky's criticism to go without a response.

Here the Commissioner describes the NRC as having "been too weak to carry out its responsibilities," the "Commission and the Staff" as having "hidden behind every ambiguity," and the Commission as having "avoided facing the implications." He goes on to critisize Mr. Stello for an "Alice-in-Wonderland" use of words. This criticism coincides with Congressman Udall's description of "staff's tortured distinctions," the "Commission's apparent determination to avoid confronting the issue directly," and "permitting staff to conceal a problem with obfuscatory language."

Over the last several years, there has been one issue here: Did Metropolitan Edison people on the day of the Three Mile Island accident deliberately not give a clear picture in order to mislead official people (NRC and State) into believing that the accident was less severe than it was. Commissioner Gilinsky and the Udall staff have concluded the answer to that is "yes." As Commissioner Gilinsky points out in his comments, he therefore believes that changes should be made at the top of Met Ed before the plant should be allowed to operate.

I agree with the Commissioner in that if I had reached the same conclusion he did, I would also believe that changes should be made. The difficulty is that the investigations have not shown that conclusion to be valid. The problem that both the Commissioner and the Udall staff have with the Commission's position is that our conclusion differs from their conclusion.

There apparently is a willingness on the part of the outside to perceive our staff, and therefore the Commission, as hiding, as avoiding inescapable evidence. It is unfortunate that most of those criticizing have not gone through the lengthy reexamination that the rest of us have. Our position has been and remains consistent with the result of the investigations. We have investigated and re-investigated and the result remains the same -- the investigators did not find that there was a deliberate - willful - withholding of information. They have resisted, admirably so, being pressured into taking a position that is different from the one that they reach honestly.

Over the past several years the NRC staff has attempted, in particular, Mr. Stello, with remarkable forebearance, to repeat over and over again the conclusions that were justified on the basis of the investigations. They have attempted to indicate the uncertain state of information that was available at the time of the accident and the confusion that reigned. As a result, yes, they concluded there was information that was not transmitted. However, they found no basis for concluding this resulted from a deliberate attempt to mislead.

As is well known to those following these episodes, the Udall staff conclusion that appears in the final report is different from the Udall staff conclusion that appeared in the draft report. The draft report conclusion was unacceptable to the NRC people who had been working with the Udall staff and were most familiar with the details of the investigation. The report conclusion was changed. The report conclusion became acceptable to the staff because the revision reflected the staff concerns and was consistent with the staff position.

The critics of the staff position have tried to use other words to describe it. When we disagree with their interpretation, they say "Ah-ha, you are now hiding behind cloudy words." I disagree. I believe we must reach our judgment on the basis of the facts. The information indicates the Commission's position is correct and the staff's position is correct. It is not Alice-in-Wonderland language. It is not obfuscatory language. It is clear: we did not conclude that the licensee personnel willfully misled the off-site people on the day of the accident. This is different from the conclusion of Commissioner Gilinsky and of the Udall staff. I regret that, but it is different.

I doubt my remarks will be interpreted as attempting to depict the true case. They will undoubtedly be depicted as an attempt to blow further smoke over the issue. I also regret that. However, the staff is being unfairly vilified.