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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

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BEFORE THE COMMISSION

OFFICE OF SECRETARY
DOCKETING & SERVICE

In the Matter of)
METROPOLITAN EDISON COMPANY, ET AL.)
(Three Mile Island Nuclear Station,)
Unit No. 1))

Docket-No. 50-289
(Restart)

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NRC STAFF'S BRIEF IN RESPONSE TO CLI-84-18

Jack R. Goldberg
Counsel for NRC Staff

October 9, 1984

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I. INTRODUCTION

On September 11, 1984, the Commission issued an Order (CLI-84-18) regarding the management issues in the restart proceeding.^{1/} In that Order, the Commission decided to review five issues: (1) whether further hearings are warranted on the three issues which the Appeal Board remanded to the Licensing Board in ALAB-772 (adequacy of Licensee's training program, the 1979 mailgram from Herman Dieckamp to Congressman Udall, and leak rate testing practices at TMI-1); (2) whether the Appeal Board had the legal authority to remove Charles Husted from supervisory duties for non-licensed personnel without providing him with notice and an opportunity to request a hearing; (3) whether, in view of changed

^{1/} In another Order issued on September 11, 1984 (CLI-84-17), the Commission denied Licensee's request to stay the reopened management hearings ordered in ALAB-772 and granted TMIA's request to lift the stay of the hearing on the Hartman allegations related to leak rate testing practices at TMI-2 ordered in ALAB-738.

circumstances, further hearings are required on the Hartman allegations (as directed by the Appeal Board in ALAB-738) separate from the restart proceeding; (4) whether any of the information discussed in NUREG-0680, Supp. No. 5, requires further hearings; and (5) whether further hearings are required to determine the final disposition of the status of any individuals separated by Licensee or the Commission from the operation of Unit 1. The Commission directed the parties to use the traditional standards for reopening a record^{2/} in addressing these issues. The Staff's position on each of these issues follows.

2/ The traditional tripartite test for reopening a record has been stated as follows:

- (1) Is the motion timely?
- (2) Does it address significant safety (or environmental) issues?
- (3) Might a different result have been reached had the newly proffered material been considered initially?

Pacific Gas and Electric Co. (Diablo Canyon Nuclear Power Plant, Units 1 and 2), ALAB-598, 11 NRC 876, 879 (1980). Typically reopening is sought by a party who must demonstrate, inter alia that its motion to reopen is timely. Because the Commission is now asking the parties for their views on whether various previously raised issues warrant reopening at this time, the timeliness factor is not strictly applicable to the analysis. The Staff therefore will focus on the significance of each issue and whether the new information on each issue might have caused a different result to be reached had it been considered initially.

II. DISCUSSION

A. Whether Further Hearings Are Warranted on the Three Issues Which the Appeal Board Remanded in ALAB-772

On May 24, 1984, the Appeal Board issued its decision on the management and cheating issues (ALAB-772, 19 NRC 1193 (1984)). The Appeal Board concluded that in certain respects, the evidentiary record was not sufficiently developed to support the Licensing Board's favorable findings concerning Licensee's management of TMI-1. The Appeal Board remanded the proceeding to the Licensing Board for further development of the record in two areas: Licensee's training and testing program and the circumstances surrounding the 1979 mailgram from Herman Dieckamp to Congressman Udall. The Appeal Board also reopened the record on the issue of leak rate testing practices at TMI-1.

1. Licensee's Training and Testing Program

With respect to Licensee's training and testing program, the Appeal Board stated that the principal difficulty with the Licensing Board's decision was its failure to reconsider, in a meaningful way, its earlier favorable findings in light of the cheating findings. The Appeal Board said that since the Licensing Board relied so heavily on the expert testimony of Licensee's outside consultants (especially the OARP Committee) for its original favorable findings on training and testing, it was incumbent on the Licensing Board to seek further testimony from those independent experts on whether the cheating incidents alter their earlier favorable testimony. ALAB-772, 19 NRC at 1234.

The Staff does not believe that reopening the record is warranted solely because Licensee's consultants in the original management hearing testified prior to the discovery of the cheating incidents, and consequently their testimony did not reflect the evidence on cheating and its impact on the adequacy of Licensee's training and testing program. The Appeal Board itself agreed that the reopened proceeding on cheating, especially the hearing, was "as thorough as possible." ALAB-772, 19 NRC at 1232. The Licensing Board, after reviewing the Special Master's Report on Cheating and conducting its own independent review of the entire evidentiary record (see Cheating PID, 16 NRC 281, 288-89), reviewed its earlier conclusions on Licensee's training and testing program and specifically reaffirmed its overall adequacy. Id. at 299-301. Thus, while Licensee's consultants had not considered the effect of the cheating incidents on the Licensee's training and testing program, the Licensing Board itself did so directly and concluded, in effect, that the new information did not change the Licensing Board's overall decision on the training issue. It follows that the standards for reopening the record on the training issue are not met merely because Licensee's consultants did not account for the cheating incidents in the original management proceeding.^{3/}

^{3/} The Staff acknowledges that there may have been some legitimate doubts, at the time of ALAB-772, about how the OARP Committee's testimony on Licensee's training and testing program would have been affected by the Committee's knowledge of the cheating incidents and other deficiencies. At this time, however, it is clear that the OARP Committee has evaluated the cheating incidents and other deficiencies and concluded that Licensee's training and testing program is adequate to support restart. Special Report of the Reconstituted OARP Review Committee, June 12, 1984, at 83. This confirms the Licensing Board's favorable resolution of the training issues after considering the cheating evidence and demonstrates that there is no information on this matter which likely would cause the Licensing Board to reach a different conclusion on the adequacy of training at TMI-1.

Beyond the Appeal Board's concern with the adequacy of the evidentiary record on training, the Staff examined the training issue from a broader perspective. As reflected in NUREG-0680, Supp. No. 5, § 7.0, the Staff considered a number of training-related matters which potentially could affect the overall resolution of the training issue. For example, the Staff considered the Licensee's after-the-fact response to the cheating incidents, Licensee's concern for operator attitudes, the current management involvement in training irregularities, and improvements to the training program subsequent to the cheating incidents. The Staff reviewed material contained in the BETA and RHR reports and the INPO evaluation with respect to training and concluded that none of the information therein should affect TMI-1 restart (NUREG-0680, Supp. No. 4), and that the training staff is performing adequately and is obtaining credible training results (*id.* at 4-8). The Staff also reviewed the OI reports on preaccident training irregularities from the standpoint of involved individuals and their postaccident training responsibilities. The Staff concluded that the training-related information examined since the close of the record does not raise a significant safety issue which would cause the Licensing Board to reach a different overall result. Had the Staff believed that a significant issue was raised by the training information which might have caused the Licensing Board to reach a different result, the Staff would have moved to reopen the record.

There now exists a number of evaluations and inspections of Licensee's current training and testing program which have been provided to the Commission by the Staff and Licensee, including SALP reports, INPO

evaluations, NRC Inspection Reports, a Region I Operational Readiness Evaluation, and the recent Special Report of the Reconstituted OARP Committee, which responds to the particular concerns with training expressed by the Appeal Board in ALAB-772. These evaluations and inspections are generally favorable to Licensee's training and testing program and are generally consistent with the Licensing Board's favorable resolution of the training issues. Thus, this new information on training does not raise a significant issue which likely could cause the Licensing Board to reach a different result. The Staff concludes, therefore, that the standards for reopening the record are not satisfied with regard to training.

Although the Staff does not believe that the standards for reopening the record are satisfied on the training issue, it may be in the public interest for the Commission, as a matter of discretion, to allow the Licensing Board to conduct a hearing on the training issue. The issue of the adequacy of Licensee's training and testing program is itself one of the most fundamental and important of the restart proceeding.^{4/} The presently anticipated hearing on training before the Licensing Board, whose scope has been correctly defined by the Licensing Board consistent with the Appeal Board's remand order (ALAB-772), would provide the Commission and the public with a current evidentiary record on the adequacy of training and testing at TMI-1. Such a record should resolve all reasonable concerns that there may not be in place at TMI-1 an

^{4/} In addition, as a practical matter, the current schedule for a hearing on the remanded training issue is such that it likely will be completed this fall, perhaps before the Commission decides the issues raised in CLI-84-18 and before an actual restart decision.

adequate training and testing program. For these reasons, the Staff does not oppose a hearing on Licensee's training and testing program whose scope is as presently defined by the Licensing Board.

2. The Dieckamp Mailgram

The Appeal Board remanded the Dieckamp mailgram issue to the Licensing Board because Mr. Dieckamp still holds key, high-level management positions in both GPU Nuclear and GPU and the Appeal Board believed that the record was not fully developed on this important issue. ALAB-772, 19 NRC at 1265-68. It appears from ALAB-772 that the primary reason why the Appeal Board found the record deficient, and criticized the Licensing Board for unreasonably relying on the results of the Staff's investigation of this issue, was the Appeal Board's mistaken belief that the Staff may not have actually questioned Mr. Dieckamp himself about his state of knowledge at the time he sent the mailgram. Id. at 1267. Thus, the Appeal Board questioned whether there was a sufficient basis for the Staff's testimony that the Staff had concluded Mr. Dieckamp believed the message he was trying to convey in the mailgram was true. See Tr. 13,063-64 (Moseley).

In fact, the Staff's lead investigator and witness on the information flow issue, Mr. Norman C. Moseley, questioned Mr. Dieckamp under oath at length about Mr. Dieckamp's state of knowledge at the times of the pressure spike and subsequent mailgram and about what information was conveyed to Mr. Dieckamp from others who may have had knowledge of the pressure spike. See Staff's investigative interview of Herman M. Dieckamp, September 12, 1980. Although Mr. Dieckamp's sworn statement was not introduced into evidence in the restart proceeding, it does demonstrate that in fact there was a basis for Staff's testimony that

Mr. Dieckamp believed his mailgram statement to be true.^{5/} Thus, the Licensing Board's reliance on Staff's investigation and testimony on the Dieckamp mailgram issue was not unreasonable as suggested by the Appeal Board.

The evidentiary record on this issue is not fatally deficient and there is no valid reason to have a hearing now on this issue. The Appeal Board itself recognized that "such a hearing, now five years after the fact, may not be particularly fruitful. Memories fade, making selective recall a problem." ALAB-772, 19 NRC at 1268. But the Appeal Board believed it was "worth some additional effort," and thus ordered a hearing on the issue. Because the Appeal Board's remand of this issue appears to be based, to a large extent, on its mistaken belief that there was not a sufficient basis for the Staff's testimony on which the Licensing Board relied, the Commission should rule that there is no need for a further hearing on the issue.

In summary, the Appeal Board erred in remanding the record on the Dieckamp mailgram issue. The evidentiary record is not deficient as suggested by the Appeal Board, and the Licensing Board did not unreasonably rely on Staff's investigation and testimony. There is no new information on this matter which raises a significant safety issue and which likely would cause the Licensing Board to reach a different

^{5/} The Licensing Board apparently knew that the Staff questioned Mr. Dieckamp personally: "You people have interviewed Mr. Dieckamp and everyone is [sic] involved, and I am interested in your opinions rather than the details of it." Tr. 13,063 (Chairman Smith to Mr. Moseley).

result on any issue. The Staff, therefore, does not believe that any further hearings on the Dieckamp mailgram issue are warranted.

3. TMI-1 Leak Rates

The third issue on which the Appeal Board reopened the record is leak rate testing practices at TMI-1. ALAB-772, 19 NRC at 1276-78. The Commission now has the Staff's Inspection Report 50-289/83-20, September 21, 1983, and its revision dated February 24, 1984, the Office of Investigations Report No. 1-83-028 and Supplement, both dated April 16, 1984, and the Staff's analysis of the available information on this issue, NUREG-0680, Supp. No. 5, § 4.0. On the basis of Staff's independent review of the information, the Staff concluded that "the evidence does not support a finding that leak rate surveillance tests at TMI-1 were intentionally or systematically falsified during the period investigated." NUREG-0680, Supp. No. 5, at 4-17.^{6/} The Commission also has Licensee's investigative report on TMI-1 leak rate testing practices (TMI-1 Reactor Coolant Inventory Balance Testing Report by Edwin H. Stier, June 13, 1984), which concluded (at 9) that the "evidence demonstrates that TMI-1 personnel did not manipulate or otherwise improperly influence the outcome of reactor coolant inventory balance tests." This voluminous information fails to raise any significant safety issue which would cause a different result to be reached on any issue in the restart proceeding.

^{6/} The Staff also noted, however, that it is impossible to exclude the possibility that some individual operators may have attempted to manipulate test results for some unknown reason. NUREG-0680, Supp. No. 5 at 4-17.

Not only are the standards for reopening not satisfied on the issue, but, for the reasons stated in NUREG-0680, Supp. No. 5, the Staff does not believe a hearing on this matter would serve any useful purpose.

Specifically, the evidence does not support a finding of intentional leak rate manipulation; there was no motive to falsify leak rate results; the calculational errors identified in the inventory balance test procedure have been corrected; all leak rate surveillance tests at TMI-1 are now retained regardless of the result; and modifications have been made to the makeup tank level instrumentation ("loop seal") such that hydrogen additions to the makeup tank can no longer affect indicated level. In summary, the investigations performed by OI and the Licensee, and the Staff evaluation presented in NUREG-0680, Supp. No. 5, have not identified a management integrity issue associated with past or current TMI-1 leak rate testing practices.^{7/}

B. Hartman Allegations Concerning TMI-2 Leak Rate Testing Practices

The Commission asked the parties to address whether the restart proceeding should have been reopened for a hearing on the Hartman

^{7/} The Appeal Board agreed that the overall conclusion of the OI reports on TMI-1 leak rate falsification is favorable to Licensee, but nevertheless reopened the record because the reports reveal (1) a lack of understanding of record-keeping requirements, (2) ignorance of the significance of a "loop seal" in the instrumentation system for leak rate calculations, and (3) inattention to work requests that would have highlighted the loop seal problem. ALAB-772, 19 NRC at 1278. The Staff does not believe that these items raise a significant safety issue for restart warranting reopening the record. These items, which do not appear to raise any integrity issue, but rather raise competence issues, concern past Licensee practices, not the present organization or procedures. Absent a nexus between these deficiencies and current TMI-1 personnel or procedures, it cannot be said that this new information raises a significant safety issue warranting another hearing.

allegations,^{8/} and if not, whether there should be a hearing on the Hartman allegations separate from the restart proceeding. CLI-84-18 at 8. The Staff does not believe that there should be a hearing on the Hartman allegations, either as part of or apart from, the restart proceeding.

The Staff's findings and conclusions on TMI-2 leak rate testing practices are set out in NUREG-0680, Supp. No.5, at 5-6 to 5-7 and 13-2 to 13-3. The Staff stated:

The staff findings that falsification of TMI-2 leak rate tests occurred and that negligence on the part of management created, in part, the circumstances that resulted in leak rate falsification, raise questions concerning Met-Ed character or management integrity.

Id. at 5-7. The Staff also concluded that

first-line supervision and possibly middle management was directly involved in leak rate falsification at TMI-2. The staff also concludes that Met-Ed was responsible for improper leak rate testing as well as for the poor attitudes of operators and first-line supervisors toward this test.

Id. at 13-2, 3.

The Staff further considered, however, the implications of these activities in terms of the fitness of particular individuals to hold responsible positions related to NRC-licensed activities. See id. at 13-10 to 13-19. In addition, of all the individual operators who were licensed for TMI-2 before March 1979, none who might have been involved or implicated in leak rate falsification at TMI-2 and who, therefore, were recommended by Staff for further investigation, are currently involved in TMI-1 restart activities. Id. at 5-5 to 5-6.

^{8/} The Appeal Board reopened the record for a hearing on the Hartman Allegations in ALAB-738. On September 11, 1984 the Commission lifted its earlier stay of that reopening. CLI-84-17.

There is, therefore, no purpose to be served by a hearing on TMI-2 leak rate practices as a part of the restart proceeding. In short, a hearing on TMI-2 leak rate practices would, for the most part, focus on individuals who are not involved with the management or operation of TMI-1 and consequently would produce little information material to, or likely to change the Licensing Board decision on, any restart issue.

With respect to individuals no longer at TMI-1 who may be involved or implicated in improper leak rate testing practices at TMI-2, the Staff, as it previously informed the Commission, is pursuing the possibility of separate enforcement actions under 10 C.F.R. Part 55 against selected individuals who currently possess NRC operator licenses. This approach permits narrow proceedings to which the individual, whose involvement is in question, is a party, rather than the licensee of the facility, with the attendant rights of the individual to offer evidence on his own behalf and challenge any evidence which may be used against his interests. The Staff believes this approach is clearly preferable to a general hearing on the broad issue of leak rate testing practices at TMI-2.^{9/}

In summary, the issue of TMI-2 leak rate testing practices should not be the subject of a TMI-1 restart proceeding hearing or any general hearing apart from the restart proceeding. The Staff is appropriately

^{9/} Among other disadvantages of a general hearing is the same issue regarding sanctions against individuals who are not parties to the proceeding which the Commission raised in CLI-84-18 regarding Mr. Husted. See § II.E. of this brief, infra.

pursuing individuals' involvement in leak rate testing irregularities at TMI-2 as individual enforcement matters.

C. NUREG-0680, Supp. No. 5

The Commission requested the parties views on whether any of the information addressed in NUREG-0680, Supp. No. 5, requires further reopening of the record.^{10/} CLI-84-18 at 9. The Staff's position is that nothing in NUREG-0680, Supp. No. 5, raises a significant safety issue which would cause the Licensing Board to reach a different result on any issue in the restart proceeding. Consequently, the standards for reopening the record are not satisfied for any matters addressed in NUREG-0680, Supp. No. 5.

Before discussing individually the specific subject areas addressed in NUREG-0680, Supp. No. 5, the Staff wishes to note that throughout its review of new information since the close of the record, including specifically the information evaluated in NUREG-0680, Supp. No. 5, the Staff has evaluated the new information against the standards for reopening the record and itself would have moved to reopen the record had it believed the standards were satisfied. The Staff did not, and does not now, believe that any matter addressed in NUREG-0680, Supp. No. 5, warrants reopening the record. Specifically, for the following reasons, the information on each of the subject areas of NUREG-0680, Supp. No. 5,

^{10/} The Commission stated that the parties should not address matters where motions to reopen the record have already been granted or denied on the same information cited by the Staff. CLI-84-18 at 9.

does not raise a significant safety issue which would cause a different result to be reached.

1. TMI-1 Leak Rate Falsification

This issue^{11/} is addressed in section II.A.3. of this brief, supra. For the reasons stated therein and in NUREG-0680, Supp. No. 5, § 4.0, the Staff does not believe that the standards for reopening the record are satisfied on this issue.

In contrast to the Hartman allegations concerning TMI-2, no allegations were made that leak rate test results at TMI-1 were intentionally falsified or manipulated. NRC Region I conducted a Special Inspection at TMI-1 to examine leak rate testing practices there in light of the alleged practices at TMI-2. That inspection was conducted between July 11 and September 9, 1983. (See IE Inspection Report 50-289/83-20, September 21, 1983). Based upon the results of that inspection, Dr. Thomas E. Murley, Region I Regional Administrator, requested that OI conduct an investigation to determine if there was a systematic pattern of falsification of RCS leak rate surveillance test data by control room operators at TMI-1 and to what extent, if any, Licensee's management was cognizant of, and involved in, such activity. OI completed its investigation on April 16, 1984. Based upon the results of the OI investigation, the Staff concluded:

^{11/} TMI-1 leak rate testing practices was the subject of an earlier motion to reopen the record granted by the Appeal Board in ALAB-772.

- (1) Only a small percentage of leak rate surveillance tests conducted at TMI-1 during the period examined were accomplished during periods when operator-induced evolutions occurred that would call into question the validity of these tests.
- (2) Of the questionable tests, technical analyses showed, except in three instances, the Technical Specification (TS) acceptance criteria for unidentified leakage would have been satisfied had the operator-induced evolutions not occurred.
- (3) There was no conclusive evidence to indicate any TMI-1 licensed or unlicensed operator intentionally performed plant evolutions during leak rate testing with the intended purpose of manipulating or falsifying leak rate test results.
- (4) There was no apparent motive or need to manipulate leak rate tests at TMI-1.
- (5) The investigation did not identify evidence that would indicate supervisory or management personnel placed pressure on the operators at TMI-1 to manipulate or falsify leak rate test results.
- (6) It was determined that it was common practice, during the period under investigation, for operators to discard what were deemed "invalid" leak rate test results; however, the evidence did not support a finding that the operators were performing these actions as a deliberate attempt to conceal actual leakage that was in violation of the TS acceptance criteria or to conceal this information from the NRC.

See NUREG-0680, Supp. No. 5, at 4-17 through 4-19.

In summary, the Staff concluded that the evidence did not support a finding that leak rate surveillance tests at TMI-1 were intentionally or systematically falsified during the period investigated. Therefore, the Staff does not believe the TMI-1 leak rate testing practices prior to March 1979 raise significant safety issues and does not believe that the Licensing Board would have reached a different result on any issue in the proceeding had this investigation been conducted earlier and the results been considered by the Licensing Board.

2. Hartman Allegations and Related Safety Concerns

The Hartman allegations of falsification of leak rate tests at TMI-2^{12/} was addressed in section II.B: of this brief, supra. For the reasons stated therein and in NUREG-0680, Supp. No. 5, §§ 5.0 and 13.0, the Staff does not believe that the standards for reopening the record are satisfied on this issue. Specifically, the Staff found that the following facts are supported by the NRC's investigation (i.e., both I&E in 1980 and OI in 1983-84) and by the prosecuting attorney's Statement of Facts read into the record as a part of the United States v. Metropolitan Edison Co. (Criminal No. 83-00185) trial settlement:

- (1) Some operators at TMI-2 willfully violated procedures and attempted to manipulate leak rate test results by the addition of hydrogen and/or water to the makeup tank. These operators were motivated to do so as a result of indirect pressure from management and/or a

^{12/} This issue was the subject of an earlier motion to reopen the record which was granted by the Appeal Board in ALAB-738.

desire by individual operators to obtain satisfactory leak rate test results.

- (2) The identified leak rate increased as a result of increased leakage through the pressurizer relief valves, and it became more difficult for operators to obtain satisfactory leak rate test results as the date of the accident approached. First-line supervision (i.e., shift foreman and shift supervisors) were knowledgeable of the difficulties operators were experiencing in obtaining satisfactory test results. Because of the difficulty in obtaining satisfactory results, the control room operators would run leak rate tests frequently and also would discard those results that indicated unacceptable leak rates. It was not uncommon to run the test several times on the same shift.
- (3) Operators regarded the leak rate test as unreliable and ineffective for determining actual unidentified leak rate. The test procedure developed by the Licensee was ineffective in demonstrating conformance with requirements of the Technical Specifications.

See NUREG-0680, Supp. No. 5, at 13-2.

These facts support the Staff's conclusion that first-line supervision and possibly middle management were directly involved in leak rate falsification at TMI-2. The Staff also concluded that Met-Ed was responsible for improper leak rate testing as well as for the poor attitude of operators and first-line supervisors towards this test.

NUREG-0680, Supp. No. 5, at 13-2, 13-3.

The evidence presented to the grand jury and developed by the U.S. Attorney, however, did not indicate that any of the directors or officers

of GPUN, from the time of its organization in 1982 to the date of the indictment, or any of the directors of Met-Ed during the period of the indictment, participated in, directed, condoned, or were aware of the acts or omissions that were contained in the indictment. See NUREG-0680, Supp. No. 5, at 5-4. In addition, individuals who might have been involved or implicated in leak rate falsification at TMI-2 are not licensed for, or involved in, TMI-1 operations.^{13/}

Thus, while the information developed as part of the NRC and the Department of Justice (DOJ) investigations into this matter does address significant safety issues and might well have led the Licensing Board to reach a different result with regard to the adequacy of previous TMI-1 staffing had this information been considered by the Board, the individuals possibly involved in culpable activities are no longer associated with TMI-1 operations. Therefore, there is no remaining significant safety issue regarding TMI-1 which would warrant a hearing on TMI-2 leak rate practices as part of the TMI-1 restart proceeding.

^{13/} As noted in CLI-84-18 at 8, n.3, M. J. Ross, currently Manager of Plant Operations at TMI-1, is the only individual currently involved in plant operations at TMI-1 who was formerly licensed on TMI-2 at the time of the accident. OI's investigation into leak rate practices at TMI-1 did not identify evidence of either allegations or implications that Ross was involved in any improprieties associated with leak rate testing at either TMI-1 or TMI-2. This same conclusion is also supported by the Staff in NUREG-0680, Supp. No. 5, at 13-16, 13-17. (The Staff is currently conducting a joint NRR/OI investigation with respect to specific individuals who may have been involved or implicated in improper leak rate testing practices at TMI-2 and who are currently licensed under 10 C.F.R. Part 55 at facilities other than TMI-1.)

Finally, NUREG-0680, Supp. No. 5, addresses concerns associated with Mr. Hartman other than leak rate falsification at TMI-2, namely, concerns about the estimated critical position during a reactor startup at TMI-2 on April 13, 1978 (§ 5.3), emergency feedwater (EFW) pump surveillance tests (§ 5.4), a request to shut down TMI-2 to correct leakage (§ 5.5), and the termination of Mr. Hartman (§ 5.6).^{14/} It also addresses Licensee's reporting of the Faegre & Benson Investigation Report (§ 5.7). For the reasons set forth in NUREG-0680, Supp. No. 5, § 5.0, the Staff does not believe these matters raise significant safety issues which could change the Licensing Board's decision on any issues in the restart proceeding. Specifically, the Staff concluded the following:

- (1) It was not possible to determine whether procedural violations did or did not occur during the reactor startup at TMI-2 on April 13, 1978, as alleged by Hartman. In any event, the issue does not raise questions concerning management integrity.
- (2) Hartman's concern that it was difficult to perform EFW pump surveillance tests and obtain results within the allowable acceptance criteria (reference values) was valid. IE's investigation into this matter concluded that the Licensee's review, evaluation, and implementation of revised reference values for the surveillance tests were technically correct; however, it is apparent that the bases for those changes were not communicated

^{14/} The issues addressed in §§ 5.5, 5.6, and 5.7 were not raised by Mr. Hartman but were raised as a result of NRC's investigation into the Hartman allegations.

to the operators conducting those tests. This issue does not raise questions concerning management integrity.

- (3) On the basis of the available information, there was no conclusive evidence to support the allegation that before the accident at TMI-2, a shift supervisor requested permission from the load dispatcher to shut down the plant for repairs because of high leakage from the pressurizer safety and relief valves and that permission was subsequently denied by the dispatcher. This issue also does not raise questions concerning management integrity.
- (4) Hartman was not harassed or threatened about his job for voicing his concerns about safety issues. Hartman voluntarily resigned. There is no evidence of impropriety by management in the termination of Hartman.
- (5) The Licensee failed to make a timely Board Notification concerning the Faegre & Benson Report (licensee's investigation of the Hartman allegations) and certain depositions associated with the GPU v. B&W lawsuit record.

See NUREG-0680, Supp. No. 5, at 5-18.

The Staff does not believe that items (1) through (4) above, taken either individually or collectively, satisfy the test for reopening the record. The information developed on these four matters do not raise significant safety issues, nor is it likely that had the information been known and considered by the Licensing Board earlier, it would have affected the Licensing Board's resolution of any issue.

With respect to item (5), the Commission directed the Staff in March 1983 to examine whether any reporting requirements were violated

by GPU's submittal of the report in 1983, nearly 3 years after the report had been completed. As discussed in NUREG-0680, Supp. No. 5, § 5.7, the Staff concluded at that time that the creation of the Faegre and Benson Report and the Hartman depositions themselves did not appear to give rise to any new reporting obligation under the plant Technical Specifications or specific Commission Regulations and that no material false statement by omission was made. The Staff did conclude, however, in light of the matters being adjudicated in the TMI-1 restart proceeding, that the Licensee should have made a board notification concerning the Faegre and Benson Report and the Hartman depositions. As discussed below in section II.C.3. of this brief, these past failures to evaluate and provide these documents in a timely manner have been the subject of corrective action by the Licensee. Therefore, the Staff does not consider it likely, at this time, that the Licensing Board would alter its conclusions based upon the Licensee's past failure to make a timely board notification on the Faegre and Benson Report and related depositions.

3. BETA and RHR Reports

For the reasons stated in NUREG-0680, Supp. No. 5, §§ 6.0, and 13.0, the Staff does not believe that the Licensee's failure to make timely board notifications regarding the BETA and RHR reports raises any significant safety issue which could result in a different Licensing Board decision on any issue in the proceeding.^{15/} Specifically, the

^{15/} The Staff's technical evaluation of the contents of the BETA and RHR Reports is contained in NUREG-0680, Supp. No. 4.

Staff concluded that the Licensee can be considered to have failed to meet its duty to make board notifications and its obligations under the Atomic Energy Act by failing to provide the BETA and RHR reports in a timely manner. However, based upon the the record compiled by OI during its investigation into the BETA and RHR reportability issue, the Staff does not find any basis for questioning the managerial integrity of any individual involved in these matters; i.e., the Staff is satisfied that there was no deliberate attempt or concious management decision by GPUN to withhold the information in the BETA and RHR Reports from the NRC. NUREG-0680, Supp. No. 5, at 6-3.

The Licensee's failure to have undertaken an evaluation of the BETA and RHR Reports (and the Faegre & Benson Report, discussed in section II.C.2, supra) for the purpose of determining the need for a board notification represents a lapse in the performance of the Licensee's regulatory responsibilities. NUREG-0680, Supp. No. 5, at 6-3 and 5-17. However, these past failures to evaluate and provide these reports to NRC in a timely manner have been the subject of corrective action by the Licensee, as described in letter from P. Clark to D. Eisenhut, dated June 29, 1984. As a direct result of the BETA and RHR reportability issue, GPUN provided guidance to its employees on the obligation to report relevant and material information to the NRC. In addition, the Licensee undertook a retroactive review of past documents for reportability. In May 1984, the President of GPUN again directed that the reportability of information relative to issues under review by Licensing Boards or NRC Staff be discussed with all managers and professional staff. This memorandum also directed that corporate policy

and procedure guidance be developed for this matter. See Letter from P. Clark to D. Eisenhut, dated June 29, 1984 at Encl. 9, 10, and 11, and NUREG-0680, Supp. No. 5, at 6-3 and 13-9.

Also, the content of the BETA and RHR reports was the subject of an earlier motion to reopen the record which was denied by the Appeal Board in ALAB-738, 18 NRC 177, 197-99 (1983). Licensee's failure to report the BETA and RHR reports in a more timely manner also was the subject of an earlier motion to reopen the record which was denied by the Appeal Board in ALAB-774. See note 10, supra. Therefore, the Staff's position, that reopening the record on either the content or reportability of the BETA and RHR reports is not warranted, is consistent with the Appeal Board's prior rulings on motions specifically raising those matters.

4. Training

Training is discussed in section II.A.1. of this brief, supra. For the reasons discussed therein, the Staff does not believe the standards for reopening the record are satisfied but that the Commission, as a matter of discretion, may want to require a further hearing on training in the public interest. The scope of such a hearing would be as presently defined by the Licensing Board as it interpreted the Appeal Board's order remanding this issue. See ALAB-772 and Memorandum and Order Following Prehearing Conference, July 9, 1984.

For the reasons stated in NUREG-0680, Supp. No. 5, §§ 7.0 and 13.0, the Staff does not believe the standards for reopening the record are satisfied on any aspect of training addressed in NUREG-0680, Supp. No. 5, which includes training issues beyond the scope of the Appeal Board's

ALAB-772 remand. Specifically, section 7.3 of NUREG-0680, Supp. No. 5, discusses the current status of the training program. Numerous inspections and other evaluations conducted by the Staff since the cheating incidents affirm the effectiveness of new procedures and the improved training program. The Staff also reviewed specific issues of training irregularities identified by the A. Tsaggaris memorandum of April 27, 1976, the L. Noll memorandum of approximately June 1977, and the memorandum from T. L. Book to J. P. O'Hanlon dated June 17, 1977, to determine their relevance to the issue of management integrity and the current training program. While it was clear that during the preaccident time frame, management was responsible for the poor training standards, subsequent changes in plant management and realignment of personnel have resulted in satisfactory remedial actions. A revised training program, which includes specific procedures to minimize opportunities for, and to facilitate detection of, any cheating, was put into place in the post-TMI-2 accident period. This program was the subject of a major portion of the management competence phase of the restart hearing.

A significant training issue considered by the Staff was the Licensee's certification of Floyd's successful completion of the operator requalification requirements. This was determined by the Licensing Board to be both material and false. See NUREG-0680, Supp. No. 5, at 7-10. The Licensing Board recommended that the Commission conduct an investigation into the circumstances surrounding the August 3, 1979 certification. The information developed by OI and the Licensee's own investigation on the issue led the Staff to conclude that the material

and false certification was deliberately made and that management intentionally covered up Floyd's cheating on his Fundamentals and Systems Review (FSR) examination for a period of about two years. This demonstrates a deliberate disregard of management responsibilities. The individuals with knowledge of the cheating and false certification letter were G. Miller, J. Herbein, and R. Arnold. Id. at 7-10 to 7-11 and Table 13.2 at 13-19. None of these individuals, including Floyd, presently are associated with GPUN. Therefore, this issue is no longer relevant to the Licensee's current training and testing program or to the restart of TMI-1.

Also, training program irregularities were the subject of an earlier motion to reopen the record which was denied by the Appeal Board in ALAB-774. See note 10, supra. Thus Staff's position that training program irregularities do not warrant reopening the record is consistent with the Appeal Board's specific ruling on this matter.

5. Keaten Report

For the reasons stated in NUREG-0680, Supp. No. 5, §§ 8.0 and 13.0, the Staff does not believe that the standards for reopening the record are satisfied on this issue. Specifically, the principal conclusions drawn by the Staff with respect to the Keaten Report are:

- (1) The process of review of the drafts of the Keaten Report by management did not result in a final product that was improperly influenced so as to reflect better on the Licensee than would otherwise have been the case.

- (2) Statements made by the Licensee in its December 15, 1979, response to the NRC's October 25, 1979 Notice of Violation (NOV) were not complete or accurate and were contrary to other information in the possession of the Licensee at the time.
- (3) There was no improper conduct in connection with the investigation and report of K. Lucien concerning the loss of feedwater flow leading to the accident or the incorporation of Lucien's input into the Keaten Report.
- (4) Evidence from the GPU v. B&W lawsuit documents and from the OI investigation of the Keaten Report concerning the financial/technical interface issue is at variance with the Staff's testimony that there was no indication of undue influence of financial considerations on TMI-2 operation before the accident.
- (5) The Licensee was under no obligation to provide the final Keaten Report to the NRC until requested by Commissioner Gilinsky in November, 1981.

See NUREG-0680, Supp. No. 5, at 8-36.

The two matters identified above which potentially could have warranted reopening the record are items (2) and (4). With respect to item (2), the Licensee's response to the NOV, the Staff concluded that the inaccurate, incomplete, and questionable statements raised serious questions about the Staff's ability to rely on statements made by Met-Ed. Id. at 13-5. The response was prepared by E. Wallace (then manager of Licensing for TMI), signed by R. Arnold (then Senior Vice President for Met-Ed), and reviewed by H. Dieckamp (then President of GPU). The Staff concluded that while Mr. Wallace was most closely involved in preparing

the response to the NOV, the responsibility for the Licensee's inaccurate and incomplete statements must be shouldered by Mr. Arnold, who reviewed and signed the submission to the NRC, and by Mr. Dieckamp, who reviewed the response before it was submitted. Mr. Wallace presently holds a position at GPUN associated with its Oyster Creek facility; he has no responsibility in connection with the restart or operation of TMI-1. Mr. Arnold presently holds a position with GPU that is not related to any nuclear facility; he has no responsibility in connection with restart or operation of TMI-1. Id. at 8-21, 22.

Mr. Dieckamp's overall responsibility with respect to this event is evaluated in section 13.2 of NUREG-0680, Supp. No. 5. Evidence was not developed that would indicate that Mr. Dieckamp's involvement in reviewing the response to the NOV was improper. In addition, evidence was not developed which would indicate that Mr. Dieckamp had personal knowledge that the response was inaccurate, incomplete or contrary to conclusions reached by others within Met-Ed or GPUSC. Thus, the Staff concluded that Mr. Dieckamp's involvement in the Licensee's response to the NOV was not improper and that he was not involved in any of the other events which raise questions concerning management integrity. In light of the fact that neither Mr. Arnold nor Mr. Wallace are associated with TMI-1 in any capacity, and that the Staff concluded that Mr. Dieckamp's involvement in the Licensee's response to the NOV was not improper, the Staff does not believe that the information on this issue would likely result in a different Licensing Board decision. Therefore, reopening the record on this issue is not warranted.

With respect to item (4) regarding the financial/technical interface issue, the Staff specifically evaluated the need for a reopened proceeding on this issue in NUREG-0680, Supp. No. 5, at 8-33, 8-34.

The Staff concluded:

While the information discussed above from the GPU v. B&W lawsuit documents and the OI investigation of the Keaten Report is not consistent with the unqualified statement by the staff that there was 'no indication' of undue influence of financial considerations on TMI operation before the accident, the staff finds that there is no need to seek the reopening of this issue in the restart proceeding. The ASLB's decision recited and relied on substantial evidence in addition to the particular piece of staff testimony now called into question. Much of that evidence focused on the time frame since the accident rather than the preaccident period to which the particular staff testimony was directed. Under these circumstances, the information now available on the financial/technical interface issue is not considered by the staff to have the potential to change the result reached by the ASLB in this issue. Thus, the Staff does not consider it necessary or appropriate to reopen the evidentiary record on this issue.

6. Changes to the Lucien Report

For the reasons stated in NUREG-0680, Supp. No. 5, § 9.0, there is no significant safety issue raised by this matter which could change the Licensing Board's decision on any issue in the proceeding. Specifically, the Staff concluded that, on the basis of the evidence developed by OI's investigation of changes to the Lucien Report, the circumstances and events surrounding the changes to Lucien's original (September 1, 1979) draft report do not raise questions concerning the integrity of Messrs. Hawkins, Porter or Kakarla. In addition, these changes were made by Lucien as a direct result of his meeting with Messrs. Hawkins, Porter and Kakarla on December 3, 1979. None of the individuals involved were instructed by GPU SC or Met-Ed management to make these modifications and there is no evidence that any member of

GPUSC or Met-Ed management was involved in seeking modifications to the Lucien Report. See NUREG-0680, Supp. No. 5, at 9-9. Thus, there is no new information of safety significance with regard to changes to the Lucien Report, and there is no information in this regard which is likely to change the Licensing Board's decision on any issue in the proceeding.

7. Alleged Harassment of Parks, King, Gischel^{16/}

For the reasons stated in NUREG-0680, Supp. No. 5, §§ 10.0 and 13.0, there is no significant safety issue raised by this matter which could change the Licensing Board's decision on any issue in the proceeding. Specifically, Parks, a Bechtel employee, was found by the Staff to have been harassed by Bechtel. GPUN has a derivative responsibility for the acts of its contractors. The Staff concluded that GPUN abdicated its responsibility to investigate Parks' allegation of

^{16/} In CLI-84-18, the Commission directed the parties not to file with the Licensing Board or Appeal Board separate motions to reopen the record on matters addressed in Supp. No. 5 to NUREG-0680. CLI-84-18, slip op. at 10, n.4. (September 11, 1984). On September 17, 1984, TMIA filed with the Commission a separate motion to reopen the record on the Parks, King, Gischel issue. TMIA Motion to Reopen the Record on Clean Up Allegations, September 17, 1984. TMIA filed its separate motion "to be considered as one aspect of its comments on the September 11 Order." TMIA Motion at 1. For the reasons stated herein, the Staff does not believe the standards for reopening the record are satisfied on the alleged harassment of Parks, King, or Gischel. The Staff will treat TMIA's separate motion to reopen the record on clean-up allegations as one aspect of TMIA's comments in response to CLI-84-18 and will reply, if warranted, to TMIA's specific arguments at the same time Staff replies to all other parties' comments, as the Commission envisioned when it established a schedule in CLI-84-18 for comments and reply comments on reopening the record. Thus, reopening the record on the Parks, King, Gischel issue is one of the matters addressed in Supp. No. 5 which the Commission stated it will decide after receiving all parties comments and reply comments in response to CLI-84-18.

harassment and to ensure appropriate remedial measures. The Staff found, however, that the deficiencies exhibited in the Parks matter were isolated occurrences and are not programmatic in nature. The Staff investigated three other allegations of discrimination against GPUN employees who had raised safety concerns. In each of those three cases (Hartman, Gischel and King), the Staff found the allegations to be without merit (i.e., no discriminatory acts occurred as a direct result of engaging in protected activities thus no violation of 10 C.F.R. § 50.7 occurred) and that GPUN had not acted improperly in its dealings with these employees. The Staff also found that GPUN has promulgated policies designed to protect employees who raise safety concerns, whether they are GPUN or contractor employees. See NUREG-0680 Supp. No. 5, at 13-10. In these circumstances, the allegations of harassment of Parks, King and Gischel do not raise significant safety issues, and the information developed in the investigation of those allegations is not likely to change the Licensing Board's decision on any issue in the restart proceeding.

8. Change of Operator Testimony

For the reasons stated in NUREG-0680, Supp. No. 5, § 11.0, the standards for reopening the record on this matter are not satisfied. Specifically, during the GPU v. B&W lawsuit, the testimony of W. Zewe and E. Frederick changed from their previous accounts of high pressure injection (HPI) actuation. However, based on the OI investigation, the Staff did not find any conclusive evidence of intentional misrepresentation of the facts by these operators concerning the HPI actuation at 0541.

NUREG-0680, Supp. No. 5, at 11-8. Evidence was not developed by OI that would indicate improper activity or coercion by GPUN management with respect to these operators' change in testimony concerning HPI actuation at 0541. In fact, little or no contact occurred between these operators and GPU or GPUN management concerning issues involved in the trial. Id.

9. Conclusion on NUREG-0680, Supp. No. 5 Issues

In conclusion, there is no new information on any subject addressed in NUREG-0680, Supp. No. 5, which raises a significant safety issue or which otherwise is likely to change the Licensing Board's decision on any issue in the restart proceeding. Therefore, no further hearings are required or should be held on any matter addressed in NUREG-0680, Supp. No. 5, except for the already-remanded training issue as defined in ALAB-772 and the Licensing Board's orders interpreting that remand order.

10. Other Commission Questions Regarding NUREG-0680, Supp. No. 5

The Commission stated in CLI-84-18 that if the Staff's position is that the evidentiary record in the restart proceeding does not need to be reopened on Supp. No. 5 issues, then the Staff shall explain how it reached this position in view of its statement in Supp. No. 5 that

[t]his pattern of activity on the part of the Met-Ed, had it been known at the time, would likely have resulted in a conclusion by the staff that the licensee had not met the standard of reasonable assurance of no undue risk to public health and safety. However, these matters, or the significant

facts concerning these matters, were not known to the NRC staff during the ASLB's proceeding on TMI-1 restart.

NUREG-0680, Supp. No. 5, at 13-5.^{17/}

The meaning of this quoted statement from Supp. No. 5 is that had the Staff known of the results of OI's investigations of the integrity issues at the time the Staff testified in the original management proceeding on the adequacy of Licensee's then-existing management and operating personnel, the Staff likely would have concluded that there was not reasonable assurance of no undue risk to the public health and safety by operation of TMI-1 with the then-existing management and operations personnel.^{18/} The Staff now finds no undue risk to the public health and safety by the restart and operation of TMI-1 with the now-existing

^{17/} The Commission further directed the Staff to "set forth exactly what new information led it to the above-quoted conclusion on Metropolitan Edison Co.," noting that the certification of Floyd and post-accident cheating were litigated before the Licensing Board, that the Appeal Board in ALAB-774 denied a motion to reopen the record on pre-accident training irregularities, and that the Staff was aware of the Hartman allegations in 1979. The "new" information which led the Staff to reach this conclusion is set forth in the Appendix to this brief.

^{18/} It is important to note, as stated in Supp. No. 5 at 3-1 to 3-3, that the question of management integrity per se was not explicitly addressed in the original management phase of the restart proceeding, which was concerned with Licensee's organizational structure and management competence. The integrity of individuals in Licensee's management was not the subject of testimony by the Staff or any other party. Later the relationship of certain cheating incidents to Licensee's management integrity was explored in the reopened proceeding on cheating. Subsequently, because of a number of open issues that related to Licensee's management integrity, the Staff embarked on a program to evaluate the open issues and reach an overall position on Licensee's management integrity. That program culminated in NUREG-0680, Supp. No. 5, which sets forth the Staff's findings and conclusions on each of the integrity-related issues raised since the close of the record, documents the basis for those findings and conclusions, and states the Staff's overall position on management integrity.

management and operating personnel because, as described in NUREG-0680, Supp. No. 5, § 13.1.4, the individuals currently responsible for the leadership of GPUN were not implicated in past wrongdoing on the part of Met-Ed and have made a major contribution to the improved performance of GPUN. Thus, there is no inconsistency between the Staff's present position on the integrity of Licensee's current management and Staff's testimony in the restart proceeding on the then-existing Licensee organization and management competence.

In summary, although the new information developed on certain integrity issues would likely have caused the Staff to conclude that there was not reasonable assurance that the Licensee's earlier management and operating personnel could operate TMI-1 without undue risk to the public health and safety, there is no significant safety issue which would now cause the Licensing Board to reach a different decision on any restart issue because individuals whose management integrity was called into question by the new information are no longer involved in TMI-1 operations.

Finally, the Commission requested the Staff to explain why it believes current GPUN management is acceptable in light of assertions that management may not have been adequate until 1982, noting that from 1980-1982, key GPUN personnel such as Messrs. Clark and Hukill held senior management positions, and some organizational elements that were in place prior to 1982 closely parallel the current GPUN structure. CLI-84-18 at 10-11, n.5. This issue is discussed in general for current GPUN management in sections 13.1.3 and 13.1.4 of NUREG-0680, Supp. No. 5. As stated therein, GPU's nuclear-related activities were reorganized under GPUN effective January 1, 1982. Although GPUN, as the successor

to Met-Ed, must bear the responsibility for the improper activities of Met-Ed, the Staff also considers the reorganization and consolidation of GPU nuclear activities into GPUN as a significant remedial action which has improved Licensee's performance. Id. at 13-7. The Staff's focus regarding the TMI-1 restart integrity issues, therefore, was on the potential implication or involvement of any individuals who were in management positions in GPUN. With respect to individuals such as Messrs. Clark and Hukill, who currently hold key management roles within the GPU/GPUN/TMI-1 management organization, the Staff has evaluated the involvement of these and other individuals in Met-Ed and GPUN events that could reasonably be considered to relate to their managerial integrity. Section 13.2.1 of NUREG-0680, Supp. No. 5, contains an evaluation and Staff position on the following individuals: W. G. Kuhns; H. M. Dieckamp; P. R. Clark, Sr.; R. L. Long; H. D. Hukill, Jr.; M. J. Ross; J. J. Colitz; and B. A. Mehler. For the reasons stated therein, the Staff concluded that there is reasonable assurance that GPUN can and will meet its regulatory responsibilities with no undue risk to the public health and safety with these individuals in their management positions.^{19/}

^{19/} Past Met-Ed/GPUSC/GPUN managers who were either responsible for, or involved in, events that call into question the Licensee's management integrity are identified in section 13.2.2 of NUREG-0680, Supp. No. 5. The Staff reached no conclusion on the managerial integrity of individuals who no longer hold management positions with GPUN. It is the Staff's position, and an essential part of the Staff's ability to revalidate its position on Licensee's management integrity, that GPUN must obtain Staff review and approval on a case-by-case basis prior to the assignment of R. C. Arnold, J. Herbein, G. Miller, W. Zewe, J. Seelinger and J. Floyd to responsible management positions associated with operations or maintenance of NRC-licensed facilities. For two current GPUN management officials (i.e., E. Wallace and G. Kunder) the Staff concluded that their current positions are not related to a TMI-1 restart decision.

In summary, the significant reorganization of GPU's nuclear operations into GPUN in 1982, in conjunction with a GPUN management comprised of individuals whose integrity was not found by the Staff to be lacking based on the information developed on the integrity issues, caused the Staff to conclude that current GPUN management is acceptable.

D. Separated Individuals

The Commission noted that the Licensee has temporarily removed certain individuals from the management or operation of TMI-1 until the open issues regarding management integrity have been resolved. CLI-84-18 at 8, n.3. The Commission also indicated that it may order the temporary separation of other individuals as a condition of restart. Id. The Commission requested the views of the parties on whether or not further evidentiary hearings are required to determine the final disposition of the status of those individuals and whether any such hearings can be separated from this restart proceeding.

The Staff believes that the answer to the question of whether further hearings are required regarding the status of individuals separated from TMI-1 depends on each particular individual, his potential involvement in any past acts or practices, and the position to which Licensee proposes to return him. The Staff proposes that individuals who were temporarily reassigned by the Licensee be allowed to return whenever Licensee wishes, and without Commission or Staff evaluation, provided they were not specifically identified in section 13.2.2 of NUREG-0680, Supp. No. 5, concerning past Met-Ed or GPUSC managers who were either responsible for or involved in events that call into

question the management integrity of Met-Ed, and provided they are otherwise qualified for the proposed position. Thus, for these individuals, the Staff does not believe hearings are necessary. For the individuals identified in section 13.2.2, the Licensee should submit its proposal to the Director, NRR. NRR will review and evaluate any such proposal and issue its evaluation and recommendations to the Commission. The Commission may then provide the Staff's evaluation to the parties for their comments, including whether or not evidentiary hearings are required to determine the final disposition of the individuals involved. The Staff believes that these hearings, if required, can and should be separate from the restart proceeding.

E. Whether the Appeal Board Had the Legal Authority to Remove Mr. Husted from Supervisory Responsibilities for Training Non-Licensed Personnel

1. Background

In reviewing the Licensing Board's decision on Mr. Husted's^{20/} role in the investigations and hearing on cheating issues, the Appeal Board confirmed the Licensing Board's criticism of Mr. Husted's poor attitude toward his responsibilities as reflected in his failure to cooperate with NRC investigators. ALAB-772, 19 NRC at 1222-24. However, the Appeal Board, in addition to endorsing Licensee's commitments and the Licensing Board's recommendations regarding Mr. Husted, required that Mr. Husted

^{20/} Mr. Husted was an instructor of licensed operator personnel. He was a witness, but not a party, in the restart proceeding hearing on cheating.

"have no supervisory responsibilities insofar as the training of non-licensed personnel is concerned." Id. at 1224. The Commission asked the parties to address the following legal issue arising from that Appeal Board requirement:

whether an adjudicatory board in an ongoing hearing has the legal authority to impose a condition on a licensee which in effect operates as a sanction against an individual, where that individual is not a party to the proceeding and has had no notice of a possible sanction or opportunity to request a hearing.

CLI-84-18 at 4-5.

Before directly addressing this issue, it is useful to compare and contrast the Appeal Board's decision regarding Mr. Husted with the Licensing Board's decision regarding individuals G and H. Neither Mr. Husted nor Messrs. G and H were parties to the restart proceeding, yet all three were found to have engaged in conduct which the Licensing Board (in the case of G and H) and the Appeal Board (in the case of Mr. Husted) believed warranted some appropriate sanction. With respect to G and H, the Licensing Board recognized that it did not have authority to directly sanction those individuals. As stated by the Licensing Board:

With the exception of G and H, the Board has not imposed or recommended sanctions against any company personnel. There are several reasons for this. As we noted above in our recommendation that G and H accept a voluntary suspension, no individual member of Licensee's organization has been a party to this proceeding. None have had notice of possible penalties, and because of the sequestration order, they have not even had the opportunity to confront the evidence adduced against them. We have no authority to sanction any individual without a further proceeding. But where the evidence has been reliable and definite, and where the malfeasance has been substantial we have, in fact, recommended further procedures or sanctions, as in the case with G and H.

Cheating PID ¶ 2414, 16 NRC 281, 382-83. As indicated, the Licensing Board therefore recommended that G and H accept a voluntary suspension (without pay) which was accepted by Licensee, G and H.

In contrast to the Licensing Board's recommendation regarding G and H, the Appeal Board required that Mr. Husted be removed from supervisory responsibilities insofar as the training of non-licensed personnel is concerned. ALAB-772, 19 NRC at 1224 ("We therefore require . . . that Husted have no supervisory responsibilities insofar as the training of non-licensed personnel is concerned."). This distinction between the the Appeal Board's dealing with Mr. Husted as an individual and the Licensing Board dealing with Messrs. G and H as individuals, as will be discussed below, is significant in resolving the issue which the Commission has asked be addressed.

2. Discussion

The question of whether an adjudicatory board has the legal authority to impose a condition on a licensee which in effect operates as a sanction against an individual who was not a party to the proceeding and who has had no notice of the possibility of a sanction or opportunity to request a hearing depends on how directly the individual is harmed, how specifically he is singled out, and on whether the purpose of the condition imposed on the licensee is, in fact, to operate as a sanction against the individual.

Under the Commission's regulatory scheme, the entity which holds a license issued by the Commission is responsible for all actions undertaken within its authorization. Although a licensee may delegate

certain matters to others, it is clear that the licensee retains responsibility for its employees' actions. Atlantic Research Corp., CLI-80-7, 11 NRC 413, 422 (1980). See also Union Electric Co. (Callaway Units 1 & 2), LBP-78-31, 8 NRC 366 (1978), aff'd, ALAB-527, 9 NRC 126 (1979). Sections 161(b), 103 and 161(i) of the Atomic Energy Act grant very broad authority to the Commission to take actions it deems necessary to protect the public health and safety. Assuming that the Commission finds that activities being conducted under a license are detrimental to the health and safety of the public, it can order a licensee to take appropriate action.^{21/} If such an order to a licensee directly injures an individual or entity other than the licensee, however, then the issue arises as to the notice and hearing rights, if any, of that injured individual or entity.^{22/}

^{21/} Such action has been taken by the NRC in the past. See Niagra Mohawk Power Corp. (Nine Mile Point Nuclear Station), Order for Modification of License (Effective Immediately) and Order to Show Cause, 45 Fed. Reg. 80384 (December 4, 1980); Withdrawal of Ordered Modification and Order to Show Cause and Termination of Proceedings Thereon, 46 Fed. Reg. 20341 (April 3, 1981).

^{22/} The issue of whether a nonlicensee who suffers economic injury as a result of an agency action taken against a licensee to protect the public health and safety is entitled to a hearing as of right under Section 189a of the Atomic Energy Act has arisen in a previous enforcement case. See Consumers Power Co. (Palisades Nuclear Facility), ALAB-670, 15 NRC 493 (1982), vacated as moot, CLI-82-18, 16 NRC 50 (1982). The Commission stated that ALAB-670 and the Licensing Board decision under review in ALAB-670 (LBP-81-26, 14 NRC 247 (1981)) should not be used for guidance. 16 NRC at 52. Therefore, the Staff is not relying on those cases but wishes to bring them to the Commission's attention since the issue raised therein is related to the Commission's question regarding

(FOOTNOTE CONTINUED ON NEXT PAGE)

22/ (FOOTNOTE CONTINUED)

Mr. Husted. For that purpose, the Staff notes that while the Appeal Board specifically avoided ruling on the issue in ALAB-670, the concurring opinion of Mr. Rosenthal suggests that such economic injury may confer standing on the individual:

"I accordingly join fully in the opinion for the Board. In doing so, however, I am constrained to record my doubt that, had we been compelled to reach it, the standing issue could have been decided against the union simply on the basis that only an economic interest is involved. To be sure, it is now settled that threatened economic injury (e.g., the possibility of increased utility bills) does not confer standing under the Atomic Energy Act to intervene in a construction permit or operating license proceeding concerned with other than antitrust issues. Portland General Electric Co. (Pebble Springs Nuclear Plant, Units 1 and 2), CLI-76-27, 4 NRC 610, 614 (1976); Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-582, 11 NRC 239, 242 (1980). But this is a quite different type of proceeding and there is at least room for question whether it likewise is controlled by the teachings of those cases."^{3/}

^{3/} "Among things, in sharp contrast to the order which the union seeks an opportunity to attack, the grant of a construction permit or operating license application does not serve affirmatively to impose restrictions upon otherwise lawful activities of any person and the economic impact upon members of the public (e.g., ratepayers) of such licensing action is both incidental and indirect. Although a decision on its operative significance can be left for another day, the very existence of this manifest distinction commends caution in the mechanical transfer of standing principles from one type of proceeding to another."

ALAB-670, 15 NRC at 507 (concurring opinion of Mr. Rosenthal).

The question remains as to whether the injury to the employee is within the "zone of interests" protected or regulated by the Atomic Energy Act. Several cases suggest such an employee may not meet the "zone of interests" test. See R. T. Vanderbilt Co. v. Occupational Safety and Health Review Commission, 59 Ad. L. Rep. 2d (P & F) 97 (6th Cir. 1984); R. T. Vanderbilt Co. v. Occupational Safety and Health Review Commission, 708 F.2d 570 (11th Cir. 1983); Fire Equipment Manufacturers Ass'n v. Marshall, 679 F.2d 679 (7th Cir. 1982), cert. denied, 403 S. Ct. 728 (1983).

In O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980), a nursing home which was certified as eligible to care for Medicaid and Medicare patients, and to receive reimbursement from HEW for such cases, was notified that it no longer met eligibility standards and was being decertified. Medicaid patients who would be forced to move, as well as the nursing home, sued to enjoin decertification. The Court held that the patients did not have a due process right to demand a hearing. The Court found a "distinction between government action that directly affects a citizen's legal rights, or imposes a direct restraint on his liberty, and action that is directed against a third party and affects the citizen only indirectly or incidentally." 447 U.S. at 788. In O'Bannon, the Government was attempting to confer an indirect benefit on Medicaid patients by setting nursing home standards. While some adverse impact, incidental to the Government's enforcement action, did occur, the Court concluded that it did not amount to deprivation of an interest in life, liberty or property.

In Board of Regents v. Roth, 408 U.S. 564 (1972), where the Court found an untenured teacher (Roth) who was not rehired was not denied due process, the Supreme Court stated:

Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law--rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.

408 U.S. at 577. The Court in the Roth case also examined whether any liberty interest was affected. The Court recognized two possible liberty interests. First, if the state had made charges against Roth which might have seriously damaged his standing and associations in the community,

due process would accord an opportunity to refute the charges. Secondly, had the state, in declining to re-employ Roth, imposed on him a stigma or other disability that foreclosed his freedom to take advantage of other employment opportunities, procedural due process guarantees might be available.

It is unclear whether due process rights would accrue to an individual where the action of an intervening party--the licensee--is necessary to actually cause the injury, i.e., by terminating the individuals' employment or demoting him. The Court in O'Bannon distinguished its result in that case from previous decisions as one involving action directed against a third party which affects a citizen only indirectly versus one where government action directly affects a citizen's legal rights or liberty interests. The Court discussed a hypothetical case to explain its decision. Expanding on the factual situation before it in the Memphis Light^{23/} case, the Court noted that once a utility had provided its customer a legal right to continued services as long as bills were paid, the customer had a constitutional right to a hearing on a disputed bill before its service was discontinued. However, if a utility discontinued service to a nursing home (the customer), which might cause the home to close and thus impact patients, such patients might have rights against the home but "they would have no constitutional right to interject themselves into the dispute between the public utility and the home." 447 U.S. at 788 (footnote omitted).

^{23/} Memphis Light, Gas & Water Division v. Craft, 436 U.S. 1 (1978).

Significantly, and directly material to the issue being addressed in this brief, the Court in O'Bannon stated:

We, of course, need not and do not hold that a person may never have a right to a hearing before his interests may be indirectly affected by government action. Conceivably, for example, if the Government were acting against one person for the purpose of punishing or restraining another, the indirectly affected individual might have a constitutional right to some sort of hearing. But in this case the Government is enforcing its regulations against the home for the benefit of the patients as a whole and the home itself has a strong financial incentive to contest its enforcement decision; under these circumstances the parties suffering an indirect adverse effect clearly have no constitutional right to participate in the enforcement proceedings.

447 U.S. at 789-90, In his concurring opinion, Justice Blackmun quotes L. Tribe, American Constitutional Law:

[T]he case for due process protection grows stronger as the identity of the persons affected by a government choice becomes clearer; and the case becomes stronger still as the precise nature of the effect on each individual comes more determinately within the decision-maker's purview. For when government acts in a way that singles out identifiable individuals--in a way that is likely to be premised on suppositions about specific persons--it activates a special concern about being personally talked to about the decision rather than simply being dealt with.

447 U.S. at 800-01, quoting L. Tribe, American Constitutional Law § 10-7, at 503-04 (1978) (emphasis in original).

These cases suggest that when the government acts against an entity for the purpose of affecting a specific individual who is singled out and directly affected in some adverse way by the governmental action, then, unless the public health, safety and interest requires otherwise, that individual has a due process right to prior notice and an opportunity for a hearing before his interests are affected. Based on this reading of the cases discussed above, the Staff's position is that when an adjudicatory board imposes a condition on the licensee for the purpose of

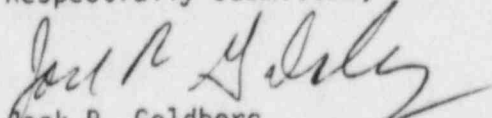
operating as a direct sanction on a specifically identified individual who was not a party to the proceeding, then the individual has been denied his right to notice and an opportunity for a hearing. In the case of the Appeal Board's requirement that Mr. Husted be removed from non-licensed operator personnel supervisory responsibilities, the Appeal Board erred.

III. CONCLUSION

None of the information on any of the issues identified by the Commission in CLI-84-18 raises a significant safety issue which would cause a different result to be reached on any restart issue. However, the Staff believes that it may be in the public interest for the Commission, as a matter of discretion, to allow the Licensing Board to conduct a hearing on the training issue which was remanded by the Appeal Board in ALAB-772 (i.e., the OARP Committee's reevaluation of Licensee's training and testing program in light of the deficiencies revealed by the cheating incidents).

The question of whether an adjudicatory board has the legal authority to impose a condition on a licensee which in effect operates as a direct sanction against an individual who was not a party to the proceeding and who had no notice of the possibility of a sanction or opportunity to request a hearing depends on how directly the individual is harmed, how specifically he is singled out, and on whether the purpose of the condition imposed on the licensee is, in fact, to operate as a sanction against the individual.

Respectfully submitted,


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Dated at Bethesda, Maryland
this 9th day of October, 1984

APPENDIX

The Staff concluded in section 13.1.2 of NUREG-0680, Supp. No. 5 that, had it known earlier of certain activities on the part of Met-Ed, the Staff likely would have concluded that Met-Ed had not met the standard of reasonable assurance of no undue risk to the public health and safety. This statement regarding Met-Ed management integrity is based upon the Staff's current knowledge of the facts surrounding four specific events:

- (1) TMI-2 leak rate falsification
- (2) preaccident training irregularities and postaccident cheating
- (3) false certification to NRC of Floyd's requalification program participation, and the related management coverup.
- (4) lack of accuracy and completeness in the Licensee's response to the NRC's October 25, 1979, Notice of Violation

As pointed out by the Commission (CLI-84-18, at 10-11, n.5), some facts associated with items (1) through (3) above were known at various times during the course of the TMI-1 restart proceeding by certain individuals on the NRC Staff. However, it was not until NRC's review of the GPU v. B&W lawsuit record, completion of the resulting OI investigations associated with these items, and the Staff's subsequent review, as documented in NUREG-0680, Supp. No. 5, that the licensing staff became fully aware of the facts in each case and the individuals involved in acts of wrongdoing. As discussed in NUREG-0680, Supp. No. 5, § 13.2.2, past Met-Ed/GPUSC/GPUN managers who were either responsible for or involved in events that call into question the management integrity of the Licensee are identified in Table 13.2 of NUREG-0680, Supp. No. 5. These individuals are:

<u>Name</u>	<u>Last GPUN Position</u>	<u>Date Left GPUN</u>
R. C. Arnold	President	09/25/83
J. Herbein	V. P. Nuclear Assurance	04/82
G. Miller	Director, Startup and Test	10/82
J. Floyd	Engineer, Senior 2, TMI-2 Safety Review Group	04/83
W. Zewe	Manager, Radwaste Operations	01/84
J. Seelinger	Manager, TMI-1	11/79
G. Kunder*	Manager, TMI-2 Safety Review Goup	-
E. Wallace**	Manager, Oyster Creek Expanded Safety Systems Facility Project	-

* Not involved in TMI-1 operations

** Manager TMI Licensing through 07/83.

While the Staff reached no conclusion in NUREG-0680, Supp. No. 5, regarding individuals who no longer hold management positions within GPUN, it is clear that in some cases the above individuals held key management positions within GPUN at the time the Staff testified in the restart proceeding.

Sections A through D of this Appendix provide a summary of the four issues identified above. Section A addresses TMI-2 leak rate falsification discussed in NUREG-0680, Supp. No. 5, § 5.1. Section B covers preaccident training irregularities and postaccident cheating as discussed in NUREG-0680, Supp. No. 5, § 7.1. Section C addresses the false certification of Floyd and the subsequent management coverup, which is discussed in NUREG-0680, Supp. No. 5, § 7.2. Finally, section D addresses the Licensee's response to the NRC's Notice of Violation (NOV), as discussed in NUREG-0680, Supp. No. 5, § 8.2. Each section contains background information and a synopsis of what information was known by the Staff and when that information was learned.

A. NEW INFORMATION REGARDING TMI-2 LEAK RATE FALSIFICATION

A brief discussion of the Hartman allegations, the suspended NRC investigation, and the Department of Justice (DOJ) investigation into the matter, was described in NUREG-0680, Supp. No. 1, dated November 1980, and Supp. No. 2 dated March 1981. By August 27, 1981, when the Licensing Board issued its PID on Procedural Background and Management Issues, no additional NRC investigation or followup had been done by the Staff. The Licensing Board, in its Management PID, acknowledged its lack of knowledge about the DOJ investigation. Thus, while the general thrust of Hartman's allegations were known to the Staff, only those Staff members who were involved in the suspended NRC investigation had any direct knowledge of information confirming Hartman's allegations or the extent to which Met-Ed management may have been involved. These individuals were under direction by DOJ not to discuss the matter with others.

Additional evidence became available to the licensing Staff regarding RCS leak rate falsification as a result of the NRR's review of the GPU v. B&W lawsuit review. This additional information was turned over to OI for use in the reopened investigation, as documented in NUREG-1020LD, which was issued September 28, 1983. More facts were uncovered as a result of the subsequent Federal Grand Jury indictment of Met-Ed in November 1983, the subsequent criminal conviction of Met-Ed on February 29, 1984, and OI's Report of Investigation dated August 15, 1984.

The following new information was not known by the licensing Staff directly evaluating Licensee's management in the original restart proceeding:

- (1) Some operators willfully violated procedures and attempted to manipulate leak rate test results by the addition of hydrogen and/or water to the makeup tank. These operators were motivated to do so as a result of indirect pressure from management and/or a desire by individual operators to obtain satisfactory leak rate test results.
- (2) The Staff was unaware until March 21, 1983 of the existence of the Faegre & Benson Report and its findings.
- (3) First-line supervision (i.e., shift foremen and shift supervisors) and possibly middle management were directly involved in leak rate falsification at TMI-2, and Met-Ed management was responsible for improper leak rate testing as well as for the poor attitude of the operators and first-line supervisors toward this test.
- (4) Falsification of TMI-2 leak rate test results did occur, and negligence on the part of management created, in part, the circumstances that resulted in leak rate falsification.

B. NEW INFORMATION REGARDING PREACCIDENT TRAINING IRREGULARITIES AND POST ACCIDENT CHEATING*

As stated in section 7.1 of NUREG-0680, Supp. No. 5, it was not until NRC's review of the GPU v. B&W lawsuit record during the first

*/ No new information (i.e., outside the hearing record) associated with postaccident cheating is identified in NUREG-0680, Supp. No. 5. The Staff relied on the evidentiary record and the conclusions of the Special Master, the Licensing Board, and the Appeal Board. However, as a result of new information regarding pre-accident training irregularities, the Staff now believes that the postaccident cheating was a direct result of the poor attitude developed during the preaccident period on the part of some managers and licensed operators towards their responsibilities and that Met-Ed failed to fulfill its responsibility as a result of negligence. See NUREG-0680, Supp. No. 5, at 7-5 through 7-10, and 13-3.

half of 1983 that three memoranda were identified that raised questions regarding Met-Ed management's knowledge of or involvement in failures to comply with NRC training requirements.

The first memorandum, dated April 27, 1976, was from A. Tsaggaris, then Supervisor of Training at TMI, to J. Herbein, J. Colitz and G. Miller. The memorandum expressed Tsaggaris' concerns about problems in the requalification program for non-shift personnel (including Herbein, Colitz and Miller). It discussed poor lesson attendance, delay in completing makeup lessons, and insufficient time spent in the control room. The memorandum also stated: "We are required by federal law to meet certain requirements for licensed individuals and in several cases we do not meet them."

The second memorandum, dated June 17, 1977, was from T. Book, then TMI-1 shift foreman, to J. O'Hanlon, then TMI-1 Plant Superintendent. The memorandum discussed the inadequacy of reactor operator training and implied that the number of hours of training recorded in operator training records was not correct.

The third memorandum, written approximately June 1977, was from L. Noll, then TMI-1 shift foreman, to G. Kunder, then TMI-1 Supervisor of Operations, and implied that training records were being falsified.

As stated in NUREG-1020LD, § 10.3, the issues presented by the GPU v. B&W lawsuit record raise a question of whether violations of commitments made in response to regulatory requirements occurred and, if so, who had knowledge of or responsibility for such violations. NUREG-1020LD goes on to state: "In the staff's view, despite the adequacy of the licensee's present training program, if there were

violations of commitments made in response to regulatory requirements and failures to have reported any such violations, such information would be material to an assessment of licensee's management integrity." In addition, because Tsaggaris was a member of the Keaten task force, the Staff requested that OI conduct a further investigation into training program irregularities as part of OI's Keaten investigation. OI's investigations into these matters were completed as follows:

Book memorandum	Q-1-83-014	05/31/83
Roll memorandum	Q-1-83-015	07/26/83
Tsaggaris memorandum	Q-1-84-004	03/22/84
Keaten Report	1-83-012	05/18/84

The Staff's review of these investigation reports confirmed the Staff's previous conclusion that the Licensee had problems with its training program before the accident at TMI-2. During the period from late 1975 through April 1976, some off-shift licensed operators (among whom were the Station Manager and the TMI-1 and TMI-2 Plant Managers) failed to meet requalification program requirements. These requirements related to frequency of watch standing and attendance at scheduled training lectures. Additional evidence was gathered that demonstrated poor implementation of the requalification training program and a poor attitude on the part of shift operators towards this program.

As stated in section 13.1.1 of NUREG 0680, Supp. No.5, "The staff is not primarily concerned, at this late date, with possible violations of NRC requalification training requirements in 1975 through 1978. However, the staff is concerned that these deficiencies and failures indicate a poor attitude and disregard on the part of management at that time for

their responsibilities and this same management held responsible positions vis-a-vis TMI-1 operations in the postaccident period."

In summary, the Staff was aware during the TMI-1 restart proceeding that the Licensee had problems with its preaccident training and requalification programs. The proceeding before the Licensing Board concentrated on the Licensee's postaccident training program. The Board's August 27, 1981, PID on Procedural Background and Management Issues found that the Licensee had in place at TMI-1 a comprehensive and acceptable training program. Following the reopened proceeding on cheating, the Licensing Board found in its July 27, 1982, PID that its conclusions of August 27, 1981, should remain in effect. However, it was not until the Staff's review of the GPU v. B&W lawsuit record was conducted, the resulting OI investigations were completed, and the Staff's evaluation of those investigations was completed, that the Staff became aware that certain preaccident Met-Ed management personnel demonstrated a poor attitude and disregard for Met-Ed Operator Requalification Program requirements and held responsible postaccident management positions associated with TMI-1 operations. Three of these managers (Herbein, Miller, and Floyd) were involved in the coverup of Floyd's cheating on his FSR examination, which was part of his Operator Requalification Program requirements.

C. NEW INFORMATION REGARDING CERTIFICATION IRREGULARITIES

As discussed in Section 7.2.1 of NUREG-0680, Supp. No. 5, during the July 1981, investigation into cheating on operator licensing examinations (HQS-81-003), the Licensee advised the NRC that J. Floyd had obtained assistance in completing two of the four areas on an internal examination

that was part of his requalification program for an NRC Senior Reactor Operator (SRO) license. In an August 3, 1979, letter signed by G. Miller to the NRC certifying Floyd for renewal of his SRO license, an examination score was cited that was obtained on a section partially completed by someone else. The Special Master received evidence on this issue during the reopened proceeding on cheating. In its July 27, 1982, PID on the reopened proceeding on cheating, the Licensing Board found that the Licensee's August 3, 1979, letter was a material false statement to the NRC. In addition, the Licensing Board recommended that the Commission direct the Staff to conduct an investigation into the circumstances surrounding the August 3, 1979 certification.

Following the close of the record, both the Licensee and the NRC conducted investigations into the false certification issue. The Licensee's investigation was completed by F. Speaker (Speaker Report) on November 2, 1982, OI's investigation into the matter was completed on March 21, 1983, (OI Report H-82-002). OI's report was referred to the Department of Justice (DOJ) and has not been publicly released. Subsequent to the OI investigation, IE concluded that a material false statement had been made. A civil penalty of \$100,000 was proposed by the Director, IE.

As part of the Staff's review of the GPU v. B&W lawsuit record, many documents were identified which indicated that Licensees' management covered up Floyd's cheating and made a subsequent false certification to the NRC. As part of the Staff's review of the Licensee's management integrity as it affects TMI-1 restart, the Staff evaluated this issue, including the management coverup, in detail. See § 7.2 of NUREG-0680,

Supp. No. 5. The facts as they are known today include the following:

1. Miller informed Herbein in a handwritten memorandum dated July 3, 1979, that "Floyd just handed in his overdue FSR exam," that he failed two sections, and that "one exam is not in his handwriting." (See B&W 796.)
2. Miller confirmed that he wrote the memorandum and discussed it with Herbein. (See Miller at Dep. Tr. 846.)
3. Senior Met-Ed management (Miller, Zechman, et al), at the direction of Herbein, conducted an investigation into the Floyd cheating event and recognized its relationship to Floyd's NRC license requirements. (See B&W 797,798 and Herbein at Dep. Tr. 318-332.)
4. Met-Ed management (Miller and Herbein) discussed the issue of Floyd's certification of NRC requalification program requirements following their investigation. (See Herbein Dep. Tr. at 319.)
5. Herbein told Miller to clear the certification letter with counsel before submitting it to the NRC. (See Herbein Dep. Tr. at 335-337.)
6. Miller's memorandum to counsel (E. Blake) of July 27, 1979, highlighted the "handwriting problem" (i.e., that portion of Floyd's examination written by another individual) and stated that this section of the examination was not being mentioned in the draft certification letter. A copy of this section of the examination was attached. (See Speaker Report Ex. 1A.)

7. The actual certification letter was submitted to the NRC on August 3, 1979. (See B&W 799.) This letter certified the successful completion of Floyd's accelerated requalification program requirements.
8. By memorandum dated August 8, 1979, Miller advised Arnold of the results of his investigation into the Floyd incident and recommended that Floyd be suspended for a two week period. (See Speaker Report Ex. 15).
9. Floyd's cheating was not reported to the NRC for 2 years, when Arnold brought the matter to the attention of the NRC during the 1981 investigation into operator cheating.
10. The Licensee's response to this event was to reassign Floyd. There was no licensee censure of Miller, nor did the Licensee investigate the involvement of Herbein, Arnold or Blake.
11. During GPU v. B&W lawsuit depositions, both Herbein and Arnold deny seeing a copy of Miller's July 27, 1979 letter to Blake with the draft certification letter attached.

In summary, while the false certification of Floyd was addressed in the restart proceeding, it was not until after the close of the hearing that the Staff determined that Licensee management knew of, and subsequently covered up, Floyd's cheating, and that the licensee knowingly made a false certification to the NRC.

D. NEW INFORMATION REGARDING THE LICENSEE'S RESPONSE TO THE NOV

As stated in section 8.3 of NUREG-0680, Supp. No. 5, it was not until NRR's review of the GPU v. B&W lawsuit record in the summer of 1983 that the Staff became aware of information which called into question the

accuracy and appropriateness of the Licensee's December 5, 1979 response to the NRC's October 25, 1979 Notice of Violation. The Licensee's response stated that the elevated relief valve discharge line temperatures were caused by a leaking code safety valve and not the PORV, and implied that a preaccident determination of this fact had been made. Thus, the Licensee argued that it had not violated Emergency Procedure 2202-1.5 by not closing the PORV block valve when discharge line temperatures had exceeded 130°F. In addition, the Licensee stated that there is "no indication that this procedure or the history of the PORV discharge line temperatures delayed recognition that the PORV had stuck open during the course of the accident." The NRC did not agree with this statement. (See Appendix A to the January 23, 1980 letter transmitting the Order Imposing the Civil Penalty.) However, it was not until NRR's review of the GPU v. B&W lawsuit record that the Staff uncovered evidence indicating the Licensee may have knowingly provided false information to the NRC in its response to the NOV. This became clear in light of the fact that the Keaten Task Force draft reports being circulated internally to upper management at the time of the Licensee's response contained information in conflict with the Licensee's response to the NOV. It was this evidence that caused the Staff to refer the matter to OI for investigation. See NUREG-1020LD, section 10.4.1.

On the basis of the information from the GPU v. B&W lawsuit documents and from OI's investigation, completed on May 18, 1984, the Staff concluded in NUREG-0680, Supp. No. 5, that the Licensee's response to Section 4A of the NOV was inaccurate and incomplete. See NUREG-0680, Supp. No. 5, at 8-21.

The three individuals most closely involved with submitting inaccurate and incomplete information to the NRC were E. Wallace, R. Arnold and H. Dieckamp. OI determined that E. Wallace, then Manager of Licensing for TMI, had the lead responsibility in developing the Licensee's response to the NOV. Wallace reported to Arnold, then Senior Vice-President of Met-Ed, who signed the response. H. Dieckamp, then President of GPU, reviewed the response prior to its submission. These inaccurate, incomplete, and questionable statements in the Licensee's response to the NOV raised serious questions about the Staff's ability to rely on statements made by Met-Ed.

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

DOCKETED
USNRC

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BEFORE THE COMMISSION

OFFICE OF SECRETARY
DOCKETING & SERVICE
BRANCH

In the Matter of)
METROPOLITAN EDISON COMPANY, ET AL.)
(Three Mile Island Nuclear Station,)
Unit No. 1))

Docket No. 50-289
(Restart)

CERTIFICATE OF SERVICE

I hereby certify that copies of "NRC STAFF'S BRIEF IN RESPONSE TO CLI-84-18" in the above-captioned proceeding have been served on the following by deposit in the United States mail, first class, or, as indicated by an asterisk, by deposit in the Nuclear Regulatory Commission's internal mail system, this 9th day of October, 1984:

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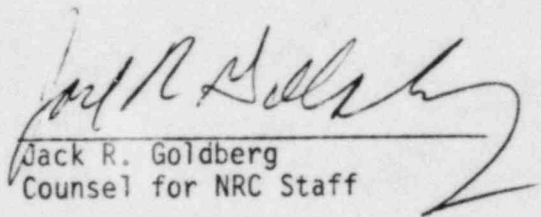
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