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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

COMMISSIONERS:

Nunzio J. Palladino, Chairman
Thomas M. Roberts
James K. Asselstine
Frederick M. Bernthal
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In the Matter of METROPOLITAN EDISON COMPANY (Three Mile Island Nuclear Station, Unit No. 1)	Docket No. 50-289 SP (Restart)

MEMORANDUM AND ORDER

CLI-85-2

Introduction

The Commission on September 11, 1984 took review of the following issues: (1) whether further hearings are warranted on the three issues which the Appeal Board in ALAB-772, 19 NRC 1193 (1984), remanded to the Licensing Board;[1] (2) whether the Appeal Board in ALAB-772 had the legal authority to require as a condition of restart that Charles Husted, who was not a party to the proceeding, "have no supervisory responsibilities insofar as the training of non-licensed personnel is concerned"; (3) whether in light of recent developments the record still needs to be

[1] Those three issues were the adequacy of licensee's training program, the truthfulness of a May 9, 1979 telegram that Herman Dieckamp, General Public Utilities (GPU) President, sent to Congressman Udall, and leak rate test practices at Three Mile Island, Unit 1 (TMI-1).

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reopened to consider leak rate falsifications at Three Mile Island, Unit 2 (TMI-2) (the "Hartman allegations"), as directed by the Appeal Board in ALAB-738, 18 NRC 177 (1983), and, if not, whether there should be a hearing on the Hartman allegations separate from the restart proceeding in order to allow the matter to be fully aired;[2] and (4) whether any of the information addressed in NUREG-0680, Supplement No. 5, "An Evaluation of the Licensee's Management Integrity as it Affects Restart of Three Mile Island Nuclear Station Unit 1, Docket 50-289" (July 1984) ("Supp. No. 5"), requires further reopening of the record. CLI-84-18, 20 NRC 808.

The Commission specified that the parties should apply the traditional standards for reopening a record in commenting on whether any new information requires reopening.[3] The Commission also directed the parties, if they believed further hearings were required, to address

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[2]The falsifications at TMI-2 occurred when Metropolitan Edison Company (Met. Ed.) operated the TMI facility. As a result of a corporate reorganization subsequent to the accident, General Public Utilities Nuclear Corp. replaced Met. Ed. as licensee. Hence both companies will be referenced in the discussion of the Hartman allegations.

[3]The traditional standards for reopening a record to consider new information are: (1) Is the motion timely; (2) does it address significant safety (or environmental) issues; and (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).

UCS asserted that the traditional standards for reopening did not apply where the Appeal Board reopened because of an inadequate record. The Commission agrees, and, accordingly, in CLI-84-18 directed the parties to apply the traditional standards for reopening only on new information.

what the scope of those hearings should be, and to "designate the specified disputed issues of fact material to a restart decision by the Commission on which further evidence must be produced and ... provide their most substantial factual and technical bases for their position on each such issue." CLI-84-18, 20 NRC 808, 809 (1984).[4]

The Commonwealth of Pennsylvania, the Union of Concerned Scientists (UCS), Three Mile Island Alert (TMIA), the Aamodts, General Public Utilities Nuclear (licensee or GPUN), and the NRC staff submitted briefs in response to the Commission's order. The Commonwealth, UCS, TMIA and the Aamodts argued that further hearings were required on specific matters.[5] The NRC staff maintained that no further hearings were required, although "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...." Licensee opposed any further hearings.

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[4]The Commission also finds the UCS arguments that the Commission improperly took review and imposed an improper standard on the parties to be without merit. Clearly the Commission has the authority to decide the issues to be adjudicated in this special proceeding. Just as clearly the Commission can require the parties to put forward their best case in order to justify further hearings. This does not amount, as UCS claims, to an adjudication on the merits, but rather to an attempt fairly to judge whether further hearings should be held.

[5]TMIA also argued that "the premise behind the Commission order is fundamentally in err" [sic], because "these issues can not [sic] be compartmentalized into discreet items as the Commission order presumes." TMIA Comments at 1, 2. The Commission disagrees with TMIA's assertion. Whether there was one or many past improper acts, the issue today is whether adequate remedial steps have been taken to provide reasonable assurance that the plant can be operated safely. Any improper acts would need to be considered in the aggregate only if they still posed a current significant safety concern.

Before discussing the merits of the issues, some mention of the quality of the parties' responses is in order. The NRC staff ignored questions specifically put to it in the Commission's order. Of the intervenors, only UCS made any attempt to comply both with the Commission's order to apply the traditional standard for reopening and to specify the disputed issues of material fact warranting a hearing.[6] The comments filed by the Commonwealth and the Aamodts were so deficient in this regard that they were of little value to the Commission. TMIA set out its view of the facts (largely through incorporating its October 1, 1984 petition under 10 CFR 2.206) without any discussion of whether the standards for reopening had been met, thus eliminating in large part the usefulness of its comments.

The Commission will not tolerate such clear disregard for its orders in the future. The Commission will take appropriate action should the staff again engage in such flagrant disregard of its responsibilities to the Commission. With regard to the other parties, nonresponsive pleadings may be rejected, and parties which consistently ignore Commission directives may be found to be in default. Statement of Policy on Conduct of Licensing Proceedings, 13 NRC 452, 454 (1982).

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[6] However, a response to two UCS comments is in order. UCS asserted in its filing that the Commission has ignored earlier filings by the parties, and that the Commission had earlier determined that management integrity issues can be separated from a restart decision. Both assertions are erroneous. The Commission has considered each set of comments as they are filed. The only Commission decision on management integrity was that certain investigations did not have to be completed prior to a restart decision because they did not raise significant enough concerns to warrant delaying a decision. The Commission has

[Footnote Continued]

Summary and Conclusion

With regard to the merits of the issues before it, the evidentiary hearings on the training and Dieckamp mailgram issues have been completed, and the Licensing Board should issue its decisions on those issues. After considering the other issues raised by the parties, the Commission finds that no further hearings are warranted in the restart proceeding. However, the Commission has decided to institute a new proceeding to consider what action to take concerning those individuals possibly involved in the TMI-2 leak rate falsifications, except for those individuals who were identified as not involved by the statement of the United States Attorney at the sentencing hearing of Metropolitan Edison Company, or those already reviewed and found not to be implicated by the NRC's Office of Investigations (OI) in its TMI-1 leak rate investigation. In addition, the Commission has decided that Husted should be given an opportunity to request a hearing on the Appeal Board's condition regarding his employment.

The Commission will discuss below whether each individual issue raised warrants reopening. Before turning to the issues before it, however, the Commission wishes to note at the outset that in this order it is expressing no view on whether the reopened proceedings must be completed prior to a decision whether to lift the immediate effectiveness

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[Footnote Continued]
never stated that the issue of management integrity can be separated from a restart decision.

of the 1979 shutdown orders. The Commission will be addressing this issue separately in the immediate future.

I. Training and Dieckamp Mailgram Issues

A. Background

The Appeal Board in ALAB-772 found the evidentiary record inadequate in two areas. The first concerned the adequacy of licensee's licensed operator training program. The Appeal Board found that the Licensing Board in its Third Partial Initial Decision failed to give adequate consideration to the effect of the so-called "cheating incidents" on the Licensing Board's earlier favorable conclusions regarding licensee's training program. The Appeal Board, noting its view that the generally positive testimony given by the Operator Accelerated Retraining Program (OARP) Review Committee and licensee's other independent consultants "was of decisional significance to the Board's initial, equally positive judgment on licensee's training program," remanded to the Licensing Board to hear from the OARP Review Committee again, this time taking into account the impact of the cheating incidents. The Appeal Board noted that by requiring additional hearings it was "further prolonging a proceeding that appears to have no end." The Appeal Board found, however, that a further hearing was required in order to "decide the pivotal issue of the adequacy of training at TMI-1...." 19 NRC at 1236-37.

The second remanded issue involved a May 9, 1979 mailgram from Herman Dieckamp, GPU President, to Congressman Udall and to Commissioner Gilinsky. The mailgram stated "there is no evidence that anyone interpreted the 'Pressure Spike' and the spray initiation in terms of reactor core damage at the time of the spike nor that anyone withheld any information."[7] There are conflicting statements as to how several employees interpreted the spike at the time it occurred, and licensee did not report the spike until a day or two after it occurred.

Although no party pursued this matter, the Appeal Board held that the Licensing Board, which had decided not to pursue the matter beyond relying on staff's investigation, should have pursued the matter on its own. The Appeal Board found that Dieckamp "is still a high level 'presence' at GPU Nuclear," and that it is important not to leave this matter "dangling." 19 NRC at 1267-68.

B. Parties' Comments

The Commonwealth, TMIA, UCS and the Aamodts all argued that the record should be reopened on the adequacy of licensee's operator training program. TMIA also argued that hearings are warranted on the Dieckamp mailgram issue. Licensee opposed hearings on both issues. The NRC staff maintained that hearings are not required on either issue, but it

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[7]The "pressure spike" refers to the sudden increase in containment pressure during the accident from about 3 to 28 psig, followed by a rapid decrease to 4 psig. The spike was due to the burning or explosion of hydrogen, which can be symptomatic of core damage.

might 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.

C. Analysis

The restart proceeding, which is being held in response to the TMI-2 accident, is perhaps unique in the degree to which it has examined licensee's fitness, and in the degree of public interest in its outcome. More importantly, the evidentiary hearings on these two issues have been completed, and the parties are currently preparing proposed findings of fact and conclusions of law.

The Commission has determined that it will as a matter of policy allow the Licensing Board to render a decision on these two issues. The training issue is one of the central issues in the proceeding, and the Commission believes that the matters raised by the Appeal Board concerning the adequacy of the training program should be addressed by the Licensing Board. With regard to the Dieckamp mailgram, Dieckamp retains a high-level position within licensee's parent organization, and the Commission has decided that any lingering questions on this issue also should be addressed by the Licensing Board.

The Commission emphasizes, however, that its decision is based on public policy considerations, including the public policy value in having these issues ventilated in a forum accessible to the public and the fact that the evidentiary hearings on these two issues have been

completed. The Commission accordingly need not decide whether these hearings are legally required.

Finally, the Commission notes with approval the Licensing Board's decision to complete the hearings on the training and Dieckamp mailgram issues before beginning formal discovery on leak rate falsification issues. The Commission, finding that the training issue is more significant than the mailgram issue, directs the Board to give priority attention to the training issue, and to issue a decision on the training issue first, if working on the mailgram issue would delay issuance of the training decision. If the Board is able to give the Commission its ultimate conclusion on the training issue and the essence of its supporting rationale at any appreciable time (e.g., a week or more) before its complete partial initial decision on the issue, the Commission requests the Board to do so.

II. TMI-2 Leak Rate Testing Practices

A. Background

Harold Hartman, a control room operator at TMI-2 prior to the accident, alleged that leak rate tests, which were used to assess whether primary system leakage surpassed technical specification limits, were purposely manipulated and records of such tests falsified or destroyed at TMI-2 prior to the accident to cover up the fact that over an extended period of time the results of the tests exceeded technical

specification limits.[8] Hartman specifically alleged that shift supervision was aware of such improper conduct.[9] After a preliminary investigation into these allegations, the NRC in April 1980 referred the matter to the Department of Justice (DOJ) for criminal investigation and halted its own investigation.

The only evidence relating to the Hartman allegations which was provided to the Licensing Board was contained in two supplementary safety evaluation reports prepared by the NRC staff. Both referenced the Hartman allegations, noting that DOJ was investigating the matter and that the NRC inquiry had been suspended.[10]

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[8]The technical specifications at TMI-1 and -2 establish a maximum rate of one gallon per minute (gpm) for unidentified leakage from the reactor coolant system. Tests to measure leakage must be taken at set intervals and, if the specified rate is exceeded and cannot be limited within four hours, the plant must be shut down.

[9]Hartman alleged other violations of regulatory requirements besides TMI-2 leak rate falsification. For instance, he alleged that during a startup a rate inhibit alarm was received, but the Shift Supervisor directed actions in violation of procedures. He also alleged, among other things, that a request to shut down TMI-2 for reactor coolant system leakage repairs was denied. These matters were not addressed by the Appeal Board in ALAB-738. See note 16, infra.

[10]NUREG-0680, Supp. No. 1 stated that the allegations regarding falsification of leak rate data at TMI-2 were being investigated by the Justice Department, and that "[t]he allegations raised concerns regarding the principles of compliance with operating procedures and management philosophy and actions.... We can draw no conclusion on this item pending the completion of the ... investigation[]." Supp. No. 2 stated "completion of the investigation could turn up information which is related to past management practices," and that the NRC would resume its investigation after DOJ completed its investigation. Supp. No. 2 concluded that "on the basis of information thus far obtained ... there appears to be no direct connection with the Unit 2 accident."

The Licensing Board in its First Partial Initial Decision, covering the management issues, noted the limited information on the matter, and stated that "[s]ubject to [the DOJ investigation] ... we find no deficiencies in the corporate or plant management ... that have not been corrected and which must be corrected before there is reasonable assurance that Unit 1 can be operated safely." 14 NRC 381, 557.

After Hartman testified in the GPU v. Babcock and Wilcox (B&W) litigation,[11] the Aamodts and TMIA requested the Appeal Board to reopen the record on the Hartman allegations. In ALAB-738 the Appeal Board ordered the record reopened and referred the allegations to the Licensing Board for further hearings. 18 NRC 177 (1983). The Appeal Board, noting that the matter had lain dormant until revived by an examination by the B&W trial record, held that the Hartman allegations raised significant safety issues. The Appeal Board stated that alleged violations of technical specifications, noncompliance with proper operating procedures, and destruction and falsification of records at Unit 2 before the TMI-2 accident -- all assertedly under the auspices of at least first level management -- had serious implications for any proposed

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[11] GPU sued B&W in the United States District Court for the Southern District of New York (80 Civ. 1683(RO)), claiming that B&W should be held liable for causing the TMI-2 accident. That lawsuit was settled after nearly three months of trial. Much of the information developed in that trial appeared to relate to licensee's management competence and integrity, and hence appeared relevant to the restart proceeding. Accordingly, the Commission directed the NRC staff to review the trial material, and provided the parties to the restart proceeding an opportunity to comment both on the material and on staff's review, NUREG-1020, "GPU v. B&W Lawsuit Review and its Effect on TMI-1" (September 1983).

restart of Unit 1. The Appeal Board also noted that the Hartman allegations fell within the scope of issues that the Commission directed be resolved through the hearing process, and that it could not make a final judgment on licensee's management competence and integrity without developing a record on the Hartman allegations.[12]

In response to various then-unresolved issues, including the Hartman allegations, licensee on June 10, 1983 committed to several organizational changes. Licensee committed to reassign personnel, with the exception of the Manager of Operations, Michael Ross, such that no individual licensed to operate TMI-2 prior to the accident would work in an operational position at TMI-1. Licensee also committed to place degreed engineers on shift to provide operational quality assurance coverage on a full-time basis until the open issues were resolved. Further, licensee stated that until the open issues were effectively resolved, it would reassign personnel "such that those functions which provide an overview assessment, analysis, or audit of plant activities ... will contain only personnel with no pre-accident involvement as exempt Met Ed employees at TMI-1 or 2." Finally, licensee committed to reallocate the priorities and assignments within the Office of the President of GPU Nuclear.

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[12]Among the matters the Commission directed the Licensing Board to examine was "[W]hether the actions of Metropolitan Edison's corporate or plant management (or any part or individual member thereof) in connection with the accident at Unit 2 reveal deficiencies in the corporate or plant management that must be corrected before Unit 1 can be operated safely." 11 NRC 408, 409 (1980).

On October 7, 1983 the Commission took review of whether the hearing on the Hartman allegations should be stayed until the Commission's Office of Investigations (OI) had completed an investigation it had recently started on the Hartman allegations. To preserve the status quo, the Commission stayed the Appeal Board decision pending receipt and consideration of the parties' comments. (Unpublished Order of October 7, 1983.) At the time it issued the order the Commission was concerned that concurrent efforts by OI and the Licensing Board on the Hartman allegations could involve a duplication of effort and constitute a possible source of complaint of harassment of witnesses.

After the Commission stayed the hearing, DOJ asked the Commission to stay further agency activity related to the Hartman allegations until the then pending criminal trial, United States v. Metropolitan Edison Company, Crim. No. 83-00188 (M.D. Pa.), which involved the leak rate practices at TMI-2, had been completed. The Commission agreed to cooperate with the Department of Justice and suspended the OI investigation.

The Commission held an open meeting on November 28, 1983 to hear from GPU on its June 10, 1983 management organization proposal and any subsequent changes.[13] GPU in its presentation stated that its June 10, 1983 plan had been implemented, and also committed to the following furtner steps. First, GPU would elect three outside directors "with

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[13]This meeting was held as part of the Commission's review of whether to lift the immediate effectiveness of the 1979 Orders which require that TMI-1 remain in a shutdown condition.

meaningful credentials and demonstrated independence" to the GPU Nuclear Board of Directors. Second, these new directors would comprise a Nuclear Safety and Compliance Committee of the GPU Nuclear Board, which would employ a staff to monitor the operation and maintenance of the GPU system nuclear units.[14] Third, the Nuclear Safety and Compliance Committee would periodically issue reports regarding the operation and maintenance of the GPU system nuclear units, and those reports would promptly be provided to the NRC and the public. Fourth, Robert Arnold, who had been President of GPU Nuclear, was reassigned to non-nuclear work within the GPU system. Philip Clark, formerly Executive Vice President, replaced Arnold as President of GPU Nuclear, while E.E. Kintner, formerly Vice President, became Executive Vice President. Both Clark and Kintner were elected members of the Board of GPU Nuclear.[15]

Subsequently, on February 6, 1984, GPU Nuclear announced further changes to its organization. John F. O'Leary, former Deputy Secretary of the Energy Department and GPU Board member since October 1979, was elected Chairman of GPU Nuclear. Clark, President and Chief Operating Officer of GPU Nuclear, was also appointed Chief Executive Officer. Herman Dieckamp, former Chairman and Chief Executive Officer of GPU

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[14]Licensee notified the Commission on March 15, 1984 that Messrs. Lawrence L. Humphreys (Chief Executive Officer of UNC Nuclear Industries), Warren F. Witzig (Chairman, Nuclear Engineering Department, Pennsylvania State University), and Robert V. Laney (consultant in nuclear and energy project management) had been elected to the GPU Nuclear Board of Directors, and that they would make up the Nuclear Safety and Compliance Committee.

[15]The Commission heard oral presentations by the other parties on December 5, 1983 on GPU's proposal.

Nuclear since its inception, remained only as a Director of GPU Nuclear, although he continued to hold the position of President, Chief Operating Officer, and a Director of GPU.

Metropolitan Edison Company ("Met. Ed.") entered into a plea agreement on February 29, 1984 with the United States which ended the criminal prosecution. Met. Ed. pleaded guilty to one count of the indictment charging it with failure to establish, implement, and maintain an accurate and meaningful reactor coolant system water inventory balance procedure to demonstrate that unidentified leakage was within the allowable limits. It also pleaded no contest to six other counts of the indictment, including those which charged the company with improper manipulation of TMI-2 leak rate tests to generate results that would fulfill the company's license requirements.

After the settlement, the Commission asked the federal district court to provide the Commission with the record of the grand jury proceeding which led to the indictment of Metropolitan Edison. The court denied the request. United States v. Metropolitan Edison Co., Crim. No. 83-00188 (M.D. Pa. June 25, 1984).

On September 11, 1984, the Commission issued an order lifting the stay of the hearing. CLI-84-17, 20 NRC 801. Simultaneously, the Commission sought the views of the parties on whether in light of changed circumstances the record still needed to be reopened on the Hartman allegations and, if so, what the scope of the hearing should be. CLI-84-18, 20 NRC 808.

B. Parties' Comments

The Commonwealth, TMIA, and UCS urged the Commission to allow the hearings on TMI-2 leak rate practices to be held, while the NRC staff and the licensee opposed those hearings.

The Commonwealth argued that even though the Hartman allegations resulted in the criminal conviction of the licensee, further hearings are warranted because information on past TMI-2 leak rate practices has not been fully disclosed to the public. The Commonwealth asserted that without further inquiry it is unable to conclude that no one currently within TMI-1 management had knowledge of the leak rate falsifications, and that the question of who within the GPU organization had knowledge of or participated in the falsification of TMI-2 leak rate tests should be resolved prior to TMI-1 restart.

TMIA agreed with the reasons for hearings provided by the Appeal Board in ALAB-738. TMIA also relied extensively on statements made by the U.S. Attorney for the Middle District of Pennsylvania in recommending that the court accept the plea bargaining arrangement reached between the United States and Metropolitan Edison. For example, the U.S. Attorney told the court that he was prepared to introduce evidence that Metropolitan Edison had engaged in the practice of falsifying data and discarding records in order to stay within the leak rate specifications required under its NRC license.

TMIA argued that, ever since the Hartman allegations surfaced, GPU has provided dishonest responses regarding the matter and that high level officials such as William Kuhns, Chairman of the Board of GPU, Herman Dieckamp, President of General Public Utilities (GPU), Philip

Clark, President of GPU Nuclear (GPUN), and E.E. Kintner, Executive Vice-President of GPU Nuclear, and the Board of Directors are directly responsible for providing less than candid responses. TMIA claimed that licensee continues to deny and cover up the facts associated with the falsification scheme, noting that licensee, even though it pled guilty, told the court that it did not admit any facts which would support a finding of guilt. Accordingly, TMIA believed that the record should be reopened so that management responsibility for the data falsification and the alleged continuing coverup can be examined.

UCS argued that the systematic, widespread and long-standing falsification of leak rate tests at Unit 2, undertaken to allow the plant to operate when it should have been shut down for safety reasons, is a grave indictment of the integrity and competence of the licensee and constitutes sufficient reason for precluding restart. UCS maintained that GPUN bears continuing responsibility for these acts.

Like TMIA, UCS believed that GPUN is engaged in a continuing coverup regarding the matter. UCS stated that GPUN's effort both before and since the guilty plea has been to disassociate itself from the TMI-2 leak rate falsification by reassigning potentially involved individuals, and that this reshuffling is a sham. UCS stated that Unit 2 operators with clear potential direct involvement in leak rate falsification have been placed in responsible positions important to safety at TMI-1.

UCS stated that GPUN continues to deny that leak rate falsification took place, and to date has taken no disciplinary action against any person involved in or responsible for leak rate falsification. UCS asserted that GPUN is now just beginning a thorough investigation into

the Hartman allegations, and that GPUN will seek to use every possible avenue to minimize the problems and to deny rather than correct them.

The Aamodts stated that the Commission cannot rely on OI's investigations and staff's findings. The Aamodts claimed that the NRC staff's judgment cannot be relied on because staff kept the Hartman allegations out of the restart proceeding. The Aamodts expressed concern about a conclusion in OI's report on TMI-1 leak rate practices that Michael Ross, Manager of Plant Operations at TMI-1, did not have any knowledge of leak rate falsification at Unit 2 because he was only on duty a few hours each month. They believed that the OI conclusion on Ross was unreasonable. They stated that Ross testified in the restart proceeding that he had frequent interchanges with TMI-2 operators and that he was in daily contact with the manager of TMI-2. Therefore, the Aamodts concluded, he must have had knowledge of leak rate practices at TMI-2.

Licensee, on the other hand, saw no need for hearings. Licensee stated there needs to be resolution of the Hartman allegations because the lack of such resolution prevents it from making full use of individuals associated with leak rate testing at TMI-2. It argued, however, that any further investigations and public proceedings which may grow out of the need to develop the facts should not be done in the context of the TMI-1 restart proceeding.

Licensee noted that it and the NRC were investigating leak rate testing practices at TMI-2, and that the investigations will provide an adequate basis for resolving the status of the separated individuals. Licensee also argued that any hearings should be separate from the restart proceeding because, pending the outcome of these investigations,

licensee has agreed that, except for Ross, who has been cleared of involvement in the leak rate falsifications by the NRC investigators and the NRC staff, no individual licensed to operate TMI-2 prior to the accident would operate TMI-1.

Licensee quoted the U.S. Attorney's statement in support of the plea bargaining agreement in the criminal proceeding that its senior management had not been found by the U.S. Attorney to have participated in, directed, condoned or been aware of the facts or omissions that were the subject of the indictment. Licensee argued that in the absence of any involvement with the Hartman allegations by current TMI-1 management, there is no need to reopen the restart hearings on the Hartman allegations.

With respect to the arguments made by TMIA and UCS that licensee has not admitted that TMI-2 leak rate tests were falsified, licensee stated that it has not had the basis to admit or deny the allegations of leak rate falsification because investigation of these allegations has not been completed. Licensee asserted that during the pendency of the criminal case it was unable to interview those individuals involved in leak rate testing at TMI-2. Licensee stressed that as soon as the criminal case was completed it engaged Edwin Stier to conduct an independent investigation of leak rate practices. Licensee asserted that once the facts have been gathered, licensee and others will be in a position to conclude whether leak rate falsification occurred at TMI-2.

With respect to UCS' allegations that no disciplinary action has been taken against persons involved in or responsible for leak rate falsification, licensee argued that it is unreasonable to expect licensee

to take any action before the full facts have been developed and before the affected individuals have been given the right to respond and confront individuals speaking against them.

The NRC staff in concluding that hearings are not warranted relied heavily on the statements by the U.S. Attorney at the sentencing hearing. Staff believed, based on the statements by the U.S. Attorney, that first-line supervision and possibly middle management were directly involved in leak rate falsification at TMI-2, but that there is no indication 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 covered by the indictment, participated in, directed, condoned, or were aware of the facts that led to the indictment.

In addition, staff asserted that individual operators licensed at TMI-2 prior to the accident who might have been involved in or implicated in leak rate falsification at TMI-2 are not currently involved in TMI-1 operations. Staff excepted Michael Ross from this category. Staff, based on the available evidence, concluded that Ross had not engaged in any wrongdoing.

Staff concluded that although the Hartman allegations raised significant safety issues and, if considered, might well have led the Licensing Board to reach a different result with regard to the adequacy of previous TMI-1 staffing, "the individuals possibly involved in culpable activities are no longer associated with TMI-1 operations." Staff Comments at 18. Therefore, in the staff's view 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.

C. Analysis

The leak rate falsifications at TMI-2 clearly have a significant bearing on any evaluation of Met. Ed.'s preaccident performance. However, the issue before the Commission today is whether, in view of the changes in licensee's personnel, organizational structure, and procedures, the TMI-2 leak rate falsifications still meet the standards for reopening the restart proceeding, i.e., whether they currently raise a significant safety issue which might have affected the Licensing Board's decision. This determination cannot be based solely on an examination of the extent of pre-accident wrongdoing and the fact that the Licensing Board made its original management decision subject to the Hartman allegations (the factors addressed by the Appeal Board), but must also consider undisputed events in the past five years which bear on whether the prior significance of the falsifications has now been eliminated, and whether any significant safety issues still remain.[16]

To determine whether the Hartman allegations still raise a significant safety issue, the Commission must first consider whether the

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[16] TMIA appears to argue that some of Hartman's other allegations warrant reopening. See note 9, supra. Those issues, which were fully explored in NUREG-0680, Supp. No. 5, even if true do not raise current significant safety concerns because they primarily relate to pre-accident procedures and individuals no longer employed in operational positions at TMI-1.

personnel likely responsible for the falsifications under Met. Ed. are now in responsible management positions at GPU Nuclear or directly associated with the operation of TMI-1.[17] If the personnel are still the same, then there is merit to the argument that there has been a change only in name, not in substance, and the integrity concerns raised by the Hartman allegations remain significant. However, if the persons likely responsible for or involved in the TMI-2 leak rate falsifications are not assigned to responsible management or operational positions at TMI-1, then the Hartman allegations no longer raise concerns about the integrity of those who will operate TMI-1. In that event, however, the Commission further should consider whether the new personnel, organizational structure, and procedures provide reasonable assurance that similar procedural violations will not recur.

1. Whether the Personnel Likely Responsible for the Falsifications Under Met. Ed. are Also in Responsible Management Positions at GPU Nuclear or Directly Associated With the Operation of TMI-1

There have been significant changes in licensee's personnel since 1979, including many since the record originally closed in 1981. Metropolitan Edison Co. has been replaced by GPU Nuclear as the licensee

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[17] The Commission does not believe that individuals in other positions, even if implicated in the Hartman allegations, pose a risk to the safe operation of the plant. The present system of checks and balances and procedural safeguards ensures that no individual in other positions can adversely affect the plant's operation. See discussion infra.

at TMI-1, and GPU Nuclear has a new chairman and revised Board of Directors, a new Nuclear Safety and Compliance Committee, a new President, Executive Vice President, Vice President of TMI-1, Chairman of the General Operations Review Board, and numerous other lower-level managers.[18] In addition, until the Hartman matter is resolved licensee has committed not to return any individuals (except Michael Ross) licensed to operate TMI-2 prior to the accident to operational positions at TMI-1.[19]

With these changes in mind, the Commission has reviewed all operators and supervisors licensed at TMI-2 prior to the accident, and those managers in the line of command over operations up to the level of Vice President of Generation,[20] to identify those likely to have had knowledge of or involvement in the leak rate practices prior to the accident, and hence who may have condoned or participated in the falsifications. Of

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[18]Philip Clark, GPU Nuclear President, informed the Commission during oral presentations on August 15, 1984 that of the twelve senior GPU Nuclear employees, eight had joined the GPU system after the TMI-2 accident, and three of the remaining four had no involvement with Met. Ed. Of 435 key personnel (including managers, technical/professional and licensed operators), 235 joined GPU after the accident and another 100 had been employed within the GPU system prior to the accident, but not with Met. Ed.

[19]The Commission does not rely on two other commitments by licensee -- to reassign exempt employees and provide round-the-clock quality assurance coverage by degreed engineers -- in its analysis of the Hartman allegations. With regard to licensee's fourth commitment -- to expand its Board of Directors and create a Nuclear Safety and Compliance Committee -- the Commission infra makes the commitment a condition.

[20]The Vice President of Generation is the highest position possibly implicated by the U.S. Attorney's statement at the sentencing hearing. See NUREG-0680, Supp. No. 5 at 5-6.

these individuals, only two are currently employed in responsible management positions at TMI-1, and only one, Michael Ross, remains in an operational position. The other is Brian Mehler, manager of the Radwaste Department. In addition, the Commission has considered the impact of the continued presence of William Kuhns, Chairman of GPU, and Herman Dieckamp, formerly Chairman and Chief Executive Officer of Met. Ed. and now President, Chief Operating Officer and a Director of GPU, and a member of the Board of GPU Nuclear.

Michael Ross, the Manager of Operations at TMI-1, is clearly in a significant safety position. Indeed, the Licensing Board observed that it "was pleased to have the opportunity to observe Mr. Ross so thoroughly because he may be the most important person on the TMI-1 operating team as far as the public health and safety is concerned." 14 NRC 381, 438 (1981).[21] Recognizing Ross' significance, the Commission directed OI to examine his involvement at TMI-2 when it investigated pre-accident leak rate practices at TMI-1.

OI in its investigation interviewed Ross and many others under oath regarding his involvement at Unit 2, and reviewed records of his activities at TMI-2. Those interviewed by OI included shift supervisors who were licensed on both TMI-1 and -2 prior to the accident, the pre-accident TMI-2 Supervisor of Operations, previous TMI-1 Plant Superintendents, a

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[21]The Licensing Board went on to note its belief that licensee's reliance on Ross was justified, and that the Board "was very favorably impressed by his appearances." 14 NRC at 440. Later allegations that Ross was involved in the cheating incidents were determined to be unfounded. 16 NRC 281, 333, affm'd 19 NRC 1193 (1984).

former TMI-1 and TMI-2 Shift Foreman, and engineering personnel. The evidence developed by OI showed that Ross' role at TMI-2 was minimal, that during the period falsifications took place he was present at TMI-2 only the minimum time necessary to maintain his Unit 2 license,[22] and that he was not involved in the falsifications:

> "During these interviews, particular emphasis was placed on determining if the current TMI-1 Operations Supervisor (Michael Ross) was either aware of or involved in the falsification of leak rate surveillance tests at TMI-2. None of these interviewees, though, either alleged or implicated Ross in any improprieties at TMI-2 or TMI-1. Additionally, they supported earlier testimony given by Ross to the NRC that he had only minimal involvement in TMI-2 operations.

OI Supplemental Report 1-83-028 at 2.

Hence the only evidence even possibly linking Ross with TMI-2 leak rate falsifications is that he was cross-licensed on TMI-2, and therefore he could be presumed to have had some knowledge of TMI-2 activities. In view of OI's conclusions, the Commission finds that the mere fact that Ross was cross-licensed does not indicate that he was aware of the falsifications. The Commission concludes that it is highly unlikely that Ross knew of or was involved in leak rate falsifications at TMI-2, and that his continued presence at TMI-1 does not raise a safety concern.

There is a greater likelihood that Mehler, who was a shift supervisor at TMI-2 prior to the accident, had knowledge of or was involved in the falsifications. However, the relevant evidence is circumstantial

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[22] See, e.g., OI Supplemental Report 1-83-028, Exhibit 1 at 25; Exhibit 2 at 23-24; Exhibit 7 at 6-7, 17; Exhibit 8 at 45; Exhibit 9 at 21; Exhibit 12 at 26.

rather than direct,[23] and, in any event, Mehler is now employed in the radwaste department, and therefore has no direct involvement in operating the reactor. The Commission has decided based on available information that, given the lesser safety significance of his present position, no further action regarding Mehler is necessary for TMI-1 to be operated safely, because retaining him in his present position does not pose a significant risk to public health and safety, at least for the time before the separate hearings on this issue can be completed.

Even though these are the only two individuals of concern currently in management or operational positions at TMI-1, the Commission must also address the possible return of other pre-accident TMI-2 operators and their supervisors. Licensee has committed not to return individuals licensed at TMI-2 prior to the accident to operational positions at TMI-1.

The Commission has decided to modify licensee's commitment somewhat to provide added assurance that none of those likely involved in the TMI-2 falsifications, or who had direct management supervision over operations, occupy responsible management or operational positions at TMI-1 without specific Commission approval. To accomplish this, the Commission will require that no pre-accident TMI-2 operator, shift supervisor, shift foreman, or any other individual both in the operating

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[23] The Commission agrees with staff's statement in NUREG-0680, Supp. No. 5 that there is no direct evidence of improper acts by Mehler. However, the evidence indicates that falsifications were so widespread that, for purposes of this decision, the Commission will presume that all regular TMI-2 operators and shift supervisors might have known of the falsifications. (Ross was not a regular TMI-2 shift supervisor.)

crew and on shift for training as a licensed operator at TMI-2 prior to the accident be employed at TMI-1 in a responsible management or operational position without specific Commission approval. "Operational position" as used in this condition includes any position involving actual operation of the plant, the direction or supervision of operations, or independent oversight of operations. This condition shall also apply to the pre-accident Vice President, Generation, TMI-2 Station Manager, TMI-2 Superintendent, and TMI-2 Supervisor of Operations, all of whom were implicated by the United States Attorney in his Statement of Facts at the sentencing hearing. See NUREG-0680, Supp. No. 5 at 5-4.[24] However, as explained supra, this condition shall not apply to Ross, and the Commission has determined consistent with this condition that Mehler may continue in his present position. However, Mehler may not be transferred to another position covered by this condition without prior Commission approval. As explained infra, the Commission will institute a separate proceeding which will address the status of any individual currently employed at or wishing to return to a licensed nuclear power facility in an operational or responsible management position. The condition imposed above will remain in effect until that hearing has been completed.

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[24]The Commission notes that the NRC staff in NUREG-0680, Supp. No. 5 stated that certain specified individuals (Zewe and Seelinger) could not be returned to responsible management positions without staff approval solely because of their possible involvement in TMI-2 leak rate falsifications. The Commission finds that these individuals should be treated the same as others who were in equivalent positions. Accordingly, their employ is limited only by the above-imposed condition.

The Commission has also considered GPU Nuclear's upper management, of which only William Kuhns and Herman Dieckamp possibly could be held accountable for the criminal acts at TMI-2. There is currently no direct evidence that either Kuhns or Dieckamp knew of, condoned, or was involved in leak rate falsifications at TMI-2. In the Change of Plea and Sentencing of Metropolitan Edison on February 28, 1984, United States Attorney David Queen stated that the evidence developed in the grand jury inquiry does not indicate that any of the Directors and Officers of GPU Nuclear from its inception in 1982 to the date of the indictment, or any of the Directors of Met. Ed., "participated in, directed, condoned or was aware of the acts or omissions that are the subject of the indictment." Queen specifically included Kuhns and Dieckamp in this category. The Commission recognizes that neither it nor the public has access to the information before the grand jury which led to this statement. However, the Commission believes it is justified in relying on a good faith statement by the U.S. Attorney to the court.

Moreover, the Commission does not believe that executive managers at their level ordinarily are involved in daily plant operations to the extent that they would be familiar with the details of how normal surveillance procedures are carried out, nor does the Commission believe they should be. Cf. Dieckamp testimony in hearing on training at 28615 ("I was not knowledgeable about specific plant systems and their detailed purpose or the procedures for operating"). We believe the positions of Messrs. Kuhns and Dieckamp are so far removed from actual operations

that it would be highly unlikely that either knew of the leak rate practices.[25]

The Commission has nonetheless given considerable thought to the arguments that (1) Kuhns and Dieckamp should be held responsible for the acts of those under them, whether or not they knew what was occurring, and (2) if they did not know what was occurring, they should be faulted for not knowing because of the apparent widespread nature of the falsifications. If the Commission subscribed to either theory, it could find that there should be a hearing on the Hartman allegations in the restart proceeding.

The Commission cannot find from the available evidence that Kuhns and Dieckamp were responsible for the attitude that allowed the falsifications to occur. The Commission is concerned with the apparent extent of falsification and the attitude that allowed such acts to occur. However, the Commission places primary responsibility for that attitude on those managers in charge of day-to-day plant operation, not on Kuhns and Dieckamp.

Nor does the Commission subscribe to the view that individual executive managers and Board members such as Kuhns and Dieckamp should be held personally responsible for all acts of subordinate employees. The Commission believes that only a few high-level employees are in such positions of responsibility that their acts may be considered synonymous

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[25]The Commission notes in this regard that none of those interviewed by OI suggested that executives such as Kuhns or Dieckamp had any actual knowledge of leak rate practices.

with those of the company, and therefore that the executive managers as part of the corporate entity should be held responsible for their acts. However, even in those cases the company or executive managers should not necessarily be censored for the improper acts, if adequate corrective actions, such as discipline or removal, are implemented. As for other employees, the Commission expects executive managers and Board members to encourage a policy of discovering any problems or improper acts and of taking appropriate corrective action. However, the Commission will not hold, purely as an abstract matter, that executives such as Kuhns and Dieckamp are completely responsible for the acts of individual employees. For such responsibility to attach, there must be some knowledge of or involvement in those acts at the executive level. The Commission has found none in the present case.

Given the apparent extent of the leak rate problems, however, the Commission does fault Kuhns and Dieckamp for not having procedures in place to bring the leak rate problems to higher management's attention. Again, there is no reason to expect or require senior executives to be involved in or directly supervise day-to-day plant operations, but they should have procedures in place so that significant problems come to their attention. The Commission finds that, if falsifications were as widespread as it appears, plant management should have been aware of it and stopped it, and senior management should have been aware of plant management's failure. However, this failure must be viewed in context with remedial steps subsequently taken. The Commission is convinced that with the current organizational structure and procedures any future such failures will be identified to senior management. See discussion

infra. Since there was no apparent personal involvement by Kuhns or Dieckamp in the wrongdoing, and given the remedial procedures now in place, the Commission has concluded that the continued presence of Kuhns or Dieckamp does not result in the Hartman allegations raising a current significant safety concern.[26]

2. Whether GPU Nuclear has Appropriate Personnel, Operational Structure, and Procedures to Assure That Such Procedural Violations Will Not Again Occur

Clearly the leak rate falsifications demonstrate significant past procedural deficiencies. However, they are but one more example of Met. Ed.'s pre-accident failings in this area. The restart proceeding was not intended to litigate all licensee's past failings, but rather to determine whether TMI-1 can be safely operated now. See discussion infra on TMI-1 leak rate practices. The Commission is satisfied that the extensive examination of GPU Nuclear in this proceeding is sufficient to ensure that the personnel, procedures, and organization currently in place provide reasonable assurance that similar procedural deficiencies will not recur.

With regard to the specific issue of leak rate tests, there are numerous daily or weekly tests, in addition to leak rate tests, which,

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[26]The Commission has also considered the arguments that licensee is engaged in a continuing coverup of the TMI-2 leak rate falsifications. Licensee states it has been unable to pursue the matter because of the grand jury investigation, and accordingly took no action until the criminal trial was completed. Licensee is now investigating the matter. These actions do not indicate a coverup.

pursuant to NRC requirements, must be run at a nuclear plant. A practical method to assure that all these tests are run correctly and honestly is through general oversight of operations by independent organizations reporting to senior management. The Commission in this connection directed the Licensing Board to examine "whether Metropolitan Edison has made adequate provision for groups of qualified individuals to provide safety review of and operational advice regarding Unit 1." CLI-80-5, 11 NRC 408, 409 (1980). The Licensing Board noted that "GPU Nuclear Corporation has instituted major organizational and staffing changes in order to provide additional safety review and operational advice regarding TMI-1," and that:

> GPU Nuclear Corporation's safety review and operational advice programs are designed to assure that activities are performed in accordance with company policies and applicable laws, standards, policies, rules, regulations, licenses, and technical requirements; that proposed plant, test and procedural modifications received independent review; that events, including those that require prompt reporting to the NRC, are investigated and corrected in a manner which reduces the probability of recurrence of such events; and that trends which may not be apparent on a day-to-day basis or by consideration of individual items are detected and appropriate action taken.

14 NRC at 519-20. The Licensing Board after examining these programs concluded that "Licensee has made adequate provisions for groups of qualified individuals to provide safety review of and operational advice regarding TMI-1." 14 NRC at 528. The Commission will not repeat the details of licensee's safety review process here, but notes its general agreement with the Licensing Board's comments.

In addition, as indicated supra, licensee has expanded its Board of Directors, and created a Nuclear Safety and Compliance

Committee of that Board. The Committee, which will have an independent staff of its own, is designed to monitor the operation and maintenance of the GPU System's nuclear units, with specific attention to adherence to procedures and license requirements. This will provide even further assurance that operational tests will be overseen thoroughly. To ensure that these commitments remain in place, the Commission has decided to adopt them as conditions.

GPUN's quality assurance (QA) program also acts to ensure that surveillance procedures such as leak rate tests are properly done. The Licensing Board, noting that licensee's overall QA organization and staffing for TMI-1 "has been restructured and improved since the TMI-2 accident," stated that the major areas of improvement were "greater involvement of the QA organization in the review and approval of quality-related aspects of procedures for operations, maintenance, inservice inspection, modifications and procurement; in the performance of inservice inspections, nondestructive examinations, routine inspections, verification, surveillance and audit activities ...." 14 NRC at 425, 427. The Licensing Board was "satisfied that Licensee's QA organization and program will be in a position to reasonably assure, or bring to the attention of top management in those cases where it cannot assure that the organizations which make up the plant and corporate structure are performing properly the functions for which they were intended." Id. at 428.

Further, licensee's basic organizational structure has been substantially improved with the creation of GPU Nuclear. The

Licensing Board examined, among other things, licensee's management structure, corporate organization, on-site organization, and technical resources, and found all to be adequate. The Commission finds that the Licensing Board's examination of licensee in all these respects ensures that these pre-accident procedural deficiencies no longer raise a significant safety concern.

3. Summary of Current Significance of Hartman Allegations

The Commission therefore finds that the pre-accident TMI-2 leak rate falsifications do not raise a currently significant safety issue. Those likely involved in the improper acts are not employed in responsible management or operational positions at TMI-1, and as a result of the in depth examination of licensee in the management proceeding, the Commission has confidence that GPU Nuclear has the necessary integrity and competence to comply with procedures. The Commission concludes that the Hartman allegations no longer raise a significant safety issue which might have affected the Licensing Board's decision, and therefore reverses the Appeal Board's decision to reopen the record on this matter.

4. Institution of a Separate Proceeding

The Commission in the order taking review of this issue also asked whether, if a hearing on the Hartman allegations were not legally required, there should be a hearing separate from the restart proceeding to allow the matter to be fully aired. The Commission has decided that some hearing is warranted in order to determine the ultimate status of

those likely involved in the TMI-2 leak rate falsifications, which includes those licensee has segregated from operational duties at TMI-2 and those now working at other nuclear facilities.

The Commission has decided that a separate proceeding would be appropriate for several reasons. As explained supra, the Hartman allegations do not raise a significant issue for current operation of TMI-1. Hence there remains little reason to litigate that issue within the restart proceeding. Further, the individuals likely involved are now dispersed throughout the country. The Commission believes those individuals should receive notice of this hearing and be allowed to participate. A hearing into the involvement of those who are or may be employed by other licensees clearly has no bearing on the restart of TMI-1.

Accordingly, the Commission in the near future will issue a notice of hearing instituting a separate hearing on the TMI-2 leak rate falsifications. While that notice will specify the scope of the hearing and the procedures to be followed more precisely, the Commission intends the hearing to develop the facts surrounding the falsifications in sufficient detail to determine the involvement of any individual who may now work, or in the future desire to work, at a nuclear facility; specifically, whether any such individual participated in, or knew of and condoned, or by their dereliction or culpable neglect allowed the leak rate falsifications at TMI-2, and, if so, what action is appropriate. The hearing will not address those specifically cleared by the U.S. Attorney in his

statement at the sentencing hearing, which includes Kuhns and Dieckamp.[27] As explained supra, the Commission feels it is entitled to rely on that statement, and it does not believe that agency resources should be used to duplicate the work of the grand jury where the result of that inquiry is known. Finally, the hearing will not address Michael Ross because, as explained supra, the Commission finds, based on OI's investigation into TMI-1 leak rate practices, that the possibility of his involvement is so remote that it does not warrant further consideration.

III. TMI-1 Leak Rate Testing Practices

In September and October of 1983 the NRC staff through a series of Board Notifications notified the Appeal Board that, contrary to its earlier assertions in NUREG-0680, Supp. No. 2, there were indications that leak rate falsification may have occurred at TMI-1. This conclusion was based on a review of 645 test records over the period from April 1, 1978 to March 31, 1979. That review identified thirteen instances of

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[27] The U.S. Attorney stated that "the evidence presented to the Grand Jury and developed by the United States Attorney does not indicate that any of the following persons participated in, directed, condoned or was aware of the acts or omissions that are the subject of the indictment. And they are William G. Kuhns, Herman M. Dieckamp, Robert C. Arnold, James S. Bartman, Shepard Bartnoff, Frederick D. Hafer, Richard Heward, Henry D. Hukill, Edwin E. Kintner, James R. Leva, Bernard H. Cherry, Phillip R. Clark, Verner H. Condon, Walter M. Creitz, Robert Fasulo, Ivan R. Finfrock, William L. Gifford, Robert L. Long, Frank Manganaro, Ernest M. Schleicher, Floyd J. Smith, William A. Verrochi, Raymond Werts and Richard F. Wilson.

The list of individuals I just read includes all of the Directors and Officers of GPU Nuclear Corporation from its organization in 1982 to the date of the indictment and all the Directors of the Defendant Company during the period covered by the indictment."

water additions, eleven instances of hydrogen additions, thirteen instances of feed-and-bleed operations, and one of all three kinds of instances, that were not properly accounted for in the leak rate test calculations. This matter accordingly was referred to OI for investigation.

Subsequently, the Aamodts filed a motion with the Appeal Board requesting that the record be reopened on this matter. UCS and the NRC staff supported the Aamodts' motion. OI completed its investigation report into this matter while the Aamodts' motion was pending before the Board. OI Investigative Report No. 1-83-028.

The Appeal Board in ALAB-772, 19 NRC 1193, granted the motion to reopen the record on this issue. The Appeal Board stated that it necessarily followed that this matter might have made a difference to the Licensing Board's decision because the Licensing Board had made its decision "subject to" the Hartman allegations. The Appeal Board found the new "allegations" potentially more significant than the Hartman allegations because they related to TMI-1.

The Appeal Board also found that its conclusion was reinforced by OI's investigative report on TMI-1 leak rate practices. The Appeal Board noted that the overall conclusions of the report were favorable to licensee in that OI found neither a systematic pattern of falsification nor a motive to falsify the leak rate data. The Appeal Board noted, though, that the OI report disclosed (1) a lack of understanding regarding record-keeping requirements; (2) ignorance by both operating staff and management of the existence and significance for leak rate

calculations of a "loop seal" in the instrumentation system;[28] and (3) inattention during the pre-accident period to work requests that would have highlighted the loop seal problem.

The Appeal Board stated that the OI reports had not been introduced into evidence in the proceeding and had not been subject to cross-examination. It held that the type of material presented by OI is best scrutinized by the Licensing Board as part of its review of all of the circumstances surrounding the leak rate testing practices at Unit 1. The Appeal Board directed the Licensing Board to consider TMI-1 leak rate practice in conjunction with the hearing it had previously ordered in ALAB-738 on TMI-2 leak rate practices.

D. Parties' Comments

The Commonwealth, the Aamodts, TMIA, and UCS advocated that hearings are warranted on TMI-1 leak rate practices. The NRC staff and the licensee disagreed.

The Commonwealth argued that while OI did not find systematic falsification of leak rate testing at TMI-1, it found some irregularities in testing practices and management procedures. The Commonwealth believed that whether these problems have been properly resolved by current management is significant to TMI-1 restart, and that the Commission cannot safely conclude that the leak rate testing problem is history until an evidentiary hearing has been held.

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[28] The "loop seal" provided a mechanism by which additions of hydrogen would affect the leak rate tests results.

The Aamodts noted that while the conclusions in the OI report are favorable to GPUN, the OI investigations have not been entered into the record of the proceeding and therefore cannot form a legal basis for a Commission decision.

TMIA argued that while leak rate falsification was not as pervasive at Unit 1 as at Unit 2, manipulations and wide-spread disregard of license requirements occurred at Unit 1. TMIA asserted that the OI report on Unit 1 indicated that "bad" leak rates at Unit 1 were routinely discarded in violation of NRC and license requirements and tests showing negative leak rates within one gpm were accepted as valid, even though the operators were well aware that such tests were not legitimate and could not reflect actual plant conditions.[29] TMIA noted that these are the precise violations to which Met. Ed. pled guilty regarding Unit 2. TMIA claimed, for example, the procedures were routinely violated, with the blessing of Ross. TMIA asserted that even if the violations were not for the purpose of concealing actual leakage in excess of technical specification requirements, manipulations were done to mislead the NRC as to the adequacy of licensee's procedures.[30] In TMIA's view, at the

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[29]TMIA asserted that the Commission should not rely on the OI investigation. It stated that the Department of Justice decision to indict Met. Ed. made the criminal nature of leak rate falsification painfully clear to TMI-1 operators interviewed by OI, and accordingly it is not surprising that the operators denied actual knowledge of falsification.

[30]TMIA argued that neither OI nor the staff have yet explained why "spurts" of hydrogen would have been added in the particularly small quantity evident from OI's technical review, other than for the purpose of affecting leak rate test results.

point at which management recognized that the system for identifying leakage was not working, there could no longer be assurance that the plant was safe, and management should have immediately responded to the problem. TMIA concluded that Unit 1 management in condoning such activities evidenced no greater respect for NRC requirements and obligations than those responsible for Unit 2 violations. TMIA accordingly concluded that the staff conclusion that "none of the operational or management personnel at TMI-1 were involved in culpable activities" is clearly wrong.[31]

TMIA also made an argument apparently related to the truthfulness of current TMI-1 employees. TMIA noted that a Region I inspector, Dr. Jin Wook Chung, discovered in a Unit 1 inspection in 1983 the existence of a "loop seal" through which hydrogen could be added for the purpose of affecting leak rate tests, and that Chung stated in an OI interview that it was inconceivable that Michael Ross or other GPUN representatives were not aware of the loop seal prior to this inspection. TMIA, noting that Chung also indicated that one would presume based on publication of the Hartman allegations that Ross and other personnel in GPUN would have looked at Unit 1 leak rate mechanisms in light of those allegations to determine if there was a loop seal at

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[31] TMIA referenced the interview of former operator John Banks, the only operator interviewed who identified a possible motive for falsification at TMI-1. TMIA stated that Banks asserted that Michael Ross frequently passed remarks to the operators to "get a good leak rate", and that some of the operators might have interpreted Ross' statements as encouraging record falsification, if necessary. See note 38, infra.

Unit 1, concluded that it is not credible to believe that the existence of the loop seal in the makeup tank was not discovered until the 1983 Region I inspection, as GPUN claims.

UCS is also of the view that the pattern of similarities between the practices at Unit 1 and Unit 2 are strongly suggestive that the leak rate falsification at Unit 2 extended to Unit 1, albeit on a smaller scale, and that denials of the operators had been given undue weight. UCS' comments to a large degree repeat those stated by TMIA. In addition, UCS calculated that about 6% of the Unit 1 leak rate tests reviewed by OI involved the addition of hydrogen or water or feed-and-bleed operations, all of which affect leak rate calculations. UCS noted that the practice of discarding bad leak rate tests violated at least four different technical specifications and administrative procedures.

UCS stressed that staff's conclusion that leak rates were not falsified at TMI-1 is based not on facts but on unproven assumptions. Specifically, UCS attacked the staff conclusion that the relatively low percentage of tests showing possible manipulation, as compared with TMI-2, demonstrated a lack of a systematic pattern of falsification. UCS argued that although it was not often necessary to cheat to get a good leak rate at TMI-1, manipulations were made when necessary to get an acceptable leak rate. UCS also attacked the staff conclusion that there was a lack of motive to falsify because it was not hard to get a good leak rate test at TMI-1. UCS disputed this conclusion, stating that leak rate falsification is not inherently more excusable for being less frequent, if the need to falsify is also infrequent.

UCS maintained that Ross must have known about the discarding of bad tests and the acceptance of negative tests. UCS stated that Ross is universally regarded by the operators at TMI as eminently knowledgeable of all aspects of the operation of TMI-1, and that he has a reputation of being a stickler for detail. UCS argued that Ross's denial of knowledge of the loop seal lacks credibility and undermines the believability of his other testimony.

With respect to whether the standards for reopening the record have been satisfied, UCS maintained there was no real dispute. UCS noted that, since no party argued to the Appeal Board that the evidence of leak rate falsification could not change the result of the Licensing Board decision endorsing management integrity, they cannot do so now.

Licensee argued that the standards for reopening the record had not been satisfied. Licensee maintained that the OI Report dispelled any notion that leak rate practices at TMI-1 could be equated with those at TMI-2. While licensee recognized that the OI report did disclose some deficiencies in licensee's leak rate testing practices at Unit 1, licensee stated that those deficiencies had nothing to do with leak rate falsification or manipulation, and that the Appeal Board did not suggest that the information in the OI reports in itself met the standards for reopening.

Licensee also disagreed with the UCS and TMIA suggestion that adding hydrogen to the makeup tank during a leak rate test was necessarily improper. Licensee claimed that intervenors failed to recognize that there were legitimate operational reasons why hydrogen periodically was added to the makeup tank. Licensee further asserted that none of

the hydrogen additions would have affected leak rate tests in such a way that, if the additions had not been made, the limits for leakage would have been exceeded.

Licensee also disagreed with TMIA and UCS assertions that the practice of discarding leak rate tests was intended to cover up excessive leakage. Licensee argued that only those tests deemed "invalid" were not kept. Licensee claimed that far from attempting to conceal derogatory information about plant conditions, invalid tests were discarded because they were not indicative of true plant conditions.

Licensee also attacked UCS' suggestion that leak rate falsification can be inferred from the acceptance of negative leak rates within 1 gpm as valid. Licensee stated that at times during the operation of TMI-1, the standard deviation associated with a leak rate test ranged approximately from 0.2 to 0.7 gpm. As a result, assuming no unidentified leakage or a very low unidentified leakage, one would expect close to half of all leak rate tests to be negative. In other words, licensee stated that due to the inherent variability of the test, negative leak rates were simply indicative of low levels of unidentified leakage and their retention does not suggest the falsification or manipulation of leak rate tests.

The NRC staff agreed with licensee that the standards for reopening the record are not satisfied on TMI-1 leak rate practices. Relying heavily on the OI report, it concluded that no allegations have been made that leak rate tests at TMI-1 were intentionally falsified or manipulated, and that the OI report had concluded that only a small

percentage of leak rate surveillance tests conducted at TMI-1 during the period examined were accomplished during the periods where operator-induced evolutions occurred that would call into question the validity of these tests. Staff noted that of the questionable tests, technical analysis showed that, except in three instances, the technical specification acceptance criteria for unidentified leakage would have been satisfied had the operator-induced evolution not occurred. It also asserted that there is no conclusive evidence that 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. Staff stated that there was no apparent motive or need to manipulate leak rate tests at TMI-1, and that the OI 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. Accordingly, staff did not believe the Licensing Board would have reached a different result on any issue in the proceeding had the OI investigation been conducted earlier and the results been considered by the Licensing Board.

C. Analysis

The standards for reopening require a consideration of three factors: (1) whether the motion to reopen is timely; (2) whether the information raises a significant safety concern; and (3) whether the information might have led the Licensing Board to reach a different result. No one disputes the timeliness of the present motion, and the

Commission accordingly will limit its discussion to the latter two factors.

The OI investigation into TMI-1 leak rate practices included sworn interviews of all preaccident and current TMI-1 control room operators, shift foremen, and shift supervisors, who actually conducted leak rate tests during the period under investigation. A large number of preaccident and current staff personnel and site and corporate management officials were also interviewed under oath. The Commission finds that this investigation was thorough, and that there is no reason to believe that further hearings would produce significant new information on the possible irregularities in leak rate test practices. The Commission finds that there are no significant factual disputes concerning leak rate practices at TMI-1,[32] and that the facts as currently known do not raise a significant safety issue which might have led the Licensing Board to reach a different result.

The information developed by OI establishes that, unlike at TMI-2, there was no reason to falsify leak rate tests at TMI-1. There was no excessive leakage. Moreover, as indicated in Supp. No. 5, out of the 645 leak rate tests examined, in only three cases would the leak rate

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[32]Although TMIA, UCS, the Commonwealth and the Aamodts all argue that hearings are necessary, their basic dispute appears to be with the conclusions reached by OI, rather than with the underlying facts. None of these parties have produced evidence to show that there were more numerous acts of possible falsification than OI found. What is at dispute is really how the material should be interpreted and what inferences should be drawn from the facts.

have been excessive if the additions had not occurred.[33] This is far different from the practice at TMI-2 where it appears that deliberate falsifications occurred on a regular basis.

The OI investigation revealed that leak rate testing was considered a ministerial monitoring duty at TMI-1 prior to the accident.[34] It was not difficult to obtain an acceptable leak rate test, and most operators relied on other plant parameters to determine actual leakage. Hence little significance was given to leak rate testing practices. Under these circumstances, it is not surprising that some irregularities in the data may appear. There is no evidence of falsification beyond speculative inferences that could be drawn solely from the circumstance of a few irregularities in the data and some superficial similarity between leak rate practices at TMI-2 and TMI-1.[35] The Commission finds

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[33]The UCS argument that a few falsifications are as culpable as many where the need to falsify is less frequent has no applicability here because there was no need to falsify at all to obtain a satisfactory leak rate test.

[34]The Commission also notes that there was a margin of error in the leak rate tests. Thus negative leak rates could be expected where there was low leakage, and acceptance of negative leak rate tests does not show any improper motivation.

[35]There is even some question about the interpretation of the data as demonstrating improper additions. The NRC staff agreed with licensee's own investigative report that "the method of identifying water additions and hydrogen additions to the makeup tank is necessarily subjective ... and, therefore, disagreement in interpretation can be expected." Supp. No. 5 at 4-19. The Commission need not address this conflict because of its finding that the few possibly improper tests, even if improper, do not meet the standards for reopening.

The Commission also notes, however, that it is not expressing approval for the way leak rate tests were conducted prior to the

[Footnote Continued]

the circumstantial evidence indicating there might have been a few improper leak rate tests conducted in 1978-1979 does not raise a significant safety concern that might have changed the Licensing Board's decision.

With regard to discarding invalid tests, this practice did violate NRC requirements. However, there is no evidence of a deliberate attempt to discard tests at TMI-1 to hide excessive leakage or to mislead the NRC. Rather, as noted by the Appeal Board, the evidence indicates a lack of understanding regarding record-keeping requirements.[36] As stated by the Appeal Board in denying a motion to reopen based on "new" information of pre-accident deficiencies in the training program:

> The OI report and supporting documents show what, by this time, should not be news to anyone -- that there were significant shortcomings, to say the least, in licensee's training program before the 1979 TMI-2 accident.... This proceeding was not instituted to provide a forum in which to litigate directly all possible errors of the past.... The "new" information ... simply provides support for one of the underlying assumptions of the proceeding. It is redundant and, as such, its significance is questionable. It follows that it would not have likely affected the Licensing Board's decision on training ... in any significant respect.

[Footnote Continued]

accident. It appears clear there were problems with the testing procedures, and those problems should have been corrected at that time. However, that issue is no longer material to the current safe operation of TMI-1. See discussion in text infra.

[36] With regard to the other two negative findings by the Appeal Board -- the failure to discover the "loop seal" and inattention to work requests regarding the loop seal -- the Commission finds these failings to be of minimal significance to the restart proceeding. The loop seal in itself was not important; what mattered was whether hydrogen was being improperly added. So long as falsifications were not occurring, it did not matter whether there was a mechanism by which they could occur. In addition, the issue of handling work requests was fully litigated in the proceeding regarding licensee's maintenance program.

[Footnote Continued]

ALAB-774, 19 NRC at 1356. The logic of that decision applies equally well here.[37]

The Commission has examined the additional issues regarding TMI-1 leak rate practices raised by the intervenors as arguably requiring a hearing and finds that they do not support the need for additional hearings. The questions about Ross are based on little more than speculation. The major argument to support the conclusion that Ross is lying is that he knows so much about plant operations that he must have known what was going on. The Commission has carefully reviewed Ross' explanation and finds it to be credible. We do not agree that Ross must have known of the irregularities at TMI-1, given their infrequency and the mundane nature of the leak rate testing process. Nor do we find his denial of knowledge of the loop seal particularly significant. While it does appear that licensee could have discovered the loop seal problem at TMI-1 at an earlier date, that a construction anomaly provided a method for manipulation of leak rate test results is not important; what is

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[Footnote Continued]

That program has been substantially revised, and any additional pre-accident probelms are not significant to the current program.

[37] The Commission thus disagrees with the Appeal Board's conclusion that the OI investigation supports its conclusion to reopen. Indeed, that decision appears directly contrary to the above-quoted statement in ALAB-774. The Commission also disagrees with the Appeal Board's finding that it necessarily follows that the TMI-1 questions might have affected the Licensing Board's decision because the Hartman allegations might have. Circumstantial evidence indicating there may have been a few instances of possible improprieties do not raise concerns similar to those raised by the TMI-2 allegations, where it appears from the available evidence that deliberate falsification occurred on a regular basis. No one at TMI-1, unlike at TMI-2, has alleged that leak rates were falsified, and at most there is only some limited circumstantial evidence of falsifications.

important is whether hydrogen was intentionally being added to falsify the leak rate test results. So long as no improper additions were being made, it matters little whether there is a technical means whereby such additions could be made.

Nor do the similarities of the TMI-1 irregularities to those at TMI-2 necessarily mean there was deliberative falsifications at TMI-1.[38] The leak rate tests at TMI-1 in most cases would have been acceptable even without the additions; hence even in those cases there was no need to falsify. At TMI-2 there apparently was a motive to falsify, and the available evidence indicates that there was widespread falsification with the intent to deceive the NRC. There has been no similar showing at TMI-1.

Hence the Commission concludes that hearings on TMI-1 leak rate practices are not warranted.

IV. The Appeal Board's Condition Concerning Mr. Husted

A. Background

Charles Husted was a licensed operator training instructor. The Special Master, Licensing Board and Appeal Board all expressed concern with Husted's attitude because he failed to cooperate with NRC

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[38] The statement by Banks that test results could have been falsified in response to statements by Ross "to get a good leak rate test" was, at most, equivocal. Banks first stated there was no motive to falsify, and later, after followup questioning, stated that maybe someone else might have been intimidated into falsifying leak rate tests to obtain acceptable results.

investigators and testified in a less-than-serious, flippant manner. Neither the Special Master nor the Licensing Board recommended sanctions, although the Licensing Board, partly in response to Husted's attitude, required licensee to develop criteria for training instructors and to have the training program audited. The Licensing Board also recommended that Husted's performance receive particular attention in the audit.

Subsequent to the Licensing Board's decision, licensee promoted Husted to Supervisor of Non-Licensed Operator Training. The Appeal Board, noting its view of the importance of attitude in an instructor, seriously questioned licensee's judgment "in promoting Husted to an important position with management responsibilities." 19 NRC at 1224. The Appeal Board also noted in this regard that as a manager "Husted will presumably also have a role in establishing the criteria for training instructors and developing the audit program imposed by the Licensing Board, at least in part, as a remedy for his own failure to cooperate with the NRC," Id. Based on the above, the Appeal Board imposed as a condition of restart that Husted "have no supervisory responsibilities insofar as the training of non-licensed personnel is concerned." Id.

The Commission took review of "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, 20 NRC at 811. The Commission further stated that, if it

determined the Appeal Board erred, it would then decide whether to take separate enforcement action against Husted.

B. Parties' Comments

The Commonwealth stated the Commission can impose conditions on management conduct related to TMI-1 operation, and that any other view would make Commission inquiry into management integrity meaningless.

UCS generally supported the Commonwealth's views. UCS added that if a hearing is required, it should be held before restart because the Appeal Board's order implied the plant could not be safely operated with Husted in the questioned position.

TMIA, without addressing the issue presented, maintained that the issue the Commission should be concerned with is licensee's employment practices, as demonstrated by Husted's promotion.

Licensee acknowledged that the Commission can require separation of individuals from safety-related work on a finding that separation is necessary to protect the public health and safety. Licensee stated this is not such a case, and NRC Boards in an ongoing hearing do not have the legal authority to impose a condition which would in effect operate as a sanction against an individual, when that individual is not a party to the proceeding and has no notice of a possible sanction or opportunity to request a hearing. Licensee claimed that due process required notice and an opportunity for hearing where administrative action threatens an individual's livelihood.

Staff read relevant Supreme Court cases as suggesting "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." Staff Comments at 43. Based on this reading, staff concluded that the Appeal Board erred.

C. Analysis

There are two separate bases which arguably may provide Husted a right to a hearing -- Section 189a of the Atomic Energy Act and the due process clause of the Fifth Amendment of the Constitution. We will treat each in turn.

1. Section 189

Any interested person with the requisite standing may seek to intervene in a Section 189a licensing proceeding. To establish standing, an individual must at a minimum show (1) the action being challenged could cause injury in fact to that individual, and (2) such injury is within the zone of interests protected by the Atomic Energy Act. See, e.g., Portland General Electric Co. (Pebble Springs Nuclear Plant, Units 1 and 2), CLI-76-27, 4 NRC 610 (1976). While an individual who suffers economic injury as a result of a Board's decision to bar him from working in a certain job would meet the first standard, it is unresolved in the courts whether economic injury in such a case would be within the zone of interests protected by the Atomic Energy Act. See, e.g., Consumers Power Co. (Palisades Nuclear Facility), ALAB-670, 15 NRC

493, 506 (1982) (concerning opinion of Mr. Rosenthal), vacated as moot, CLI-82-18, 16 NRC 50 (1982).

2. Due Process

The due process clause of the Fifth Amendment prohibits a federal agency from depriving an individual of "liberty" or "property" interests without providing that individual an opportunity for a hearing.[39] A person's liberty interest is implicated "[w]here a person's good name, reputation, honor or integrity is at stake because of what the government is doing to him," or where the government's action "imposed ... a stigma or other disability that foreclose[s] his freedom to take advantage of other employment opportunities." Board of Regents v. Roth, 408 U.S. 564, 573 (1972). Merely making a discharged employee less attractive for employment is not a deprivation of liberty. See, e.g., Johnson v. University of Pittsburgh, 435 F. Supp. 1328 (W.D. Pa. 1977). Thus, for example, no hearing is required where the discharge is for insubordination and failure to perform certain duties. Capers v. Long Island R.R., 429 F. Supp. 1359 (S.D.N.Y.), affm'd sub nom. Harris v. Long Island R.R., 573 F.2d 1291 (1977).

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[39] Individuals indirectly affected by government action may not have any hearing rights. See O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980). In O'Bannon the Supreme Court held that the patients in a nursing home were only indirectly affected when the government acted against the nursing home, and therefore the patients did not have any hearing rights. The action here is not so indirect that the holding in O'Bannon would clearly apply.

"To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it." Roth, supra, at 577 (emphasis added). Thus, for instance, the government may not prevent an individual from working in his chosen profession without providing him notice and an opportunity to request a hearing, see, e.g., Orr v. Trinter, 444 F.2d 128 (6th Cir.), cert. denied, 408 U.S. 943 (1971), although there is no hearing requirement where the only thing at stake is a specific job with no claim of entitlement. See Cafeteria and Restaurant Workers Union v. McElroy, 367 U.S. 886 (1961).

3. Holding

The Commission has decided, in view of the way this issue has been presented, not to resolve the difficult questions presented. No Board has addressed the specific questions before the Commission, the real party in interest (Husted), who is not a party to this proceeding, has not been asked for his views, and the parties have not devoted considerable attention to this issue. The Commission therefore finds that definitive resolution of these issues should wait for a case where they can more appropriately be decided.

In fairness to Husted, however, the Commission has decided to provide him an opportunity to request a hearing on whether the Appeal Board's condition barring him from supervisory responsibilities insofar as the training of non-licensed personnel is concerned should be vacated. Husted has twenty days after the service of this Order to

request such a hearing. If he does request such a hearing, the Commission will assign the matter to an Administrative Law Judge for hearing separate from this proceeding.

Finally, the Commission must address Husted's status, should he request a hearing. The Appeal Board noted that the Supervisor of Non-Licensed Operator Training instructs those on the career path to becoming licensed operators and has management responsibilities. The Commission finds that there are sufficient safeguards in place to assure that allowing Husted to serve in this position during the pendency of any hearing would not pose any risk to the public health and safety. Husted would have no involvement in the direct operation of TMI-1, and would be only one of a number of persons involved in the training of non-licensed individuals. Accordingly, should Husted request a hearing, the Commission has decided that the Appeal Board's condition should not remain in effect during the pendency of that hearing.

V. Staff's Change of Position

A. Background

Staff in Supp. No. 5 to NUREG-0680 found that new facts from OI investigations and from other relevant material concerning four matters -- (1) TMI-2 leak rate falsifications, (2) false certification and management involvement in the coverup of cheating (the certification of Floyd), (3) pre-accident training irregularities and post-accident cheating, and (4) adequacy of responses to an October 1979 Notice of Violation -- revealed a pattern of activity that, "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 [Licensing Board's] proceeding on TMI-1 restart." Supp. No. 5 at 13-5.

The Commission, in the order taking review of whether further hearings are required in the restart proceeding, directed staff, if it believed the record did not need to be reopened on Supp. No. 5 issues, to explain how it reached this conclusion in view of the above statement. The Commission also directed staff to "specify what testimony it gave before the Licensing Board that it would now change, and why that change in testimony does not require reopening." 20 NRC at 814.

B. Parties' Comments

Staff stated that the concerns in Supp. No. 5 are with licensee's prior management and operating personnel, and that it finds no undue risk to public health and safety with the current management and personnel. Staff concluded "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." Staff comments at 33. Staff noted that integrity per se was not an issue in the restart proceeding, and hence was not the subject of testimony. Contrary to Commission instruction, staff did not state what testimony in the restart proceeding, if any, it would change.

TMIA maintained that staff's distinction between pre- and post-1982 licensee is unfounded. TMIA stated that the resignation of Arnold by itself, the only significant change in licensee's management, is insufficient to support staff's conclusion. TMIA argued that the Licensing Board found in licensee's favor in 1981 because of licensee's reorganization in 1980, and that staff erred in stating that the reorganization occurred in 1982 and hence that management subsequent to 1982 is acceptable.

Finally, TMIA challenged staff's assertion that it now has new information on the false certification of Floyd and the Hartman allegations. TMIA claimed there is no new information on the Floyd matter, and that the staff knew of the significance of the Hartman allegations during the hearing.

UCS noted that staff's statement in Supp. No. 5 is in effect an "admission that the decisional record in this case excludes information on integrity which the staff concedes would have dictated a different result." UCS Reply Comments at 10. UCS claimed that staff's position that the decisional record developed by the Licensing Board is irrelevant in view of the new management is "absurd," stating that such a conclusion would make the whole adjudicatory process irrelevant. UCS also challenged staff's statement that it was not aware of this information at the time it testified in the original management hearing. UCS pointed out that staff sat through the hearings on the cheating

incidents while well aware of the TMI-2 leak rate falsifications,[40] the training problems, and the false certification of Floyd, but nonetheless endorsed restart. UCS finds staff's position "disingenuous," stating that staff's actions indicate a willingness to disregard substantial evidence of a lack of integrity in order to support restart.

C. Analysis

The potential impact of staff's "likely" change of position can be assessed by considering the relationship of each of the four items cited by staff to the Licensing Board's decisions, followed by an assessment of its significance to the Licensing Board's overall finding that the management issues had been resolved for the purpose of restart. We will therefore address each of the four matters cited by staff in turn.[41]

1. The Hartman Allegations

Clearly the Licensing Board found the Hartman allegations relevant to its decision, but, in the absence of further information, concluded that they should not be a bar to restart. The Licensing Board in making this determination relied on staff's description of the matter. 14 NRC at 557. See discussion supra.

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[40]Staff in its comments indicated that only those members of staff who had worked on the NRC investigation had information regarding the truthfulness of Hartman's allegations, and they had been asked by the Justice Department not to discuss the information with others.

[41]This matter deals with the adequacy of the evidentiary record, and hence the traditional standards for reopening based on new information are inapplicable.

Staff asserted that the following is the information which it did not know 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 [licensee's report into the technical basis for the Hartman allegations].

(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."

Staff Comments, Appendix at 4. These four pieces of information amount to a recognition that falsifications did occur, and that management was at least in part responsible. As explained supra, however, those responsible are not currently in responsible management or operational positions at TMI-1. The Hartman allegations therefore no longer raise a significant safety issue for operation of TMI-1, and staff's likely

change of position to the extent it was based on this issue is not now significant.

2. Certification of Floyd

Staff stated that "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 made a false certification to the NRC." Staff Comments, Appendix at 10.

The false certification of Floyd was litigated before the Licensing Board. The Board concluded that Gary Miller (former Station Manager), with John Herbein's (former Vice President, Met. Ed.) knowledge and assent, made a false certification to the NRC. The Board also found that the evidence raised questions about Miller's competence, and directed that until the matter was further resolved any involvement of Miller in TMI-1 operations must be under the direct supervision of an appropriately qualified licensee official. The Board further noted there was no evidence of improper conduct at any level higher than Herbein's, and that Herbein was no longer employed by GPU Nuclear.[42] 16 NRC at 354-55.

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[42] If staff is implying there is now evidence of involvement of others in management, e.g., Arnold, our review has disclosed no evidence beyond that available to the Licensing Board, and staff has cited none. The Licensing Board knew of Arnold's involvement in licensee's personnel action regarding Floyd. In addition, Arnold was the individual who brought this matter to the NRC's attention, and, regardless, he is no longer associated with TMI-1 operations.

Thus, the Licensing Board clearly recognized the significance of this matter, and, in fact, expressed concern regarding staff's position on this matter. 16 NRC at 353.[43] Floyd, Herbein and Miller are no longer employed by GPUN, and, as a result of the OI investigation, the Commission has issued a Proposed Notice of Civil Penalty of $100,000 against GPUN (held in abeyance at DOJ's request).[44] Since there is no new evidence implicating other individuals at TMI-1 in this incident and the Board did not rely on staff's judgment here in the first place, we do not believe staff's likely change of position might have changed the Licensing Board's decision. Under these circumstances, staff's likely change of position because of this issue has minimal or no significance.

3. Pre-accident Training Irregularities and Post-accident Cheating

Staff's position on new information concerning preaccident training irregularities and postaccident cheating is as follows. "Staff was aware during the TMI-1 restart proceeding that the Licensee had problems

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[43]The Licensing Board found that "[t]he NRC Staff takes a surprisingly mild position on the August 1979 certification issue .... at no place in the Staff's testimony or in the proposed findings and comments before us does the Staff discuss the untrue representation in the [certification] letter ... We do not understand this silence.... We recommend that the Commission direct the staff to conduct an investigation ... We are somewhat disconcerted, however, because no component of the NRC Staff protested in this proceeding the false information in the certification to the NRC... Perhaps [the Commission's Office of Inspector and Auditor] should be enlisted to participate in any such investigation." 16 NRC at 353.

[44]The Commission notes in this regard that Floyd on November 16, 1984 was convicted in the District Court for the Middle District of Pennsylvania because of this incident.

with its preaccident training and requalification programs. The proceeding before the Licensing Board concentrated on the Licensee's postaccident training program." Staff did not become aware until after the Board's decisions "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." Staff Comments, Appendix at 7. In general this attitude was shown in non-attendance and condoning non-attendance at training and a general management inattention to the requirements of the training program then in place.

This issue was addressed by the Appeal Board in ALAB-774. TMIA had moved to reopen the record based on the same pre-accident training irregularities now cited by staff. The Appeal Board held as follows: "The OI report and supporting documents show what, by this time, should not be news to anyone -- that there were significant shortcomings, to say the least, in licensee's training program before the 1979 TMI-2 accident. ... The 'new' information ... simply provides additional support for one of the underlying assumptions of this proceeding. It is redundant and, as such, its significance is questionable." 19 NRC at 1356. The Appeal Board went on to note that any information bearing on licensee's existing training program could be pursued in the reopened hearing on training.

The issue then is whether staff's likely change of position because of this issue has any significance in view of ALAB-774. There might have been some significance if staff during the hearing had changed some of its favorable testimony on the training program. However, at this

point in time pre-accident training irregularities have little or no significance regarding the adequacy of the current training program, see ALAB-774, 19 NRC 1350 (1984), and the post-accident cheating discussed by staff has been fully litigated. Moreover, additional hearings on the effect of the cheating on the adequacy of licensee's current training program were held subsequent to staff's likely change of position, and staff had the opportunity to present any revised views it had in those hearings. Staff chose not to present any changed testimony explaining its "likely" change of position, and completion of those proceedings should eliminate any significance in staff's likely change of position because of this item.

4. Licensee's Response to the NOV

The fourth issue cited by staff concerns the accuracy and completeness of licensee's response to the October 25, 1979 Notice of Violation (NOV) imposing a civil penalty on licensee for actions leading to the TMI-2 accident. Staff stated that it was not until after the close of the evidentiary record that it uncovered evidence indicating that the licensee may have knowingly provided false information to the NRC in its response to the NOV.[45] This matter was not specifically litigated, although licensee's response to the accident was litigated.

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[45]There is a related issue here. The Keaten Report was changed to conform to the false information in the response to the NOV when the Task Force apparently accepted those changes without independent assessment. Staff in Supp. No. 5 discounts this matter by stating "[t]he evidence does not support a conclusion ... that such changes were

[Footnote Continued]

This issue raises a significant safety concern regarding whether individuals in licensee's management made material false statements to the NRC in that, if true, it reflects some lack of integrity in licensee's management. However, the two individuals primarily responsible for this response -- Robert Arnold and Edward Wallace -- are no longer associated with TMI-1 activities. Accordingly, the Commission finds that staff's likely change of position regarding this issue is not currently significant enough to warrant further hearings.[46] Since the Commission has decided that this issue is no longer significant because of the removal of Arnold and Wallace, licensee is to notify the Commission before returning either of these individuals to responsible positions at TMI-1.

5. Overall Impact of Staff's Likely Change of Position

Even though, as indicated above, none of the items cited by staff for its likely change of position taken individually are significant enough to require hearings beyond those now underway, we must still consider the impact that a possible change of position by staff might have had on the Licensing Board's overall finding on licensee's management.

[Footnote Continued]

the result of any influence on the task force by management." Supp. No. 5 at 8-14. See discussion infra .

[46] As discussed infra, the Commission finds that there is no factual dispute regarding Dieckamp's decision not to become involved in this matter, and that his decision not to involve himself is not culpable.

Staff in Supp. No. 5 stated that the four cited matters collectively indicated "a pattern of poor attitude toward training responsibilities and leak rate testing requirements, a failure to provide accurate and complete statements to the NRC, an unwillingness to admit violations of NRC requirements and a failure to promptly report cheating and its subsequent coverup." Based on this, staff "would likely [have concluded] that the licensee had not met the standard of reasonable assurance of no undue risk to public health and safety." Supp. No. 5 at 13-5.

Those statements in Supp. No. 5 directly conflict with staff's testimony in the restart proceeding. For instance, one issue specified for the restart proceeding was "[w]hat are the views of the NRC inspectors regarding the quality of the management of TMI Unit 1 and the corporate management, staffing, organization and resources of Metropolitan Edison." CLI-80-5, 11 NRC 408, 409 (1980). The Board, at staff's urging, found that "the NRC inspectors believe the Licensee to be capable of properly managing and safely operating TMI Unit 1." 14 NRC at 504. The Board noted in this regard that it had "relied very heavily upon the Staff's proposed findings on this issue...." Id. at 502.

Similarly, the Licensing Board noted that, "[b]ased upon intangible subjective observations, the NRC staff witnesses believe that the senior management for TMI and GPU Nuclear are probably above the norm for other utilities the Staff has looked at in reviewing six plants in the last year for near-term operating licensees.... The Staff witnesses had

nothing unfavorable to report and had no recommendation for further inquiry." Id. at 430.[47]

The question then concerns what impact there would have been on the Licensing Board's decision had staff testified that licensee "had not met the standard of reasonable assurance of no undue risk to public health and safety," and, correspondingly, whether staff's statement that it would "likely" have so testified invalidates the Licensing Board's overall favorable finding on licensee. The Commission finds that staff's "likely" change of position does not invalidate the Licensing Board's decision. First, there was substantial other testimony on licensee's acceptability. Second, and more important, the Licensing Board examined individual issues bearing on licensee's acceptability. The Board, which was charged with fully inquiring into licensee's acceptability, could not have accepted staff's assertions without inquiry into the underlying events. Hence, while this testimony could have had a significant impact on the Licensing Board's deliberations and the course and timing of the hearing, the issue before the Board would have involved the seriousness of these events, and whether adequate corrective action had been taken. Therefore it likely would at most have led to further consideration of the specific issues cited by staff, in light of staff's altered views, rather than to further hearings on some abstract notion of corporate adequacy. The need for hearings on those issues has been discussed supra.

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[47] Numerous other witnesses also testified on this issue, and many [Footnote Continued]

D. Summary

Of the four issues cited by staff for its likely change of position, one is currently pending before the Licensing Board (training), one was already fully litigated (Floyd certification), and two are no longer significant to the operation of TMI-1 (Hartman allegations and response to NOV). Thus, we do not find staff's new position to be of such significance as to warrant any further hearings beyond those now ongoing.

VI. Alleged Discrimination Against Parks, King and Gischel

A. Background

Messrs. Park, King and Gischel raised health and safety concerns regarding the way the cleanup of TMI-2 was being conducted. They first raised these concerns to the licensee, and then to the NRC and the public. Each eventually left TMI-2, either by transfer (Parks and Gischel) or dismissal (King). OI issued an investigative report on these matters in two parts. The first part covered the alleged safety concerns, while the second concerned the alleged discrimination. OI Investigative Report No. H-83-002. The factual circumstances surrounding each case is discussed in detail in Supp. No. 5. We provide a brief summary below.

[Footnote Continued]

individuals in licensee's management structure testified before the Board. The Board discussed each individual in licensee's management structure in finding that structure acceptable.

Gischel, who was the GPUN Plant Engineering Director at TMI-2, suffered a stroke in June 1982. He subsequently consulted Corporate Stress Control Services, Inc. about some physical impairments resulting from the stroke. He was advised that he should take a neuropsychological examination, and one was scheduled for him. He did not take the exam, and subsequently Stress Control advised the licensee of its view that he should take the exam. Licensee and Gischel had a running disagreement about whether he had to take the exam as a condition of continued employment. The disagreement was ended by agreeing that Gischel would accept a transfer to a non-nuclear job.

King, who was the Plant Operations Director at TMI-2, was also at the same time the President of Quiltec, which provided engineering services to nuclear power plants. Several GPUN employees had gone to work for Quiltec after resigning from employment with GPUN. Upon learning of King's involvement with Quiltec, Arnold had him suspended without pay. This was revised to suspension with pay until, after a further investigation, King was fired. King maintained there was no conflict of interest because Quiltec did not solicit GPUN employees.

Parks, a Bechtel[48] employee, worked as an Operations Engineer in the Site Operations Department. Parks had four specific complaints of harassment: (1) he was relieved of his duties as Alternate Startup and Test Supervisor; (2) he was interrogated as part of a Bechtel investigation into alleged violations of conflict-of-interest standards; (3) he

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[48]Bechtel is a prime GPU contractor on the cleanup of TMI-2.

was replaced as the primary Site Operations (SO) Department representative on the Test Working Group (TWG) for the Reactor Building Polar Crane Project; and (4) he was placed on leave of absence with pay and prohibited entry to the jobsite.

The Department of Labor (DOL) investigated the Parks matter and concluded that Parks had been discriminated against for raising health and safety concerns. The NRC staff in Supp. No. 5, consistent with DOL's findings, found that the above four actions were improper. Staff also found three additional improper acts bearing on the integrity of GPUN management.[49]

Bechtel's position is that Parks by making grave accusations concerning the professional competence and integrity of several of his coworkers lost his ability to function as a member of the professional organization at TMI-2. The DOL complaint was settled when Bechtel transferred Parks to a job in California.

B. Parties' Comments

TMIA asserted that the "'whistle blowers' had struggled for months to bring their concerns [of substantial safety significance] to the attention of GPU management, in hopes they would be resolved. Not only

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[49]These acts were: (1) Comments by Barton (GPUN) threatening to fire or suspend Parks for publicly airing his allegations; (2) statements by B. Kanga (Bechtel) to Parks advising him not to publicly state his concerns, as another employee who had gone public had been humiliated; and (3) Kanga's statement to Parks that he had put Bechtel in a bad light with a client and stood a good chance of being fired.

were their concerns ignored by management, the 'whistle blowers' were subjected to harassment which intensified when they persisted in voicing their legitimate concerns." TMIA Motion to Reopen at 5. TMIA maintained the OI investigation confirmed that the safety violations occurred, and that GPU harassed those trying to voice their concerns. This, TMIA asserted, "has created an atmosphere of fear and intimidation making individual disclosures of safety violations impossible." Id. at 13. In TMIA's view, these actions are the clearest demonstration "of the nexus between GPU's lack of competence and their lack of integrity." Id.[50]

Staff concluded that only Parks was harassed, and that this harassment was an isolated occurrence and not programmatic in nature. Staff, noting that GPUN has now promulgated policies designed to protect employees who raise safety concerns, found that this issue does not meet the standards for reopening.

Licensee stated that it commissioned Edwin Stier to investigate this matter, and Stier concluded that there had been no harassment. Regarding OI's conclusions, licensee stated they raise questions only about Robert Arnold, who is no longer associated with TMI-1.

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[50]TMIA also asserted that Joyce Weinger, King's secretary, was discriminated against because she supported King. We do not address Weinger's case because it does not appear the action taken against her was related to raising safety concerns, and therefore that matter does not fall within the NRC's jurisdiction.

C. Analysis

There do not appear to be any material issues of disputed fact here regarding the basic actions taken. It is unquestioned that (1) these individuals raised safety concerns, and (2) they thereafter lost their jobs at TMI, either by firing or transfer.[51] However, in each case there does appear to be a dispute regarding whether the evidence indicates a connection between those two events.

The Energy Reorganization Act of 1974 (42 U.S.C. 5851) and the Commission's regulations (10 CFR 50.7) protect employees from discrimination for raising health and safety issues. Hence, if it were to be established that licensee's upper management (which oversees both TMI-1 and TMI-2) engaged in a pattern of discrimination against or condoned discrimination against individuals because they raised safety concerns, this might raise a significant safety/integrity issue which could have changed the Licensing Board's decision. See ALAB-738, 18 NRC 177, 198 (1983) ("reprisals against whistleblowers-employees -- if they are proven and if a nexus to TMI-1 management is suggested -- certainly reflect negatively on management integrity and would provide a basis for further exploration").

We will first discuss the case of King. King, while a GPUN employee, was also President of a company hiring GPUN employees (Quiltec). In addition, King had sent current GPUN employees to act as Quiltec representatives. GPUN, although it did not have a clear

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[51] We note that no party has moved to reopen because of the procedural violations themselves.

conflict of interest policy, did have a policy of strictly limiting recruiting of employees from other companies with which they did business and, equally as strenuously, protecting their own employees from outside recruitment. The Commission has concluded from the facts developed by OI that licensee's actions concerning King were not improper, and that there is insufficient evidence to warrant a hearing on the inference that licensee's actions were motivated by the fact that King had raised safety concerns.

The Commission notes in this regard that the only reasonable criticisms of licensee here are that a Bechtel employee had a private procurement investigation of King conducted, that licensee acted peremptorily in suspending King without pay based on the limited information it then possessed, and that the timing of King's suspension and ultimate removal was unfortunate.[52] None of these criticisms raise a significant safety issue. The investigation by the Bechtel employee appears to have been at least partly based on a personality conflict, and GPUN did not approve of that investigation. Regarding the second criticism, licensee had sufficient information to act against King when it did, and that action was substantiated by a later inquiry. Moreover, licensee revised the suspension to one with pay to obtain further information from King regarding his safety concerns. Finally, while the

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[52]With regard to TMIA's speculation that management knew of King's involvement with Quiltec at an earlier date, but did not become concerned until King began raising safety concerns, the Commission finds that such speculation would be based on no more than rumor and, accordingly, does not raise a significant safety concern.

timing of the suspension may have given the appearance that it was retaliatory, the evidence does not support such a conclusion. Appearances alone do not raise significant safety issues warranting a hearing. Hence the Commission finds that this issue does not raise a significant safety concern which might have altered the Licensing Board's decision.

We next turn to Gischel. The issue here concerns licensee's motivation in requiring Gischel to take a neuropsychological examination.[53] In essence, licensee was faced with contradictory medical advice. On the one hand, Stress Control advised licensee that Gischel needed to take the neuropsychological examination for a full evaluation of his condition, and that in the absence of an exam Gischel posed a risk to himself and others in unescorted areas of the plant.[54] On the other hand, Gischel's physician stated that there was no need for him to take the examination.

The Commission concludes GPUN did not act improperly under these circumstances. The evidence developed by OI indicates that licensee was motivated by concern for Gischel's physical problems, and, indeed, if licensee had not acted as it did it could have been criticized for failing to act regarding a potential safety concern. The Commission further notes in this regard that it was Gischel, not licensee, who

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[53]Gischel made numerous other complaints of harassment. The Commission agrees with the staff's analysis that these other complaints were without merit. See Supp. No. 5 at 10-21, 10-22.

[54]TMIA criticizes the actions of Stress Control in this case. The motivations and acts of Stress Control are not at issue here. To the extent TMIA is arguing that GPUN and Stress Control together acted improperly, any such inference is based on pure speculation.

continued to change the ground rules and the format for taking the examination.

As in the case of King, this controversy happened to occur at the same time that Gischel was raising safety concerns. While this may have given the appearance of retaliation, the evidence does not support such an inference. Hence, the Commission concludes that this issue does not raise a significant safety concern which might change the Licensing Board's decision.

Finally, we turn to Parks. The actions taken against Parks present a more difficult question than those taken against King and Gischel. If the NRC staff's findings of harassment are accepted, then licensee is responsible for discrimination against Parks. While the Commission does not necessarily agree with all staff's conclusions, the Commission has decided to accept those conclusions for the purposes of this analysis because, even if accepted, those conclusions do not warrant further hearings.

The issue then is whether the harassment found by staff meets the standards for reopening, i.e., whether it raises a significant safety issue which might have affected the Licensing Board's decision. The Commission finds that it does not for the following reasons. First, Parks was a Bechtel employee, and Bechtel must bear primary responsibility for his harassment, although GPUN bears responsibility for acts of its contractor.[55] Second, there has been no showing of a widespread

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[55]The cleanup at TMI-2 is being conducted as a joint effort by GPU [Footnote Continued]

pattern of discrimination against more than one individual. Third, Robert Arnold, the major GPUN official involved, is no longer associated with TMI-1 activities. Fourth, these acts occurred at TMI-2, not TMI-1, and hence they relate to the safe operation of TMI-1 only insofar as there is an overlap of individuals or policies. The Commission finds that the removal of Arnold eliminates any such overlap. Fifth, licensee has now adopted clear policies to prevent any future harassment or intimidation. For these reasons the Commission concludes that this issue does not require hearings.

VII. The Keaten Report

A. Background

Licensee shortly after the accident established an internal task force to investigate certain aspects of the accident. That task force, headed by R.W. Keaten, produced several drafts before the final report -- the Keaten Report -- was issued. Several questions were raised regarding some of the changes made by management to the report from draft to draft.

In addition, the review of the Keaten Report raised a question concerning the accuracy of information contained in licensee's response to the NRC's October 25, 1979 Notice of Violation (NOV). In particular,

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[Footnote Continued]

Nuclear and its contractor Bechtel. The limited direct involvement of GPUN employees in any acts of harassment do not raise a significant safety issue because of the remedial acts taken by GPU Nuclear management, see Supp. No. 5 at 13-9, and because of the limited nature of that involvement.

licensee in response to the NOV stated "there is no indication that this procedure [concerning closure of the power operated relief valve (PORV) block valve] or the history of PORV discharge line temperatures delayed recognition that the PORV had stuck open during the course of the accident," and that elevated relief valve discharge line temperatures "do not appear to have been the result of a leaking PORV," but rather were related to a leaking code safety relief valve. The Keaten task force draft reports being circulated internally to upper management at the time of licensee's response to the NOV contained information in conflict with the above two statements.

Staff after reviewing OI's investigative report concluded that "licensee did willfully violate the emergency procedure and that statements were made by the licensee in its response to the NOV that were neither accurate nor complete and that were contrary to other information in the possession of the licensee." Supp. 5 at 8-19. Regarding the individual's involved, staff concluded that while E. Wallace (now at Oyster Creek) "was most closely involved ... the responsibility for the licensee's inaccurate and incomplete statements must be shouldered by R.C. Arnold, who reviewed and signed the submission to the NRC, and by H.M. Dieckamp, who reviewed the response before it was submitted and chose 'not to intervene.'" Id. at 8-21.

B. Parties' Comments

TMIA argued that the Task Force "improperly modif[ied] findings and conclusions on its own initiative." TMIA 2.206 Petition at A-173. TMIA alleged the changes were made to improve GPU's litigative posture in GPU

v. B&W, to conform the Keaten Report to the false response to the NOV, and to present GPU to the NRC in a better light. TMIA maintained this is significant because Keaten and Long, the central task force members, were and continue to be part of GPUN's management structure.[56]

With regard to the false response to the NOV and the corresponding incorrect changes to the Keaten Report, TMIA stated "what is perhaps most disturbing is the company's continued support for the false premise upon which Licensee's dishonest response to the Notice of Violation was based.... Clearly, Licensee is either suffering from serious perceptual problems, or feels obligated to persist in maintaining self-serving, noncredible positions." Id. at A-180-81.

TMIA next argued that licensee has misrepresented to the Commission the purpose of the Keaten Report. TMIA compared statements by Kuhns and Dieckamp to the Commission that the Report was only for internal purposes with statements by Keaten and Arnold that they recognized the report would be made public. TMIA also argued that the nature of the changes made to the Report, and the various rationales for those changes, belie the view that the report was only for internal use.

Finally, TMIA maintained that licensee improperly withheld the Keaten Report from the restart proceeding. TMIA argued the Report was directly relevant to issues in the proceeding, and licensee's "various excuses [for why it did not provide the report] not only contradict

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[56] Long is currently the GPUN Vice President for Nuclear Assurance, while Keaten is the Director of Engineering Projects, GPUN.

themselves, but, when viewed together, appear implausible." Id. at A-200.

UCS argued that further hearings are required on licensee's response to the NOV and the revisions to the Keaten Report. UCS asserted the false response to the NOV "is a direct and damning indictment of licensee's management integrity." UCS maintained the revisions to the Keaten Report were made to conform it to the false NOV response, "to shift blame away from GPU in preparation for the company's litigation against B&W and generally to minimize or remove concessions of regulatory violations or even misjudgment on the part of licensee's management." UCS Comments at 49. UCS claimed that this shows that licensee is not interested in learning the lessons from TMI-2 when to do so might imply fault or responsibility, and demonstrates a lack of integrity. UCS argued there must be a limit to the NRC's tolerance of licensee removing implicated individuals without disavowing their acts, and that the denials by Keaten, Long and Arnold of any attempt to dictate the contents of the Keaten Report because of positions taken in the NOV response are incredible. Rather, UCS claimed, the evidence shows that Keaten allowed the task force to be used as a tool in management's efforts to deceive the NRC.

UCS argued that material false statements were made to the NRC "and that current GPU management has neither disavowed them nor held anyone accountable." UCS maintained that these facts, if proven, establish "that GPU lacks the integrity to be entrusted with a license to operate a nuclear plant," and therefore the standards for reopening are met. UCS comments at 52.

The Commonwealth maintained that changes to the Keaten Report were made to avoid liability in GPU v. B&W, and to conform to the misleading response to the NOV. The Commonwealth argued that although the sequence of events is clear, two questions remain to be resolved through hearings. Those questions are whether all those who may have influenced the Report have been identified, and "[w]ould current management of GPU and do current management practices at TMI-1 preclude a repetition of a similar episode, and how?" Commonwealth Comments at 5.

Staff found no improper influence in the revisions to the Keaten Report, and that licensee was under no obligation to provide that Report to the NRC earlier than it did. Regarding the licensee's inaccurate response to the NOV, staff concluded that reopening is not warranted because the individuals responsible (Arnold and Wallace) are no longer associated with TMI-1, and because Mr. Dieckamp's involvement was not improper.

Licensee stated that the only issue raised here concerns the response to the NOV, and no hearings are warranted because neither of the individuals implicated is involved with TMI-1 restart.

C. Analysis

There are four separate matters which must be considered -- the changes to the Keaten Report, licensee's response to the NOV, licensee's obligation to provide the Keaten Report to the NRC, and licensee's recent statements and actions regarding that Report. We will discuss each in turn.

1. Changes to the Keaten Report

Some of the changes discussed by TMIA do appear clearly to be designed to improve licensee's image in the Report. For instance, the conclusion that "the general operational condition appears to indicate a lack of management awareness of problems, an insufficiently stringent standard by which to evaluate operations, and/or a management philosophy which accepted this situation, at least in the short run" was changed to "the task force did not perform a thorough review of the role played by TMI management relative to the identified problems...." Similarly, the thought that if certain specific actions had been taken by the licensee "the operators might have had sufficient information to recognize the stuck valve" was changed to "the need for improved means for identifying a stuck open PORV might have been recognized."

While there are no factual controversies regarding what changes were made, there is some controversy regarding the reason for those changes. It can be argued from the existing information that the changes were made to make licensee look better, both from a litigative posture and otherwise. The question we see is whether that issue warrants hearings. In our view, revisions to an internal report, even if designed for some external use, do not raise serious integrity concerns unless there is a showing that false information was used negligently or intentionally. The changes here for the most part reflected differences in judgment regarding managerial matters rather than technical matters of fact or expert judgment. The only apparent false information we are aware of in the Keaten Report is the same information as in licensee's response to the NOV. That information was

inserted in the Keaten Report based on reliance on Wallace. We see no integrity concern in the mere fact that a task force in preparing a report relied on representations made to it. While in hindsight it appears reliance should not have been placed on Wallace, in the absence of any other evidence indicating an improper motive, we believe the act at the time was reasonable.

In addition, the Licensing Board in addressing licensee's response to the accident did not rely on licensee's testimony. The Licensing Board found the testimony of Keaten and Long "more positive than appears warranted." 14 NRC at 539. The Appeal Board, in addressing a challenge to licensee's witnesses on this issue, found "that the direct testimony of licensee's witnesses was not particularly probative or responsive to the issue at hand. But we also find that the Licensing Board appears to share that view, inasmuch as it did not rely on their testimony to any significant extent in reaching its conclusions on [this issue].... Thus, although the testimony of licensee's witnesses ... was not especially useful, it also did not provide the evidentiary basis for any critical finding by the Board." 19 NRC at 1258-59. Thus further information on licensee's view of the accident would not have had any impact on the Licensing Board's decision.

In sum, then, the Commission finds that the changes to the Keaten Report, even if designed to improve GPU's position, do not raise a significant safety issue which might have changed the Licensing Board's decision.

2. Licensee's Response to the NOV

There are no factual controversies regarding licensee's response to the NOV. It appears that licensee made material false statements in its response, but the two individuals primarily responsible (Arnold and Wallace) are no longer associated with TMI-1. The only individual left who was involved in any way is Dieckamp, and we see no significant factual disputes regarding his involvement. He reviewed the matter, found the argument "kind of thin," and chose not to intervene. While in hindsight this may have been unwise, it does not raise a significant safety concern.

With regard to the UCS challenge to licensee's practice of shifting employees in question away from TMI-1, the Appeal Board in ALAB-772 discussed this issue in connection with whether further hearings were warranted on the "information flow" issue:

> We would agree that, if further hearing established significant improper action by ... any employee -- the corporate entity itself must bear some of the responsibility. The degree would depend on the circumstances and conduct involved. In that sense, then, the corporate entity can never be held blameless for past acts. But the question here is whether the corporate entity can reasonably assure more responsible conduct by its managers in the future. A corporate entity is a 'person' in the legal sense that it can sue and be sued and incur responsibilities, but in a real sense it can 'act' solely at the direction of individuals. Replacing high level managers can therefore effect a corresponding substantive change in the philosophy and overall behavior of management .... [I]t cannot be gainsaid that [the absence of the implicated individuals] from the ranks of licensee's managers removes a large hurdle in licensee's path to proving it is competent to manage TMI-1 in a safe manner.[98]

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[98] We also note that the 'corporate entity' to which TMIA refers has been denied permission to operate TMI-1 for more than five years. Virtually every aspect of its plant management and operation has undergone, and will continue to be subject to, scrutiny by the NRC and myriad external

> organizations (including intervenors) greater than that to which most other plants are subjected. Thus, it cannot be fairly said that the corporate entity has escaped sanction for its action in connection with the TMI-2 accident."

19 NRC at 1264-65, 1265 n.98. With the removal of Arnold and Wallace, further hearings on this issue are not warranted.

3. Licensee's Obligation to Provide the Keaten Report to the NRC

There is no factual dispute regarding the circumstances under which licensee provided the Keaten Report to the NRC, although contrary inferences can be drawn regarding why the licensee did not provide it earlier. Any failure here would not be a material false statement, as the NRC staff has concluded that it was already aware of the technical information in the Report, but rather a violation of the Board Notification procedures, which require that all new information which is relevant and material be provided to the Boards in a timely fashion. Regardless, although licensee perhaps should out of discretion have provided it to the Board, the Commission finds no serious concern here warranting a hearing.

4. Licensee's Recent Statements and Actions Regarding the Report

Intervenors argued that licensee is now misrepresenting the purpose of the Report, and that licensee has failed to take appropriate action against those implicated in wrongdoing by OI. The Commission finds nothing warranting a hearing in licensee's contradictory statements regarding the purpose of the report. Those statements indicate that the

purpose of the Report was an internal study, but it was recognized that the study might well be made public and hence have a public impact.

Nor do we believe a hearing is warranted on licensee's disciplinary actions (or lack thereof). There is no controversy regarding what acts were taken, but rather with regard to the propriety of those acts. We do not find licensee's practice of defending its employees prior to a formal determination of wrongdoing unreasonable. While Wallace and Arnold have been implicated in wrongdoing, they have not been found guilty, and we do not believe licensee's actions toward these individuals raise any significant integrity concerns which might have affected the Licensing Board's decision, and accordingly they do not meet the standards for reopening.

VIII. Changes to Lucien Report

A. Background

Shortly after the accident K.P. Lucien, an employee of Energy Incorporated (EI), under contract with GPU, investigated the factors that led up to the loss of feedwater during the accident. Lucien issued a report on September 1, 1979 which was critical of the startup and test program at TMI-2. Members of the startup and test program disagreed with Lucien's report and set up a meeting with Lucien to discuss their disagreement. As a result of that conversation Lucien made several changes to his report. The issue is whether anyone acted improperly in connection with those changes.

B. Parties' Comments

TMIA, citing its 2.206 petition, stated that further hearings are required on this issue. TMIA made no argument regarding why the record should be reopened, instead merely stating its view of the facts of this issue and their significance.

The NRC staff concluded that this matter does not meet the standards for reopening. Staff maintained that the changes to the Lucien Report do not raise questions about the integrity of the individuals involved, and there is no evidence that anyone in licensee's management was involved in the changes.

Licensee maintained that this issue raises no integrity concern, and hence does not provide a basis for reopening.

C. Analysis

TMIA has presented no factual disputes which would warrant further hearing. Rather, the questions TMIA raise involve the inferences to be drawn from the facts presented by OI in its investigative report. We have examined the facts involved and do not believe that they warrant further hearings, or that the inferences which can reasonably be drawn from those facts warrant further hearings.

We will address two illustrative examples. TMIA maintained that Lucien's original finding that certain startup and test records may have been falsified was improperly changed. Lucien's original conclusion had been based on his review of records showing tests had been completed in one day when those tests could not physically have been done in one day. Lucien changed his conclusion when it was explained to him that only the

date the overall testing process was finished was placed on the records. Lucien, based on this understanding, found that the discrepancy in the records "was the result of 'poor' administrative practices and record-keeping."

The second example concerns the handwritten memo accompanying Lucien's report when it was delivered to the Keaten Task Force. That memo stated, "[p]er our understanding with R. Keaten, please launder this to bring it into line with your presentation of the forthcoming master task force report." Both Lucien and Long, to whom the memo was addressed, stated that the term "launder" meant only make the report conform with the written structure of the Keaten Report. TMIA concluded that "launder" was intended to mean conceal. TMIA supported this conclusion by arguing that the final Keaten Report was in fact substantially less critical than the Lucien Report.

We do not agree with TMIA's inference that Lucien and Long are lying. The explanation given by Lucien and Long is reasonable, and the fact that the Keaten Report differed from the Lucien Report does not show an intent to conceal. We are aware of no direct evidence of wrongdoing in this matter, and hence conclude that hearings are not warranted.

IX. Change in Operator Testimony at GPU v. B&W Trial

A. Background

During the review of the GPU v. B&W lawsuit record, it was determined that the trial testimony of W.H. Zewe (former TMI-2 Shift

Supervisor) and E.R. Frederick (former TMI-2 operator) concerning whether high pressure injection (HPI) had been manually initiated on the morning of the accident differed significantly from previous statements made under oath by Zewe, Frederick, and C.C. Faust (former TMI-2 operator). These three individuals had previously stated that HPI had been manually initiated when the last two reactor coolant pumps were secured. At the GPU v. B&W trial, however, Zewe did not remember whether HPI had been initiated at that time, while Frederick testified that HPI could not have been initiated.

OI's investigation indicated that the changes in testimony were brought about by GPU's trial attorneys and were based on technical analyses that had been prepared subsequent to their prior statements. It also appears, however, that there is some question about the truthfulness of Frederick's statement at trial and to OI that he had never previously taken a position on whether HPI had been initiated. Staff in NUREG-0680, Supp. No. 5 indicated that because of this concern, and his possible involvement in TMI-2 leak rate falsification, it would withhold Frederick's TMI-1 Instructor Certification until these issues are resolved.

B. Parties' Comments

TMIA, without addressing whether there are factual disputes and whether the standards for reopening are met, argued that further hearings are required on this issue. TMIA's position is apparently based on its conclusion that the change in testimony "was the result of pressure exerted by GPU's attorneys and/or management, and likely

untruthful." TMIA 2.206 petition at A-238-39. TMIA also appeared to imply that licensee should have changed its official TMI-2 accident "sequence of events."

Staff concluded that the standards for reopening are not met because there is no "conclusive evidence of intentional misrepresentation," nor any evidence indicating improper activity or coercion by GPUN management. Staff comments at 30.

Licensee stated this issue does not warrant reopening because there is no evidence "that licensee management influenced or made any attempt to influence the testimony of the operators in the B&W litigation." Licensee comments at 26.

C. Analysis

There are no factual disputes here except for the concern about Frederick's earlier position. We believe staff's actions concerning Frederick are reasonable, and that hearings on this issue would serve no useful purpose. We note in this regard that TMIA's inference that the change in testimony must have been improperly motivated is unsupported by any factual evidence, and it appears the change in testimony resulted from new technical analyses which had not previously been available to Zewe and Frederick, and which were brought to their attention by GPUN counsel to refresh their memories. We also believe licensee was under no obligation to modify its official sequence of events because it is no longer material to any regulatory action, and, accordingly, licensee is under no obligation to revise that document when new information becomes

available. Hence, this issue does not meet the standards for reopening the record.

X. Financial/Technical Interface

A. Background

One issue the Commission directed the Licensing Board to examine was whether the relationship between licensee's "corporate finance and technical departments is such as to prevent financial considerations from having an improper impact upon technical decisions." CLI-80-5, 11 NRC 408, 409 (1980).

The only evidentiary presentation by the NRC staff on this issue was in the SER Supplement on management issues, NUREG-068(Supp. No. 1. Staff in Supp. No. 1 stated that there was no indication undue influence of financial considerations on TMI operation before the accident. Licensee presented the testimony of H. Dieckamp.

Since no intervenor presented evidence or proposed findings on this issue, the Licensing Board found it to be an uncontested matter. 14 NRC at 514. The Licensing Board concluded that "Licensee's organizational framework and its practice of committing substantial resources to its nuclear business provides reasonable assurance that the relationship between its corporate finance and technical departments is such as to prevent financial considerations from having an improper impact upon technical decisions." Id. at 518. The finding was affirmed by the Appeal Board. 19 NRC at 1272.

The Licensing Board also examined other issues involving licensee's finances in response to TMIA Contention 5. See 14 NRC at 479. These issues included whether licensee (1) deferred safety-related maintenance and repairs beyond the point established by its own procedures, (2) failed to keep accurate and complete maintenance records related to safety items, and proposed an excessive cut in the maintenance budget.

Staff's review of the GPU v. B&W lawsuit documents and OI's Keaten investigative report suggested that insufficient resources had been made available at TMI-2 prior to the accident, particularly with regard to the secondary side of the plant. Staff in Supp. No. 5 thus stated that "[t]his conclusion is at variance with staff's testimony" in the restart proceeding. Supp. No. 5 at 8-33.

B. Parties' Comments

TMIA, which again presented its view of the facts with no explanation of whether those facts meet the standards for reopening, would relitigate the entire issue of financial considerations.

Staff stated reopening is not required because the Licensing Board relied on substantial evidence besides the now-questioned staff statement, and because much of that evidence focused on the post-accident period.

C. Analysis

The Commission has determined that this new information does not meet the standards for reopening. With regard to the

financial/technical interface issue, the Commission finds that much of the evidence before the Licensing Board focused on the post-accident period, and that the new information -- which is primarily concerned with pre-accident matters -- does not raise questions regarding licensee's present financial commitments.

To the extent that TMIA is arguing that the entire issue of maintenance and financial considerations should be relitigated, there was evidence in the restart proceeding indicating that prior to the accident licensee had insufficient resources devoted to nuclear operations. Any new information does not significantly add to the record in that regard. The concern today is with licensee's current program. That program has been fully evaluated, and the new information does not raise serious concerns about the adequacy of that system.

XI. Timely Reporting of the BETA/RHR Reports

A. Background

The BETA and RHR consultant reports were prepared for licensee in early 1983,[57] and were subsequently provided to the NRC. The NRC's Executive Legal Director in a June 14, 1983 memorandum concluded that "[t]he licensee can be considered to have failed to meet its duty to make a Board Notification and its obligations under Section 186 (of the

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[57] The BETA report was an efficiency study of TMI and Oyster Creek prepared by Basic Energy Technology Associates, Inc.

The RHR report, prepared by Rohrer, Hibler & Replogle, Inc., assessed operator attitudes at those facilities.

Atomic Energy Act) by failing to provide the BETA and PUP reports in a more timely fashion."

TMIA moved to reopen the record on this issue, and the Appeal Board denied that motion in ALAB-774.

B. Parties' Comments

TMIA, again without addressing whether there are material facts in dispute or whether the standards for reopening are met, stated this issue requires reopening. TMIA argued that licensee had improper motives for withholding the reports, i.e., the adverse publicity which would result and the Appeal Board's possible interpretation of the reports' findings, and that licensee was willing to make a Board Notification only when threatened by the NRC staff. TMIA maintained that this evidences "serious integrity problems," and sets "an extremely bad example from top management to subordinates as to what Licensee's legal responsibilities are." TMIA 2.206 petition at A-243.

Licensee stated the Appeal Board already addressed this issue in ALAB-774, and there is no new information on this issue.

The NRC staff maintained that this issue does not warrant reopening because the OI investigation revealed no basis for questioning the managerial integrity of any of the individuals involved. Staff also found that adequate corrective action has been taken to remedy licensee's failure to evaluate and provide the reports to the NRC in a more timely fashion. Finally, the staff noted that its position is consistent with that taken by the Appeal Board.

C. Analysis

The Commission in its order taking review of whether further hearings are required stated "[t]he parties should not address matters where motions to reopen have already been granted or denied on the same information cited by staff, but rather should specify what, if any, new information which has not yet been passed on by a Board warrants reopening of the record." CLI-84-18, 20 NRC ___ (1984).

This issue was fully explored by the Appeal Board in ALAB-774. The Commission decided not to take review of that decision. The parties have brought forward no new information, and, accordingly, no further analysis is needed. This issue does not warrant further hearings.

Summary

The Commission has decided to allow the Licensing Board to render a decision on the Dieckamp mailgram and training issues. The Commission has also decided to institute a separate proceeding on the Hartman allegations, and to offer Husted an opportunity to request a hearing on the Appeal Board's condition barring him from working as a supervisor in the training of non-licensed personnel. The Commission has decided that hearings are not warranted on any other issue. Finally, the Commission has decided to impose the following conditions on licensee:

(1) No pre-accident TMI-2 operator, shift supervisor, shift foreman, or any other individual both in the operating crew and on shift for training as a licensed operator at TMI-2 prior to the accident

shall be employed at TMI-1 in a responsible management or operational position without specific Commission approval.

"Operational position" as used here includes any position involving actual operation of the plant, the direction or supervision of operators, or independent oversight of operations.

This condition shall also apply to the pre-accident Vice President, Generation, TMI-2 Station Manager, TMI-2 Superintendent, and TMI-2 Supervisor of Operations. This condition shall not apply to Michael Ross, and Brian Mehler may continue in his present position consistent with this condition.

(2) Licensee, in the absence of Commission authorization to the contrary, is to retain its expanded Board of Directors and its Nuclear Safety and Compliance Committee.

Commissioners Asselstine and Bernthal disapproved this Order. Their separate views are attached. The additional views of Chairman Palladino and Commissioners Roberts and Zech are also attached.

It is so ORDERED.

For the Commission

SAMUEL J. CHILK
Secretary of the Commission

Dated at Washington, D.C.
this 25th day of February, 1985.

DISSENTING VIEWS OF COMMISSIONER ASSELSTINE

In its August 9, 1979 order establishing this proceeding, the Commission concluded that it lacked the requisite reasonable assurance that Three Mile Island Unit 1 can be operated without endangering the health and safety of the public. Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit No. 1), CLI-79-8, 10 NRC 141, 142 (1979). The Commission's order enumerated a series of specific concerns supporting that conclusion, including: the special safety vulnerabilities in the Babcock and Wilcox design and the consequent greater burden that these reactors impose on the plant operators; the potential interaction between Unit 1 and the damaged Unit 2; the potential effect of cleanup activities at Unit 2 on the safe operation of Unit 1; the deficiencies in emergency planning and station operating procedures which were so apparent during the Three Mile Island accident; and last, but not least, the serious questions about the management capabilities and technical resources of the licensee which came to light as a result of the accident. Although the NRC staff had developed a detailed set of required corrective actions to address many of these concerns, which the Commission expressly endorsed, the Commission found that these actions alone were not enough to restore the Commission's confidence in the licensee's ability to operate this plant in a safe manner. Therefore, the Commission determined that a hearing was required on the issues specified in its order. The Commission further determined that this hearing must be completed, and the resulting decision of the licensing board must be reviewed by the Commission, prior to restart of the facility. Id.

In the ensuing years, a number of hearings have been held on the issues identified in the Commission's August 9, 1979 order. In addition, subsequent events have broadened the scope of the issues which are relevant to a decision on whether the licensee can operate TMI-1 without endangering the health and safety of the public. Perhaps more than anything else, these events have served to focus attention in this proceeding on whether the licensee has demonstrated the requisite competence and integrity to operate the plant in a safe manner. These events, and the concerns they raise, are not insignificant. Indeed, several events were so significant that they caused the NRC staff to conclude that it could not support its previous testimony in favor of the licensee's competence and integrity. These events include among others: the deliberate falsification of leak rate tests at TMI Unit 2 prior to the accident and the resulting criminal conviction of the licensee for failure to even have a valid leak rate test; the widespread cheating by TMI-1 operators on company-administered tests and NRC licensing examinations as part of the requalification process for licensed operators; the false certification and management involvement in the coverup of cheating by a licensed operator during the requalification process; failures in the licensee's pre-accident and post-accident training programs; evidence of contractor discrimination against an employee for seeking to raise safety concerns; evidence of widespread failures to follow safety procedures in the TMI-2 cleanup, and inaccuracies in the licensee's response to the October 25, 1979 Notice of Violation which resulted from the TMI accident. Some of these events -- most notably, the training and cheating incidents -- are or have been the subject of hearings, but most

have not. Some have also been covered, in varying degrees, by investigations by our Office of Investigations.

The question now before the Commission is whether additional hearings are needed in order to fulfill the requirements in the Commission's 1979 order prior to deciding to allow the restart of TMI-1. I conclude that further hearings are required in four areas to fulfill the Commission's commitments in the 1979 order. These areas are: (1) the Parks allegations regarding discrimination and widespread violations of safety procedures in the TMI-2 cleanup; (2) the staff's change in position on the question of the licensee's managerial competence and integrity; and, (3) TMI-2 leak rate falsification and TMI-1 leak rate falsification.

Parks Allegations

As OI's May 18, 1984 report on the Parks allegations notes, the Department of Labor has substantiated Mr. Parks' allegation that he was discriminated against by the licensee's contractor for raising safety concerns regarding the TMI-2 cleanup. In addition, OI's September 1, 1983 report on allegations regarding TMI-2 safety procedures found widespread violations by the licensee's contractor. The report went on to identify the failure of senior licensee management to monitor responsibly the contractor's work and to hold the contractor accountable as the underlying cause of the violations of TMI-2 safety procedures.

The Parks allegations, and the ensuing OI reports, raise several issues which may be relevant to the licensee's managerial competence and integrity to operate TMI-1. These issues include: the extent of discrimination against employees for raising safety concerns; any involvement of licensee personnel; the implications of the discriminatory actions for the competence and safety attitudes of the licensee's management, and the significance of the procedural violations and their relationship to a determination on the competence and integrity of the licensee's operation of TMI-1. An opportunity for a hearing should be afforded on these issues.

Staff's Change in Position

The staff's change in position presents perhaps the most compelling case for further hearings to fulfill the Commission's commitments in the August 9, 1979 order. In its July 1984 re-evaluation of the licensee's management integrity, the staff found a pattern of activity by the licensee which, had it been known by the staff at the time the staff formulated its position on management in the restart proceeding, "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 the public health and safety." NUREG-0680, Supp. No. 5, p. 2-2. The staff went on to conclude, however, that the licensee's present organization was acceptable. Id. That judgment was based upon a variety of factors: the staff's finding on the significance and extent of licensee participation in the pattern of events which the staff identified as the basis for its change in position; the staff's finding that the pattern of events which it identified as

significant was all-inclusive; the staff's finding that the present licensee organization was a new organization in all significant respects, and the staff's findings regarding subsequent performance of the licensee's new organization.

It is clear that the staff's change in position would have substantially affected the licensing board's earlier positive conclusion on the licensee's competence and integrity. I cannot believe that the board or the Commission would have found acceptable a licensee organization which the NRC staff found to lack the requisite competence and integrity. This fact, together with the staff's refusal to identify the specific portions of its previous testimony which are no longer valid, provides a compelling reason for further hearings on the broad question of the licensee's managerial competence and integrity. That reason is further bolstered by the fact that there has been no opportunity for hearing on the many judgments made by the staff, and the extensive new information relied upon by the staff, in support of its current conclusion that the present licensee organization possesses the requisite managerial competence and integrity to operate the plant in a safe manner. Further, the Licensing Board has never been given an opportunity to address the issue of whether all necessary remedial actions have been taken in response to these problems. Given these factors, it is beyond question that the present hearing record on the licensee's management competence and integrity is stale and hardly serves as an adequate record upon which to make a decision.

Under these circumstances, the need to provide an opportunity for further hearings on the competence and integrity of the licensee's current organization is clear. Such hearings should include: a review of the present TMI-1 organization; consideration of the staff's reasons for its change in position and other factors affecting the validity of the licensing board's previous conclusions on the question; the significance and implications of a pattern of misconduct by the licensee; the information and analysis which the staff points to in support of its new conclusion regarding the competence and integrity of the licensee's current organization; and the need for additional corrective actions.

TMI-2 and TMI-1 leak rate falsifications

I also disagree with the Commission's treatment of the TMI-1 and TMI-2 leak rate issues (Hartman allegations). I believe that hearings are required on these issues and that those hearings must be a part of the TMI-1 restart proceeding. The reasons given by the Commission order for not reopening the record on the TMI-2 leak rate issues are very interesting and may have some relevance to whether the Commission can allow restart while the hearings proceed; however, on the issue of whether the TMI-1 record should be reopened, they are largely irrelevant.

We need not make predictions as to whether our hearing boards would find these issues relevant to restart because the Appeal Board has already decided that the restart record should be reopened to hear these issues.

Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit No. 1), ALAB-738, 18 NRC 177 (1983) and ALAB-772, 19 NRC 1193 (1984).

The Board found that the Hartman allegations raised significant safety issues, stating:

> Whether the Hartman allegations raise significant safety issues need not detain us long. Alleged violation of technical specifications, noncompliance with proper operating procedures, and destruction and falsification of records at Unit 2 before the accident -- all assertedly under the auspices of at least first level management -- obviously have serious implications for the proposed restart of Unit 1. The facts that the NRC staff referred this matter to the Justice Department for criminal investigation and that the Department has presented it to two Grand Juries underscore its significance. 18 NRC at 188.

The Board said that this was clearly within an issue the Commission directed the Licensing Board to examine:

> whether the actions of Metropolitan Edison's corporate or plant management (or any part or individual member thereof) in connection with the accident at Unit 2 reveal deficiencies in the corporate or plant management that must be corrected before Unit 1 can be operated safely[.] Id.

The Board also concluded that the Hartman allegations might have affected the outcome of the Licensing Board proceeding. In fact, the Licensing Board noted its lack of information about the Department of Justice matter and made its conclusion that there were no deficiencies in corporate or plant management subject to the Hartman matter. The Appeal Board said that, in effect, the record never closed on this matter. Without an on-the- record examination of the Hartman matter, the Appeal Board said

that the record contained a material gap and that it could not make a final judgment as to the licensee's management competence and integrity without an adequate record. The Appeal Board concluded that: "'The Commission's primary commitment...to a fair and thorough hearing and decision' in this case requires no less than an exploration of Hartman's charges at [a] hearing. CLI-79-8, 10 NRC 141, 147 (1979)." Id. at 190.

In choosing to take review of the Appeal Board's decision, the Commission did not apply its usual standards for review. Normally the Commission only reverses an Appeal Board decision for a clear abuse of discretion or a clearly erroneous application of the law. 10 CFR 2.786. The Commission has not applied that standard here. Instead the Commission chose to reconsider the issue virtually without reference to the fact that the Appeal Board had already decided the issue. See, Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit No. 1), CLI-84-18, 20 NRC 808(1984).

The Commission has decided that the Appeal Board was wrong and that it need not reopen the TMI-1 hearing to take evidence on the Hartman issues. The basis for the Commission's conclusion is the mass of information available to the Commission about changes to TMI management, personnel and organization which has never been made a part of the hearing record and which has never been tested in an adjudicatory setting. In 1979, the Commission said that its decision on the management competence and integrity issues was going to be made on the record developed at a hearing before a licensing board. Metropolitan Edison Co. (Three Mile Island

Nuclear Station, Unit No. 1), CLI-79-8, 10 NRC 141 (1979). In its haste to restart TMI-1, the Commission has decided to ignore that fact.

The information upon which the Commission relies to conclude that the record need not be reopened has never been the subject of a hearing. The parties have never had an opportunity to subject this information to cross-examination. The opportunity to file written comments on written reports is hardly an adequate substitute. Further, the Licensing Board has never had an opportunity to consider that information. The Board could very well decide that further management, personnel or organizational changes are necessary after reviewing a complete hearing record on the Hartman issues. In fact, the Licensing Board made it conclusion's subject to the Hartman issues, and in effect, left the record open on these issues.

The Commission concludes, however, that it knows enough about what happened to find that there is no longer any safety significance to this issue. This conclusion is based on the changes to licensee's organization, quarantine of some personnel from operational positions, and the statement of the U.S. Attorney relating to the plea agreement between the government and licensee on the criminal indictment. I cannot agree that the record is sufficiently complete that I can conclude with certainty that there is no remaining safety significance to these issues.

There has never been a complete, public investigation of this matter. OI did not complete its investigation of this issue, and the grand jury information is not available to us for evaluation. We have some

information which clearly indicates that at least at TMI-2 the leak rate falsification was widespread and condoned, if not encouraged by, first level management. However, we do not know precisely who was involved. We also do not know whether anyone above the first level management should be held responsible. Therefore, we do not know whether all necessary remedial actions have been taken.

The Commission relies on the statement of the U.S. Attorney for its conclusion that upper level management should not be held responsible, and that there is, therefore, no further remedial action which must be taken. Unfortunately, the U.S. Attorney's statement while helpful as a starting place to begin an investigation of the issue can hardly be termed dispositive. We have no idea upon what information the U.S. Attorney's statement was based because we do not have access to grand jury materials. Also, the interests of the U.S. Attorney's office are not coextensive with those of the NRC. The U.S. Attorney is interested only in prosecution for violations of criminal statues. The standards for proving criminal violations are much higher than those we apply to determine violations of our regulations. Further, our interests go beyond mere personal involvement in a particular act. We must also determine whether corporate management should be held responsible for such actions, regardless of direct involvement, because they allowed an attitude to develop such that falsifications occurred and because they had not developed procedures to assure that upper management was aware that the facility was not operating in conformity with its technical specifications. The Licensing Board has never been given an opportunity to consider these issues, or whether

sufficient remedial actions have been taken to prevent the recurrance of such episodes and to ensure that the plant will be operated safely.

In fact, the issue of corporate responsibility will never be the subject of a hearing. The Commission has decided to throw a bone to the intervenors in the TMI-1 restart case by offering a limited hearing, outside the TMI-1 proceeding, which the Commission calls a "full airing" of the issue. That "full airing" will not address the involvement of aryone named by the U.S. Attorney in his statement. Thus, most of the GPU Nuclear management, and specifically Messrs. Kuhns and Dieckamp, are to be outside the scope of the proceeding. It will not address the issue of corporate responsibility. This hardly amounts to a "full airing" of the issue. Obviously, the U.S. Attorney was right when he said that the Commission does not really care to know the true extent of what occurred and who were responsible. All the Commission seems to care about is what control room operators were involved. Once again the Commission demonstrates its talent for going for the capillary in resolving an issue.

While our information on TMI-1 leak rates is substantially more complete than that of the TMI-2 leak rate issues, that information is not a part of the TMI-1 restart record and has never been tested in an adjudicatory proceeding. I would also reopen the record on this issue so that there can be a full airing of the issue and so that the Licensing Board has a complete record before it when making a final judgment on the management competence and integrity of the utility. This would ensure that all needed

remedial measures are required to further ensure that TMI-1 will be operated safely.

Conclusion

For the foregoing reasons, I conclude that further hearings are required on the subjects of TMI-2 and TMI-1 leak rate falsifications, the Parks allegations, and the staff's change in position on the question of the licensee's management competence and integrity. Absent a commitment to hold such hearings, I cannot find a basis for concluding that this licensee possesses the requisite competence and integrity to operate TMI-1 in a manner that will not endanger the health and safety of the public. In deciding to deny further hearings on all but the question of TMI-2 leak rate falsifications, and to narrow the scope of that issue to the point where the hearing will be little more than a sham, the Commission has both abandoned the requirements it set forth in its August 9, 1979 order and broken its commitments to the public regarding the acceptable basis for a decision to restart TMI Unit 1. By its decision today, the Commission has violated the trust of the people of central Pennsylvania.

DISSENTING VIEWS OF COMMISSIONER BERNTHAL

At the outset I feel compelled to say that I consider this unfortunate split decision by the Commission on a matter as important as the TMI proceeding to be only the latest and most outstanding public interest casualty of the extraordinarily restrictive deliberative process under which the Commission labors. That process virtually eliminates collegial decision-making as a practical possibility. And thus is the public deprived of what it deserves in the case of TMI perhaps more than in any other case considered by the Commission to date: a truly collegial decision.

As for the order itself, I have disapproved it not because I believe that further hearings on certain matters are necessarily legally required. Indeed, the information available to the Commission indicates that there have been sufficient changes in personnel and attitude in the GPU organization so as to to offer substantial assurance that the significant problems of the past will not recur. And in keeping with their legal right, the parties to this proceeding have had extensive opportunity to comment on the available information, both in writing and in oral presentations at past Commission meetings.

Thus, while I can appreciate and respect the position of my colleagues who believe that no further hearings in this matter are either required or appropriate, I believe that the path they have chosen is unwise and ill-advised.

All Commissioners agree that there would be little point to the Commission now interfering with the Licensing Board's final consideration of the Dieckamp mailgram and training issues. The Board is certainly aware of the need to expedite its decision on these matters, to the extent possible. I also agree that further hearings should be held in the Hartman matter, although I do not believe that any useful purpose was served by the Commission specifying that such hearings be held outside the scope of the restart proceeding. In addition, I agree with the majority that elementary concepts of fairness require that we issue a

formal opportunity for hearing to Mr. Husted prior to removing him from his supervisory position.

As for the other matters at issue, I depart from the position taken by the majority. It is true that the Commission has broad authority to decide which of these issues must be resolved in an adjudicatory format. Shortly after the TMI accident, the Commission announced that adjudicatory hearings would be convened on the issues raised by the accident. In my view, that was a purely discretionary decision by the Commission.

Since that decision, the Commission has proceeded to conduct off-the-record informal reviews of a number of TMI-related matters. Such reviews arguably also fall within the broad discretionary privilege of the Commission on a matter which is, after all, an enforcement proceeding under standard Commission procedure.

Nevertheless, in this case I believe that the Commission must exercise extraordinary diligence and perseverence to see that, insofar as is possible and appropriate within its special purview, it has provided the public with a complete record of the facts and events associated with the TMI accident and its aftermath, so that all reasonable public concerns and questions with respect to the long and troubled history of the TMI facilities may finally be laid to rest. There is therefore a strong, and I believe decisive, public policy value in full public hearings on all significant issues related to TMI-1 restart.

While further hearings may not be required as a legal matter on any remaining issues, policy considerations thus lead me to conclude that three outstanding matters deserve special consideration by the Commission: 1) The Staff's likely change of position; 2) The Parks allegations; and 3) TMI-1 leak rates.

As to the Staff's likely change of position, I agree that a case can be made that the four instances which are cited by the Staff are or will be resolved by one or more of the following: 1) the now-completed training

hearings; 2) a further hearing of appropriate scope on the Hartman matter; and 3) the fact that the individuals directly involved in false statements on the NOV are no longer associated with TMI-1. However, if the four instances discussed by the Staff are considered not in isolation, but as a pattern of activity which might have had a significant impact on the Licensing Board's decision, an integrated picture of all elements involved in this issue is of significant public policy importance. I therefore would support the holding of further hearings on the overall pattern of conduct cited in NUREG-0680, Supplement 5.

In the matter of the Parks allegations, as I understand it, Mr. Parks' assertions that he was harassed have been substantiated by the Department of Labor investigation. Although neither Mr. Arnold nor any of his in-line superiors at GPU who could have played a direct role in this incident are today associated with TMI-1,[1] sound public policy again suggests that the test of cross examination in a hearing be applied to determine whether the DOL investigation is indeed dispositive of this matter.

Concerning TMI-1 leak rates, the Appeal Board thought this issue sufficiently important to remand the issue to the Licensing Board in ALAB-772. Extensive information available to the Commission (but not part of the now three-year-old Licensing Board record) indicates no motive for or verifiable pattern of such falsification at TMI-1. Nevertheless, in this circumstance the Commmission should seek to be responsive to the Appeal Board's remand. On balance therefore, I would support an adjudicatory test of the off-the-record information considered by the Commission concerning TMI-1 leak rates.

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1 Although Mr. Dieckamp remains on the Board of Directors of GPU Nuclear, he is no longer involved with the day to day operations of TMI-1.

Finally, it is important to emphasize that I am under no illusion that the Commission might somehow, by convening further hearings on some or all of the issues which I have identified, satisfy all those who might oppose eventual operation of this facility. Rather, given the age of the record in this case and the significant off-the-record information on which the Commission would have to rely were restart to be authorized, I believe that the vast majority of the public will be far better able to understand and concur in whatever judgment the Commission finally makes in this matter if the Commission makes every reasonable effort to assure a thorough airing of all essential information considered by the Commission.

Separate Statement
of
Chairman Palladino and Commissioners Roberts and Zech

Our judgment on where the public interest lies regarding the necessity and value of additional formal adjudicatory hearings in this proceeding is just opposite that of our two dissenting colleagues. While we certainly respect their views, we believe it useful to summarize briefly the reasons for our position in that regard.

At this point in this prolonged proceeding, our task is to determine whether there are any remaining significant disputed issues of fact relevant to the resolution of the 1979 order which immediately suspended the license to operate TMI-1. As a matter of its discretion, the Commission in 1979 also decided to hold adjudicatory hearings, in which interested members of the public were allowed to participate, on the immediately effective suspension order. In the almost six years which have passed since the immediately effective suspension order, exhaustive adjudicatory proceedings have been conducted. We need not be apologetic to anyone on the efforts this agency has made over these six years to have identified and adjudicated all relevant significant disputed issues of fact in this proceeding. Last September, we gave all of the interested parties the opportunity to inform us of their views on any specific factual issues which remain in dispute. Those

responses together with our own review of the issues in this proceeding are the basis for our conclusion that, except as noted in our memorandum and order, no further adjudicatory hearings are warranted to resolve significant facts which remain in dispute in this proceeding and which are needed for a final decision on the suspension order. Without such factual issues to be resolved, further adjudicatory hearings would serve no proper and useful purpose. For whatever other reason they may be desirable, holding "trials" when none are required is not, in our judgment, a responsible regulatory action.

We are aware of the understandable and proper interest of the citizens of the Commonwealth in this matter. We support complete, candid, and open communications with them at all times regarding all matters relating to safety at the plant. We do not believe, however, that holding unwarranted formal adjudicatory hearings would best serve the legitimate purpose of having the public fully informed on such matters.

The fundamental issue before us is whether the record now available is adequate for us to reach a judgment on the competence and integrity of the present TMI-1 management and organization to operate the plant with reasonable assurance that the public health and safety is protected. In reviewing this matter, we have carefully considered whether, on the basis of our own evaluations, and on the basis of the parties'

responses to our September 11, 1984 order, additional disputed factual matters need to be resolved in adjudicatory proceedings. We have concluded that there are none, other than as indicated in our memorandum and order. Under these circumstances, we simply cannot agree either that it would serve the public interest, or that it would otherwise be sound regulatory policy for us to perpetuate the formal adjudicatory process which the Commission initiated as a discretionary matter in 1979 to assist it in making a decision on the immediately effective suspension order. The formal decisions which have been rendered to resolve a variety of issues in this proceeding demonstrate that the objectives of developing a full record for the resolution of contested issues has been met. There is no further purpose to be served by still another round of adjudicatory hearings. We must move on to consider a decision, one way or the other, on the continuing justification for the immediately effective suspension order. Under these circumstances, at this stage of the proceeding, it is our judgment that neither our regulatory responsibilities nor the public interest justify our acting otherwise on the question of holding further adjudicatory hearings.

Although the foregoing gives the fundamental basis for the differences between the majority and the dissenting opinions on the need for further adjudicatory hearings, we wish to respond briefly to certain specific points raised by the dissenting

opinions. Our detailed rationale on the issues raised by the dissenters is, of course, set forth in our memorandum and order.

The Staff's Change in Position.

The staff's assertion of its likely change of position rested on allegedly new information about four items. Our memorandum and order analyzes each item and concludes that none presents a significant safety issue for the operation of TMI-1. It also points out that two of the items have been or will be the subject of full board proceedings and that the remaining two items hold no continuing significance to TMI-1 operation.

Commissioner Asselstine's characterization of the staff's change in position is fundamentally inaccurate in two important respects. First, the staff did not change its position on the competence and integrity of the licensee's current management. It stated that a pattern of activity which occurred prior to and shortly after the accident "would likely have resulted in a conclusion by the staff that the licensee had not met the standard of reasonable assurance . . ." This referred to Met-Ed's organization prior to and shortly after the accident. Second, the staff took a position on the adequacy of the successor organization, GPU Nuclear, and evaluated and

revalidated its acceptability. The adequacy of GPU Nuclear has been litigated.

The Allegation of Leak Rate Falsification at TMI-1 and TMI-2.

With regard to the allegations of leak data falsification at TMI-1, the memorandum and order notes that a thorough investigation of the allegations concluded that there was no reason to falsify leak rate test results at TMI-1. The order also notes that a detailed NRC review of the test results themselves evidenced no pattern of deliberate falsification. The memorandum and order's analysis of the Hartman allegations of falsifications at TMI-2 points out the U.S. Attorney's statement, in the course of the proceedings on plea and sentencing, that "the evidence presented to the grand jury and developed by the United States Attorney does not indicate that any of the following persons participated in, directed, condoned or was aware of the acts or omissions that are the subject of the indictment. And they are William G. Kuhns, Herman M. Dieckamp . . . [1/] The order concludes that Kuhns and Dieckamp should not be deemed responsible for leak rate falsification solely by virtue of their corporate position or

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1/ Commissioner Asselstine is wrong to dismiss the U.S. Attorney's statement because of the different standards that apply to criminal violations. The quoted U.S. Attorney's statement is not couched in terms of the criminal standard.

their lack of awareness of falsification. We also found that, in view of our Office of Investigations' conclusions, it is highly unlikely that Michael Ross knew of or was involved in leak rate falsifications at TMI-2, and that his continued presence at TMI-1 does not raise a safety concern.

The order further notes that no other person involved in the TMI-2 operations during the period of leak rate falsification would be employed in a responsible management or operational position at TMI-1 without prior Commission approval.

Commissioner Asselstine's characterization of why the majority chose to approve a hearing on TMI-2 leak rate falsification outside the restart proceeding is inaccurate and misleading. He has inappropriately and incorrectly attributed motives to the majority which have no bearing on the real reasons for our decision. The majority was concerned that the TMI-2 leak rate issue would have inadequate public disclosure and that those individuals who are believed to have been involved would never be identified as culpable or exonerated, as appropriate. For the reasons stated in the memorandum and order, that purpose clearly has nothing to do with the TMI-1 restart proceeding.

The Parks Matter

The Commission memorandum and order notes that there has been no showing of a widespread pattern of discrimination, that the

acts of harassment and intimidation involved TMI-2 activities (not TMI-1), that the major GPUN official involved is no longer asociated either with GPUN or TMI-1 activities, and that GPUN has adopted clear policies to prevent future acts of harassment or intimidation.