LIC September 20, 1982

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

Before the Atomic Safety and Licensing Board

In the Matter of	)	
	)	
METROPOLITAN EDISON COMPANY	)	Docket No. 50-289 SP
	)	
(Three Mile Island Nuclear Station, Unit No. 1)	)	(Restart)

LICENSEE'S ANSWER TO AAMODT MOTION FOR THE NRC STAFF AND THE LICENSEE TO SHOW GOOD CAUSE AND/OR REOPENING OF RECORD

By Motion dated September 3, 1982, the Aamodts move[1/] that absent adequate explanation by Licensee and the Staff of their actions surrounding the discovery of unsecured radiation worker tests at TMI in May, 1982, the record should be reopened to explore this subject. Licensee opposes the Aamodt Motion.

In a recent Board Notification, the Staff provided to the Appeal Board and parties an NRC Inspection and Enforcement

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1/ The Aamodts' motion to reopen was filed with the Licensing Board; coincidently they filed related pleadings directly with the Commission and with the Appeal Board. It is not clear that the Licensing Board, rather than the Appeal Board, should entertain and decide the Motion to Reopen. Compare 10 C.F.R. § 2.717 (a licensing board has continuing jurisdiction until finality attaches to an NRC decision) with 10 C.F.R. § 2.718 (a licensing board has explicit authority to reopen a proceeding at any time prior to initial decision). See also Pacific Gas and Electric Company (Diablo Canyon Nuclear Power Plant, Units 1 and 2), ALAB-598, 11 N.R.C. 876 (1980) (following an initial decision and

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Division (I&E) inspection report. The inspection report concerned, inter alia, an incident in early May at TMI where radiation worker examination materials utilized by Licensee's training personnel were found unsecured in a training supervisor's office. The report discusses Licensee's discovery of the examination materials and Licensee's and NRC's actions subsequent to the discovery. The inspection report concludes that adequate corrective action was taken as a result of the incident.

Based on the inspection report and on information and belief, the facts surrounding this incident are:

(1) Licensee employs as an independent quality check on radiological matters at TMI an individual called a Radiological Assessor who has freedom to surveil and inspect

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briefing of exceptions but prior to oral argument on exceptions, Appeal Board reopened proceeding upon a party's motion). It is clear that the Licensing Board, in the first instance, has the inherent right and duty to determine its own jurisdiction. See, e.g., Duke Power Company (Perkins Nuclear Station, Units 1, 2 and 3), ALAB-591, 11 N.R.C. 741, 742 (1980). The Appeal Board, in a similar setting, observed that the licensing board at this juncture in a proceeding is much more familiar with the record already developed than the Appeal Board. See Duke Power Company (Perkins Nuclear Station, Units 1, 2 and 3), ALAB-597, 11 N.R.C. 870, 874 (1980). We expect this to be the case here. In any event, we urge prompt disposition of the Aamodt Motion. If the Licensing Board determines that it has jurisdiction, then we would ask that it decide the Motion as quickly as possible; if, on the other hand, it decides it does not have jurisdiction, we ask that the Motion and responsive pleadings be forwarded directly to the Appeal Board for its consideration without further pleadings or delay. Outstanding motions to reopen carry a pall which lingers over a proceeding so long as the motions remain unresolved. Every effort -- obviously consistent with procedural safeguards and due process -- should be expended to avoid unnecessary delay in deciding the Aamodt Motion.

all facets of radiological training and practices at TMI and report his observations directly to the highest levels of GPUNC management. The Radiological Assessor also provides, at management direction, routine written reports which are distributed to management and directly to NRC.

(2) On May 5, 1982, the Radiological Assessor uncovered radiation worker training examination materials in a brown file folder on a shelf in the office of the general employee training supervisor and in a drawer in an unlocked file cabinet in the same office.

(3) His observations were reported immediately to upper management in the radiological controls department and as well the next day to training management.

(4) On May 6, 1982, the general employee training supervisor was confronted with these facts by training management. His explanation for the examinations' not being better secured was judged inadequate and he was specifically instructed to adhere to examination security requirements.

(5) On May 7, 1982, training management inspected and again examination materials were found inadequately secured in the same individual's office. The materials were immediately removed by management and secured.

(6) The supervisor involved in this incident was severely reprimanded and shortly thereafter chose to resign from GPUNC before final disciplinary action had been taken.

(7) All subsequently administered examinations of the type involved were rewritten. These new exams and their grading keys have been kept locked when not in use.

(8) Licensee completed on May 7, a survey of examination security practices throughout the TMI Training Department. It was determined that the incident involving the general employee training supervisor did not represent any other training sections at TMI, and that the incident appeared to be an isolated one attributable to a single individual's practices. Through the audit, Licensee did identify general areas for continued improvement in exam security. The more general concerns identified were (a) need to review physical arrangements of cubicle offices and locking arrangements; (b) need to upgrade word processing system security; (c) need to hand-carry all examinations; (d) need to develop question banks; and (e) need to review and revise plant procedures on examination security.

(9) A subsequent audit by Licensee Quality Assurance personnel confirmed that throughout the training department all file cabinets containing examination questions, graded examinations and records are bar-locked.

(10) Licensee's Radiological Assessor in his routine report of observations on May 11, 1982, informed on-site NRC inspection personnel of the incident and discussed the details of the incident with them at that time.

(11) During the period May 11 through June 8, NRC I&E personnel conducted an inspection of Licensee's activities at TMI-1. One of the items inspected was the incident involving the unsecured radiation worker examinations. NRC reviewed the incident and Licensee's responses. In a Report (Inspection 50-289/82-07), dated July 1, 1982, NRC concluded that Licensee's response was adequate both to the specific incident and to the more general concerns which Licensee had identified during its review of all training sections between May 5 and May 7.

(12) In a Board Notification (BN-82-84), dated August 17, 1982, the Staff forwarded Inspection Report 50-289/82-07 to the Appeal Board and parties reporting that it "considers that adequate corrective actions were taken by the Licensee as a result of this incident."

Citing the Board Notification as their basis, the Aamodts now seek to reopen the record in this proceeding.[2/] As we understand the Aamodts' argument, it is two-fold. First, they argue that this is "new information which directly relates to a specific issue of the reopened proceeding, to the issues of the reopened proceeding in general, and to the Board's confidence that quality assurance practices, conditions to restart,

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2/ The Motion actually would have the Board require Licensee and NRC to make a number of what the Aamodts characterize as "good cause" showings; unless those showings were sufficient, the Aamodts argue, the record should be reopened. In any event, the Aamodts maintain "the information" [sic] should be entered into the record by stipulation. The Aamodts put the cart before the horse. It may be that Licensee (or the Staff) would have the burden of proof

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will be instituted." Motion, at 1. There is no identification of the "specific issue," issues "in general" or "conditions to restart" to which the Aamodts are referring, nor how those issues are impacted by the new information. To be sure, examinations and testing were the general subject matter of the Reopened Phase of this proceeding, but beyond that we are left to speculate as to the Aamodts' views. Second, the Aamodts allege that this matter "raises questions of the integrity of the Licensee's upper management and the NRC Staff in that this information was withheld from the purview of the reopened proceeding for over three months." The facts are that Licensee's Radiological Assessor, acting on instructions by Licensee's management, promptly in May reported the incident to NRC and that NRC in concert with its ongoing inspections of Licensee's activities at TMI-1 in a number of areas, specifically reviewed this incident and Licensee's responsive actions. The Staff's filing of its Inspection Report in the Public Document Room on July 22, 1982 (see notation "820722 . . . PDR," page 1 of Attachment 2 to Aamodt Motion) and the date of its Board Notification as August 17, 1982, hardly seem consistent with a design to delay notice to the Aamodts until after comments and reply comments on immediate effectiveness were due to the Commission.

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on issues admitted in a reopened hearing, and it may be as well that the issues in any reopened hearing would be as broad as the range of issues the Aamodts suggest are appropriate in their Motion (at 2). The record, however, has not been reopened at this juncture. Whether to reopen the record is the issue and it is the Aamodts as the proponents of reopening who have the burden. See pages 7-10, infra.

The standards used in determining whether to reopen an evidentiary record are well settled in NRC case law. The proponent of a motion to reopen has a heavy burden. In order for the moving party to prevail, the motion must be both timely presented and addressed to a significant safety or environmental issue. Additionally, it must be established that a different result would have been reached initially had the material submitted in support of the motion been considered. Kansas Gas and Electric Company, et al. (Wolf Creek Generating Station, Unit No. 1), ALAB-462, 7 N.R.C. 320, 338 (1978), and cases cited therein. See also Pacific Gas and Electric Company (Diablo Canyon Nuclear Power Plant, Units 1 and 2), CLI-81-05, 13 N.R.C. 361, 362-63 (1981) (endorsing these principles as "long-standing Commission practice").

The Aamodts' Motion falls short of this mark. Accepting the representation that the Aamodts first learned of this incident on September 2, we do not question the timeliness of the Motion. It is, however, inconceivable that a different result would have been reached in this proceeding had the incident occurred earlier and the information been before the Board for its consideration with other evidence in the reopened proceeding.

The Board found that administrative procedures Licensee put in place subsequent to the disclosures of cheating, as supplemented by administrative safeguards imposed by Board condition, are well designed to protect the integrity of

company-administered examinations. PID ¶ 2068. In this regard, the Board took care to point out:

> [The procedures] must be enforced, however; thus we are not satisfied that the new procedures alone are adequate.

Id. The Board went on to outline as conditions a system of additional safeguards it believed should be imposed, including independent auditing over a two-year "probationary" period, internal auditing of training delivery and establishment of criteria for instructor qualifications. Id. See also PID ¶ 2421.

Licensee has in place new administrative procedures to safeguard the integrity of the examination process. Although the independent audit called for by the Board's decision has not yet been conducted, Licensee has instituted its own quality control checks on training procedures.[3/] The discovery of unsecured radiation worker exams was an isolated incident attributable to a single individual's practices and not representative of security conditions in other training sections. The discovery was made by Licensee personnel exhibiting Licensee's keen awareness of the need for security.

3/ We emphasize that these actions were not confined to radiation worker training, or to licensed operator training, but spanned all Licensee training department sections. Nor has Licensee viewed the Board's conditions, requiring audits and instructor criteria, as confined to one or another training section. Licensee is proceeding with its administrative upgrading, audits and instructor qualification criteria development throughout the training department. Thus, to the extent the Aamodts view the May incident as requiring reopening because it involved a radiation worker examination rather than a licensed operator examination, their argument is without substance.

Management's response was swift and appropriate, indicative of Licensee's appreciation for the seriousness of any breakdown in procedures to safeguard examination security. Although there is no indication that examination security was breached, new examinations were immediately developed and thereafter administered; the individual was severely reprimanded and subsequently resigned. Licensee immediately initiated a review of all training areas to determine whether any other training section or whether any other individual employed less than the optimum practices, and subsequently had conducted an audit of its training sections by quality assurance personnel as a further check on examination security practices.[4/] NRC was promptly informed of the incident and their inspection concluded Licensee's response was adequate.

This is not the response of a naive, disinterested or negligent management. To the contrary, the incident displays an awareness of the need for examination security and prompt management reaction both as to substantive exam requirements and training personnel's need to adhere strictly to safeguarding practices. Under these circumstances, it is inconceivable that the Board's decision, even had it included consideration of the May incident, could have resulted in a determination unfavorable to restart.

4/ It is these same factors which led Licensee to content itself with promptly notifying NRC on-site personnel of the incident and not to deem the incident as sufficiently significant to warrant Board notification. Licensee has on a number of occasions provided notification to the Licensing and Appeal Boards of changed circumstances warranting such action. See Licensee letters of June 4, 1981; October 1, 1981; November 3, 1981; March 11, 1982; April 22, 1982; and August 10, 1982.

For the above reasons, Licensee opposes a further reopening of the record in this proceeding and urges that the Aamodt Motion of September 3, 1982, be denied.

Respectfully submitted,

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DATED: September 20, 1982.

LIC September 20, 1982

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NUCLEAR REGULATORY COMMISSION

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing LICENSEE'S ANSWER TO AAMODT MOTION FOR THE NRC STAFF AND THE LICENSEE TO SHOW GOOD CAUSE AND/OR REOPENING OF RECORD was served this 20th day of September, 1982, by hand delivery to those persons on the attached Service List designated by an asterisk (*) preceding their names; and by deposit in the United States mail, postage prepaid, addressed to all other persons on the attached Service List.

Ernest L. Blake, Jr.

UNITED STATES OF AMERICA

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