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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

In the Matter of	)	
	)	50-289RA
GPU NUCLEAR	)	50-289EW
	)	(Special Proceeding)
(Three Mile Island Nuclear Station, Unit No. 1)	)	

NRC STAFF COMMENTS IN RESPONSE TO CLI-85-19

Mary E. Wagner
Counsel for NRC Staff

January 24, 1986

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In CLI-85-19, issued December 19, 1985, the Commission asked the Staff, and other interested parties, to submit comments addressing three questions related to the requirement in CLI-85-2 that Licensee notify the Commission before returning either Robert Arnold or Edward Wallace to responsible positions at TMI-1. The Staff's responses to the Commission's questions are set forth below.

I. INTRODUCTION AND BACKGROUND

In NUREG-0680, Supplement No. 5 (Supplement No. 5), the NRC Staff concluded that Metropolitan Edison Co. (Met-Ed), the former licensee at Three Mile Island, Units 1 and 2, submitted inaccurate and incomplete information in its December 5, 1979 response (Response) to the NRC's October 25, 1979 Notice of Violation (NOV) arising from the TMI-2 accident.

By letter dated March 27, 1985 and accompanying Memorandum (together, Arnold/Wallace Memorandum), Robert Arnold and Edward Wallace submitted to the Commission a request for a hearing to determine whether

the adverse implications about their integrity provided by the Staff and OI in connection with the TMI-1 restart proceeding are factually substantiated. These adverse implications arise from the Staff's conclusions in NUREG-0680, Supplement No. 5 that Metropolitan Edison Company's December 5, 1979 Response to the NRC's October 25, 1979 NOV was "inaccurate and incomplete" and the conclusions drawn by the Office of Investigations in OI Report No. 1-83-012 (May 18, 1984).

In Supplement No. 5, the Staff did not reach conclusions regarding certain individuals who were responsible for, or involved in, events that called into question the management integrity of Met Ed where such individuals no longer held management positions within GPUN related to operation of TMI-1. (Arnold and Wallace are two such individuals.) Instead, the Staff took the position that, should the Licensee decide to assign any such individuals to responsible management positions associated with the supervision of operations or maintenance of Three Mile Island Unit 1, the Licensee should be required to first obtain Staff review and approval. The Commission, in fact, imposed a requirement that the Licensee notify the Commission before returning Arnold or Wallace to responsible positions at TMI-1. CLI-85-2, 21 NRC 282, 323 (1985).

The Commission, in CLI-85-19, indicated that it now will consider lifting the condition for prior Commission notification, and that its determination in that regard will be based in part on the information submitted in response to several Commission questions. The Staff's responses to those questions posed by the Commission in CLI-85-19 are set out below.

II. DISCUSSION

A. Answers to Commission Questions

Commission Question 1

Does any part of the following statements in licensee's December 5, 1979 NOV response constitute a material false statement:

> Metropolitan Edison believes that Emergency procedure 2202-1.5, "Pressurizer System Failure", [sic] was not violated during the period from October 1978 through March 28, 1979 notwithstanding the temperatures of the discharge line from the pilot operated (electromatic) relief valve ("PORV"). Although this procedure was understood by the plant staff, it is not clearly written and does not reflect actual plant conditions. It will be changed. However, although Metropolitan Edison is concerned about the issue, there is no indication that this procedure or the history of the PORV discharge line temperatures delayed recognition that the PORV had stuck open during the course of the accident.

Response

The Staff reaffirms its conclusion in NUREG-0680, Supplement No. 5 that Licensee's December 5, 1979 Response to the October 25, 1979 Notice of Violation contained inaccurate and incomplete information, and concludes that portions of the above-quoted Response constitute material false statements. A complete discussion of the Staff's basis for its conclusion is set forth in the attached Affidavit of William T. Russell and Robert A. Capra (Russell/Capra Affidavit).

The Staff has concluded that two portions of Licensee's Response, quoted above, are inaccurate and incomplete. These statements deal with Licensee's violation of Emergency Procedure 2202-1.5 both before and during the TMI-2 accident. With regard to the pre-accident time period, the Staff has concluded that the statement in the Met-Ed Response "Emergency Procedure 2202-1.5, 'Pressurizer System Failure', [sic] was not violated during the period from October 1978 through March 28, 1979 notwithstanding

the temperatures of the discharge line from the pilot operated (electromatic) relief valve ('PORV')," was false. Russell/Capra Affidavit ¶ 9. The statement, along with the accompanying explanation in the Response, implied that the procedure was not followed because the procedure was in error (i.e., the normal PORV discharge line temperatures were 170°-190°F, not 130°F as stated in the procedure) and because a pre-accident determination was made that the code relief valve (RV1A) was leaking, and not the PORV. As a result, the Licensee argued it did not have to follow the emergency procedure for closure of the PORV block valve. While the procedure may have been in error with respect to the normal value for the PORV discharge line temperature, the procedure was clearly applicable. The statement was false because a pre-accident determination had not been made that the PORV was not leaking and, as the result of a conscious management decision, the procedure was not followed and the block valve was not closed. Russell/Capra Affidavit ¶ 9. The false statement was material for the following reason. While the Staff disagreed with the Licensee and stated that the block valve should have been closed, the Staff accepted the Licensee's implication--that the procedure was merely ignored because of the error--as argument, and simply discounted that argument as wrong. Had the Staff focused on the fact that the procedure was not implemented because of a conscious decision by management not to close the PORV block valve (rather than failure to revise an erroneous procedure) it could have influenced the NRC's consideration of the severity of the sanction proposed in the October 25, 1979 Notice of Violation. Russell/Capra Affidavit ¶ 9.

With regard to the statement in the Response that "there is no indication that this procedure or the history of the PORV discharge line

temperatures delayed recognition that the PORV had stuck open during the course of the accident," the Staff has concluded that this statement also was false, because Met-Ed had in its possession contrary information from internal investigations and interviews that indicated that the high PORV tail pipe temperatures before the accident may have contributed to the operators' delayed recognition of a stuck-open PORV. Russell/Capra Affidavit ¶ 8. The false statement was material for the following reason. The cover letter transmitting the NOV made it clear that the NRC believed that the violation led to a situation where elevated tail pipe temperatures were accepted by operating personnel and delayed recognition of the stuck-open PORV on the day of the accident. The letter emphasized the significance of the delay and the sanction was based on the NRC's perception of the significance. Met-Ed's statement directly challenged the Staff's view, sought to reverse that view and, therefore, could have influenced the NRC's consideration of the sanction proposed in the October 25, 1979 Notice of Violation. Russell/Capra Affidavit ¶ 8.

In summary, the Staff has concluded that in the two above-described respects, Licensee's December 5, 1979 Response to the October 25, 1979 Notice of Violation constituted material false statements.

Commission Question 2

> If there was a material false statement, what knowledge and involvement, if any, did Arnold and Wallace have in making that statement?

Response

The knowledge and involvement of Messrs. Arnold and Wallace is set forth in detail in "NRR Review of NUREG-0680, Supplement 5, Conclusions In Response to the Arnold/Wallace Memorandum," (NRR Review). (A copy of

the NRR Review is attached to the Russell/Capra Affidavit.) A summary of the Staff's conclusions in this regard is provided below.

Wallace had the lead responsibility in developing the Licensee's Response to the NOV, and was most closely involved in its preparation. Wallace reported to Arnold in preparing the Response for the latter's signature. Arnold reviewed and signed the Response. See Supplement No. 5, at 8-15 to 8-21.

As to the period of operation before the accident, Arnold and Wallace assert that the Staff has misunderstood Met-Ed's basis for its denial that the emergency procedure was violated because "the NOV [Response] did not state, and did not intend to imply, that a preaccident determination that the PORV was not leaking was the reason the PORV block valve was not shut." (See Arnold/Wallace Memorandum at 64.) The Staff disagrees that such an implication is unreasonable or reflects misunderstanding for several reasons.

Wallace was responsible for the Keaten Task Force's final conclusion that Emergency Procedure 2202-1.5 was not violated. NRR Review at 17. This conclusion, which differed from the Task Force's initial conclusion that the procedure was violated, was based on Wallace's telling the task force that a preaccident determination had been made that the RC-R1A safety valve was leaking, that the PORV was not leaking, and that a work request had been issued for repair of RC-R1A. The task force did not independently review the evidence supporting Wallace's findings. NRR Review at 17. Arnold was deposed during the GPU v. B&W lawsuit concerning the interpretation of the Met-Ed Response. Arnold stated that the Response implied that a preaccident determination that the PORV was not leaking had been made and that he was not trying to evade the point made by NRC. NRR Review at 14-15. The OI investigation developed sufficient evidence to conclude

that, at the time the Response was submitted and the violation denied, Arnold was aware that the Emergency procedure 2202.1-5 had been violated. [1/] NRR Review at 14-15.

Following the outage that ended on January 31, 1979, there was significant leakage from the top of the pressurizer; this leakage continued to increase up to the time of the accident. This leakage was known to exist by all of the TMI-2 Control Room Operators, Shift Foremen, and Shift Supervisors, as well as by key management personnel. After the accident, but before the Response was submitted, Arnold and Wallace were aware of the leakage. NRR Review at 15.

While this leakage was known to exist, the source or sources (i.e., PORV and/or safety valves) of the leakage were not known by key management personnel or licensed operators responsible for implementing Emergency Procedure 2202-1.5 before the accident. After the accident, but before the Response to the NOV was submitted, Arnold and Wallace were aware that some operations personnel were not sure of the source of the leakage before the accident. NRR Review at 15.

NUREG-0600 stated that the following four symptoms of a leaking PORV and/or safety valve existed before the accident:

(1) The relief valve discharge temperatures exceeded the normal 130°F.

(2) The reactor coolant drain tank pressure and temperature were above normal.

1/ Arnold admits that the procedure was violated, but not because the block valve was not closed as an automatic reaction to PORV tail pipe temperatures' being above 130°F. NRR Review at 15.

(3) The reactor coolant makeup flow was above normal.

(4) The boric acid concentration was continually increasing in the pressurizer.

On the basis of its evaluation of Emergency Procedure 2202-1.5, existing plant conditions, and operator actions taken before the accident, IE determined that Met-Ed had violated the emergency procedure by not closing the PORV block valve and not placing the code safety valve discharge line temperatures on the analog trend recorder. Arnold and Wallace were aware of the findings of NUREG-0600 before submitting the Response to the NOV. NRR Review at 16.

In spite of the existence of all four symptoms and contrary to the procedural requirements of Emergency Procedure 2202-1.5, the Staff has found that a conscious management decision was made to violate the procedure (i.e., not shut the PORV block valve to determine whether or not the PORV was leaking). Evidence of this conscious management decision is detailed in the NRR Review at 16-17.

Wallace was aware that the Keaton Task Force had concluded in October 1979 that Emergency Procedure 2202-1.5 was violated and that this violation was due to a conscious management decision. NRR Review at 17. The task force later concluded that the procedure was not violated based solely on Wallace's representation to the task force that a preaccident determination had been made that the PORV was not leaking. NRR Review at 17.

The evidence identified during the OI investigation and the Staff's review of that evidence does support Wallace's position that a preaccident determination was made that a code safety valve was leaking;

it does not, however, support a position that a determination was made that the PORV was not leaking. Because the PORV block valve was not closed before the accident, even though all the symptoms were present requiring its closure, the Staff concluded that there was a conscious management decision not to close the block valve. This constituted a willful violation by the Licensee of the procedure. Therefore, the statement in the Response to the NOV that Emergency Procedure 2202-1.5 "was not violated during the period from October 1978 through March 28, 1979, notwithstanding the temperatures of the discharge line from the pilot operated (electromatic) relief valve" is inaccurate and incomplete. NRR Review at 18.

As for Licensee's actions during the accident, the Staff concluded in Supplement No. 5 that the statement in the Licensee's Response concerning delayed recognition that the PORV had stuck open was "inaccurate and incomplete." This conclusion was based on the Licensee's failure to disclose or take into account significant information that was contrary to the Licensee's position in its Response. The following five documents were cited in Supplement No. 5 as providing evidence that the Licensee's statement was at variance with information in the possession of the Licensee at the time the Response was filed: (1) the Met-Ed interview of W. H. Zewe on March 30, 1979 at 16, (2) the GPUSC Investigative Team interview of W. H. Zewe on April 6, 1979 at 6, (3) the testimony of W. H. Zewe before the Kemeny Commission on May 30, 1979 at 128, (4) the statement in GPU's Technical Data Report (TDR) 054, "Analysis of TMI-2 Operator Response," of October 1979 at 7 and 14, and (5) the October 29, 1979 draft of the Keaten Report at 7. NRR Review at 22.

Additional evidence was developed after the Response was filed that indicated some individuals in responsible postaccident evaluation positions also believe that high tail pipe temperatures before the accident played a role in the operators not recognizing the stuck-open PORV during the early stages of the accident. NRR Review at 23.

Licensee's task force evaluating the accident (the Keaten Task Force) and the individuals charged by Mr. Arnold to evaluate operator actions during the accident (i.e., the authors of Met-Ed's Technical Data Report (TDR) -054) had all concluded that high tail pipe temperatures before the accident may have played a role in the operators not recognizing the stuck-open PORV during the early stages of the accident. NRR Review at 23. Arnold stated that he was not aware of this information before signing the response. NRR Review at 26-27. According to Wallace, he (Wallace) was aware of the conclusions of the Keaton Task Force and TDR-054 at the time he prepared the Response, and did not doubt that many people may have felt the operators' response may have been delayed by the elevated temperatures. NRR Review at 24-25. Nevertheless, he chose to discount these findings, claiming that they were only the "opinions" of others. NRR Review at 24-25.

In summary, with respect to the violations of Emergency Procedure 2202.1-5 prior to the accident, at the time the Response was prepared, Arnold was aware that Emergency Procedure 2202.1-5 had been violated, and Wallace was aware that the Keaton Task Force had concluded that the procedure had been willfully violated. Before the Response was filed, Arnold and Wallace were aware of the leakage from the top of the pressurizer, and knew that some operations personnel were not sure of the source

of the leakage before the accident. When they submitted the Response, Arnold and Wallace were also aware of the findings of NUREG-0600 that all four symptoms of a leaking PORV and/or safety valve existed before the accident. These facts are contrary to the implication in the Response that a determination had been made that the PORV was not leaking and the statement that the procedures had not been violated. With respect to the post-accident violation, Wallace was aware, at the time he prepared the Response, of evidence including operators' statements and the conclusions of the Keaton Task Force and TDR-054 that pre-accident high tail pipe temperatures may have played a role in the operators' not recognizing the stuck open PORV during the early stages of the accident, but he discounted those findings. While Arnold may have known of the operators' statements, he has stated that he was not aware of the conclusions of the Keaton Task Force and TDR-054. Russell/Capra Affidavit ¶ 10.

Commission Question 3

> If Arnold or Wallace knew of or were involved in making a material false statement, does that knowledge or involvement indicate willful or reckless conduct by either of them.

Response

The Staff is unable to conclude on the basis of available information that the false statements in the response were willfully submitted. 2/ OI was not asked to, nor did it, reach a conclusion on the issue of whether

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2/ The Staff has consulted with OI on the question of whether additional investigation would be worthwhile. The Staff and OI jointly believe that the agency has acquired the information that is available such that it is unlikely that further investigation would produce significant additional information.

the information was willfully submitted. As to both Messrs. Arnold and Wallace, the evidence is circumstantial and insufficient to conclude they acted willfully or recklessly. However, the Staff cannot conclude that they did not so act. Russell/Capra Affidavit ¶ 11.

With regard to Mr. Arnold, there is evidence his conduct may have been willful or reckless, since he knew at the time the response was filed that procedure EP 2205-1.5 had been violated prior to the accident and the response denied that this procedure was violated. However, with regard to the procedure violation during the accident, the Staff has no direct evidence that Mr. Arnold was aware of either the Keaton Task Force conclusion or the TDR-054 conclusion that the operator's recognition of a stuck-open PORV may have been delayed by high tail pipe temperatures prior to the accident. Thus the "no indication" phrase in the Response signed by Mr. Arnold may not have been a willful or reckless disregard for the truth. Russell/Capra Affidavit ¶ 12.

The evidence to be assessed on the question of willfulness or recklessness by Mr. Wallace is more extensive than that concerning Mr. Arnold. It is clear that at the time Mr. Wallace drafted the Response, he had knowledge of information which contradicted statements in the Response. During OI's interview of Mr. Wallace, he admitted his prior knowledge of both the Keaton Task Force and TDR-054 conclusions regarding delayed recognition by the operators of the stuck-open PORV. He was also aware of the "opinions" of some operators regarding possible leakage from the PORV prior to the accident and management's decision not to follow the procedure (i.e., to not close the PORV block valve). He persuaded the Keaton Task Force to change their conclusion that the procedure was

violated based upon his representation that a determination had been made that a safety valve and not the PORV was leaking. He now states that such a preaccident determination had not been made. This evidence of Mr. Wallace's prior knowledge conflicts with his statements in the Response and is circumstantial evidence of willful or reckless disregard for the truth. However, Mr. Wallace's explanation of why he believed the statements were neither inaccurate nor incomplete is also credible and supported by evidence cited in his memorandum. See Arnold/Wallace Memorandum, passim. Russell/Capra Affidavit ¶ 13.

In summary, Mr. Arnold's and Mr. Wallace's knowledge and involvement in making the statements do provide some "indication" of willful or reckless conduct by each of them. However, this indication falls short of that necessary for the Staff to reach a conclusion by a preponderance of the evidence that either Mr. Arnold or Mr. Wallace actually engaged in willful or reckless conduct. Russell/Capra Affidavit ¶ 14.

B. Considerations in Deciding Whether to Initiate a Hearing

As described above, the Staff is unable to resolve the question of whether there was willful or reckless conduct by either Arnold or Wallace. As to each of them, there is some "indication" of willful or reckless conduct. For Mr. Wallace, more so than Mr. Arnold, there is a significant amount of credible circumstantial evidence that could indicate willfulness or recklessness, but there are also credible explanations to the contrary. Moreover, Mr. Wallace was candid and cooperative during the OI investigation of the matter, and the Staff has concluded that GPUN can and will

meet its regulatory responsibilities with Mr. Wallace in his present management position at Oyster Creek. DD-85-1, 21 NRC 263, 267 (1985).

The Staff acknowledges that, with respect to each of Messrs. Arnold and Wallace, reasonable persons could disagree on the question of whether he acted willfully, knowingly, or with a reckless disregard for the truth, in making a false statement. Russell/Capra Affidavit ¶ 15. Thus, the Staff acknowledges that "there is information which could form a reasonable basis for concluding that either Wallace or Arnold willfully, knowingly, or with a reckless disregard for the truth made a material false statement" (CLI-85-19, at 5).

The Commission has stated that if it determines that such information exists, it "will consider initiating an adjudicatory hearing to resolve whether to retain the notification requirement in CLI-85-2." CLI-85-19, at 5-6. In the Staff's view, such a hearing could serve several purposes. While the Staff is unable to reach a conclusion by a preponderance of the evidence that either Arnold or Wallace were willful or reckless, it recognizes that reasonable persons can differ on the weight to be given to, and inferences to be drawn from, the available evidence. A Licensing Board could be appointed to preside over a hearing on the matter and make the appropriate findings of fact. Such an adjudicatory hearing, in which members of the public may attend and participate, if appropriate, may bring to bear a different perspective on the issues. Importantly, a hearing may also serve to increase public confidence in the result reached. Finally, Messrs. Arnold and Wallace, who have sought a "hearing to determine whether the adverse implications about the undersigned's management integrity are factually substantiated" (Arnold/Wallace Memorandum (letter) at 2), may

feel that they can prove affirmatively that the adverse implications about their integrity are groundless and therefore would like the opportunity to clear their names.

On the other hand, the Staff, in consultation with the Office of Investigations, has reached the conclusion that the agency has acquired the information that is available such that it is unlikely that further investigation would produce significant additional information. It has been over six years since the events in question transpired. The agency has expended considerable time and resources in investigating this matter, and a hearing would likely involve the expenditure of considerably more agency resources. At the end of such a hearing, the final result may well be no different than that already reached by the Staff.

All of the above factors should be considered by the Commission in deciding whether to convene a Licensing Board to preside over a hearing in response to the Arnold/Wallace request. On balance, the Staff does not believe that a hearing is warranted. If the Commission should determine not to initiate an adjudicatory hearing, the Staff agrees it would be appropriate to lift the notification requirement imposed in CLI-85-2, given the Staff's assessment that the evidence falls short of that necessary to conclude that either Mr. Arnold or Mr. Wallace acted willfully or recklessly. [3/] Russell/Capra Affidavit ¶ 16.

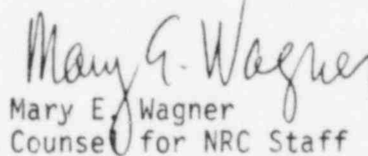
3/ The Staff has not heretofore recommended lifting the condition. Based on its merits review of the question of willfullness and recklessness in order to respond to CLI-85-19, the Staff now concludes that, because the evidence falls short of that necessary to conclude that either Mr. Arnold or Mr. Wallace acted willfully

(FOOTNOTE CONTINUED ON NEXT PAGE)

III. CONCLUSION

Portions of the December 5, 1979 Response to the NOV constituted material false statements. Messrs. Arnold and Wallace each had some knowledge and involvement in making those statements, as detailed above, but the evidence is insufficient to conclude whether either Mr. Arnold or Mr. Wallace acted willfully or recklessly in making the statements. If the Commission determines not to initiate a hearing, because the evidence falls short of that necessary to conclude that either Mr. Arnold or Mr. Wallace acted willfully or recklessly, it would be appropriate to lift the notification requirement imposed in CLI-85-2.

Respectfully submitted,



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Counsel for NRC Staff

Dated at Bethesda, Maryland
this 24th day of January, 1986

(FOOTNOTE CONTINUED FROM PREVIOUS PAGE)

or recklessly, it would be appropriate to lift the notification requirement, based on a standard that the requirement should only be maintained if willfulness or recklessness can be shown.