January 30, 2001

Mr. Mark E. Warner
Vice President, TMI Unit 1
AmerGen Energy Company, LLC
Three Mile Island Nuclear Station
P.O. Box 480
Middletown, Pennsylvania 17057-0480

SUBJECT: NRC'S INTEGRATED THREE MILE ISLAND REPORT 05000289/2000-008

Dear Mr. Warner:

On December 30, 2000, the NRC completed an integrated inspection at your Three Mile Island Unit 1. The enclosed report documents the inspection findings which were discussed on January 8, 2001, with you and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified four issues of very low safety significance (Green). All four issues were determined to involve violations of NRC requirements. However, because of their very low safety significance and because they have been entered into your corrective action program, the NRC is treating these issues as non-cited violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these non-cited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Three Mile Island facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

We appreciate your cooperation. Please contact me at (610) 337-5146 if you have any questions regarding this letter.

Sincerely,

/RA/

John F. Rogge, Chief
Projects Branch 7
Division of Reactor Projects

Docket No: 05000289
License No: DPR-50

Enclosure: NRC Inspection Report 05000289/2000-008

cc w/encl:
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U.S. NUCLEAR REGULATORY COMMISSION

REGION 1

Docket No:	05000289
License No:	DPR-50
Report No:	2000-008
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Three Mile Island Station, Unit 1
Location:	P.O. Box 480 Middletown, PA 17057
Dates:	November 12-December 30, 2000
Inspectors:	J. Daniel Orr, Senior Resident Inspector Craig W. Smith, Resident Inspector Gregory C. Smith, Sr. Physical Security Inspector
Approved by:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

Three Mile Island, Unit 1
NRC Inspection Report 0500289/2000-008

IR 05000289/2000-008, on 11/12/2000-12/30/2000, AmerGen Energy Company, LLC, Three Mile Island Unit 1. Fire protection, operability evaluations, surveillance testing.

The inspection was conducted by resident inspectors and a regional physical security inspector. The inspection identified four green findings, all of which were non-cited violations. The significance of all issues is indicated by their color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP) (See Attachment 1.)

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- **Green**. Control room operators were not prompt to follow-up on a safety-related battery room fire door problem. Control room operators made a nonconservative operability determination for the fire door. AmerGen's failure to implement compensatory measures for the battery room fire door problem is a violation of TMI operating license condition 2.c.(4), Fire Protection.

  The safety significance of this problem was very low because fire propagation between the safe shutdown trains protected by the battery room fire door was not credible. (Section 1R05.1)

- **Green**. System engineers failed to initiate corrective actions and ensure that a new turbine-driven emergency feedwater (TDEFW) pump governor oiler would not become deficient in the same manner as the replaced oiler. System engineers also failed to identify in the corrective action program that oil drained from the governor oiler was reused in the system. These problems are a violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action.

  The safety significance of this problem was very low because previous inservice testing provided reasonable assurance that the TDEFW pump remained operable with the deficient oiler. The oil that drained from the governor had been visually inspected prior to reusing it to refill the oiler. (Section 1R15.1)

- **Green**. AmerGen failed to maintain battery room temperatures within the values assumed in design basis calculation. The condition affected both station storage batteries. AmerGen's failure to establish controls to verify battery room temperatures is a violation of 10 CFR 50 Appendix B, Criterion III, Design Control.

  The safety significance of this finding was very low. Subsequent analysis by Engineering showed both station storage batteries remained operable at the lower battery room temperatures. (Section 1R22.1)

Cornerstone: Barrier Integrity

- **Green**. Auxiliary operators failed to follow procedure requirements for measuring and recording emergency core cooling system (ECCS) leakage outside containment. Senior reactor operators further failed to take action to investigate recorded ECCS leakage readings above the technical specification limit. The failure to follow procedure requirements is a violation of Technical Specification 6.8.b, Procedures and Programs.

  The safety significance of this finding was very low because actual ECCS leakage never exceeded the technical specification limit. (Section 1R22.2)

B. Licensee Identified Violations

The inspectors performed frequent reviews of AmerGen's corrective action program and did not ascertain any licensee identified violations.

Report Details

Summary of Plant Status

AmerGen Energy Company, LLC (AmerGen) operated Three Mile Island, Unit 1 (TMI) at 100 percent power throughout the inspection period.

1. REACTOR SAFETY

Initiating Events/Mitigating Systems/Barrier Integrity [REACTOR - R]

R01 Adverse Weather Preparations

a. Inspection Scope

The inspectors reviewed AmerGen's implementation of Operations Surveillance, OPS-S85, Winterization Checks. The inspection focused on the cold weather protection measures to protect the river water intake structure, borated water storage tank, and condensate water tanks. The inspectors walked down portions of these systems and independently verified the adequacy of the freeze protection measures. The inspectors reviewed AmerGen's operating procedures and controls for supplying heated water from plant systems to the river water intake and condensate water storage tanks.

b. Findings

No findings of significance were identified.

R05 Fire Protection

.1 Fire Protection Walkdowns

a. Inspection Scope

The inspectors conducted fire protection walkdowns for the:

- east and west safety-related battery rooms
- east and west battery charger rooms
- turbine-driven emergency feed pump room
- intermediate building valve gallery and penetration room
- screen house
- diesel-driven fire pump house

Follow-up was performed to verify that AmerGen had initiated compensatory measures for an inoperable battery room fire door problem identified during the walkdowns.

b. Findings

The inspectors determined that control room operators were not prompt to follow-up on a safety-related battery room fire door problem identified during the walkdown. Control room operators later made a nonconservative operability determination for the fire door. The nonconservative operability determination allowed the impaired fire door to be uncompensated for almost seven days.

On December 19, 2000, the NRC inspectors reported to control room operators (CRO) that a fire door separating both safety-related batteries had a sticky latch. The latch almost always stuck if the door knob was turned in one particular direction. After the door shut, the latch would not engage the striker plate. The NRC inspectors observed the CROs report the problem to senior reactor operators (SRO). The following day the inspectors determined that no work request or fire impairment log entry had been initiated. The SROs admitted that they failed to follow-up on the fire door problem. On December 20, 2000, a work request was initiated but a fire impairment log entry was not prepared. The NRC inspectors performed more follow-up because appropriate compensatory measures were still not initiated. The NRC inspectors raised the same initial concerns to a new day-shift operating crew.

On December 22, 2000, the inspectors discovered that SROs had not initiated compensatory measures for the degraded fire door. The inspectors also identified that the door was again left in an unlatched condition. The inspectors again clearly described the problem to the SROs. The SROs stated that they understood the inspectors' concerns and that compensatory measures would be initiated immediately and the work request prioritized.

AmerGen repaired the fire door on December 26, 2000. However, compensatory measures were never established for the fire door latch. The inspectors discussed the delays involved with repairing the fire door and implementing compensatory measures with the operations department management on December 26. AmerGen initiated a corrective action program item (CAP T2000-1076) to resolve the delay in responding to deficiencies with fire doors.

The significance of the degraded battery room fire door was evaluated with a phase 2 fire protection significance determination process (SDP) because the door separated rooms containing equipment for each of the two trains of safe shutdown equipment. The problem was determined to be of very low significance (Green) by the phase 2 fire protection SDP. The inspectors could not postulate a credible fire affecting both trains of safe shutdown for the defective battery room door latch because the fire loading in both rooms was low, especially in the vicinity of the fire door, and also that the fire door provided some defense with only a defective latch. A fire explosion in the rooms causing the door to swing open and spread fire was considered unlikely because constant ventilation maintains hydrogen concentrations well below explosive limits. Fire fighting consequences were also considered unlikely on the redundant battery room because the pre-fire plan required a water fog pattern. If the door did swing open from the water fog, the water would not likely reach the redundant battery due to the physical layout of the batteries and the fire door.

AmerGen's failure to implement compensatory measures for an inoperable battery room fire door is a violation of TMI operating license condition 2.c.(4), Fire Protection. However because of the very low safety significance (Green) of this problem and because AmerGen has since included this item in their corrective action program (CAPT2000-1076), this violation is being treated as a non-cited violation, consistent with Section VI.A.1 of the Enforcement Policy, issued on May 1, 2000 (65FR25368). **(NCV 05000289/2000-008-001)**

.2 Unannounced Fire Drill and Fire Brigade Response

a. Inspection Scope

The inspectors observed on November 28, 2000, the fire brigade response to an unannounced back-shift fire drill in the 1E 4160 volt electrical bus. The inspectors afterwards observed the drill critique. AmerGen entered the fire drill failure into the corrective action program as T2000-0987 documenting problems with drill simulation and other brigade performance issues.

b. Findings

No findings of significance were identified.

R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed AmerGen's corrective action process data base, control room operator logs, and maintenance work requests initiated during the inspection period to identify if AmerGen was properly evaluating component failures within the scope of the maintenance rule. The inspectors reviewed three specific component failures:

- failure of the B feedwater control valve differential pressure transmitter on September 27, 2000
- failure of the channel A power range nuclear instrument main console indication on December 4, 2000
- tripping of the B control building chilled water compressor on February 5, 2000

b. Findings

No findings of significance were identified.

R13 Maintenance Risk Assessment and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed AmerGen's risk management for troubleshooting and emergent repairs on the D vital bus. The inspectors observed troubleshooting activities in the field, attended system engineer troubleshooting meetings, and reviewed other plant work activities to assess the risk management.

b. Findings

No findings of significance were identified.

R14 Personnel Performance During Nonroutine Plant Evolutions and Events

a. Inspection Scope

The inspectors reviewed control room logs and interviewed control room operators regarding an unintentional transient on the feed and condensate systems that was caused by operator errors during a POWDEX vessel regeneration. The inspectors reviewed the event to determine the increased likelihood for a plant transient and the impact on mitigating systems.

b. Findings

No findings of significance were identified.

R15 Operability Evaluations

.1 Turbine Driven Emergency Feedwater Pump Governor Lubrication

a. Inspection Scope

The inspectors reviewed the circumstances leading to an equipment trouble tag (ETT) on the turbine driven emergency feedwater (TDEFW) pump governor oiler. Interviews with the system engineer and reviews of the vendor technical manual were performed to verify that the oiler was properly lubricating the governor assembly. The governor oiler was observed over several days to verify that lubricating oil was being consumed at about the vendor-recommended rate.

b. Findings

The inspectors determined that the ETT problem on the TDEFW governor oiler was normal system or oiler response. The ETT trouble tag was initiated because equipment operators had become conditioned to the previously replaced oiler that was under-lubricating. The inspectors determined that system engineers had previously not established any controls to ensure that proper oil lubrication occurred on the TDEFW governor. System engineers also had not considered corrective actions such that proper oil lubrication would be maintained with the new or replacement oiler.

The TDEFW governor oiler is a small cup and wick arrangement. Oil is drawn out of the cup through capillary action and drips internally to the governor. Under-lubrication may affect governor and TDEFW pump operation. The turbine vendor recommends about two to five drips per hour or a teaspoon over an eight hour period. This consumption should require the oil to be refilled in the cup about every two days. The governor assembly must also not be in a bath of oil or its operation may be affected. A drain line to an open plastic bottle exists to ensure that the governor housing remains properly drained of the oil.

On September 23, 2000, AmerGen replaced the governor oiler because of a cracked oil cup. On December 18, 2000, equipment operators initiated an equipment trouble tag because the new oiler required frequent refills and was sometimes discovered empty during routine rounds. The inspectors discovered through interviews that some operators had called the system engineers asking if it was acceptable to refill the oil cup from the open container in the oil drain rig. The system engineers appropriately replied that using spent and open oil was an unacceptable practice because of foreign material exclusion concerns. The system engineers also learned that some operators had already reused the oil after performing a visual inspection on the collection bottle. The system engineers performed a bench test on the replaced oiler and determined that the old oiler was only providing about two drops per day lubrication.

The inspectors determined that the previous TDEFW pump oiler had degraded substantially below the turbine vendors recommendation for governor lubrication without identification by plant personnel. This problem, if left uncorrected, could also allow a degradation of the new oiler to go unnoticed and impact TDEFW pump operability. The problem was determined to be of very low safety significance (Green) by the SDP because past inservice testing surveillances on the TDEFW pump provided reasonable assurance that the TDEFW governor was operable.

AmerGen's failure to identify a deficiency in a TDEFW governor oiler and take corrective action such that the problem does not recur is a violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action. AmerGen's failure to also document instances of potentially defective or used oil addition to the governor oiler is also a violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action. However, because of the very low safety significance of these problems and because AmerGen has since included these items in their corrective action process (CAPs T2001-0018 and T2001-0019), this violation is being treated as a non-cited violation, consistent with Section VI.A.1 of the Enforcement Policy, issued on May 1, 2000 (65FR25368). **(NCV 05000289/2000-008-002)**

.2 High Pressure Injection Pump Lubricating Oil Deficiencies

a. Inspection Scope

The inspectors reviewed deficiencies identified during high pressure injection (HPI) pump surveillance tests. The problems involved oil pressure above the vendor recommendation for the oil system that supports the speed changers on the A and B HPI pumps.

b. Findings

No findings of significance were identified.

R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed identified operator workarounds, the caution tag database, and walked down control room operating panels, local operating panels and equipment. The reviews were performed to determine the cumulative effect of equipment deficiencies on system performance, operator response, or increased likelihood for an initiating event.

b. Findings

No findings of significance were identified.

R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance tests performed for:

- emergent repairs on an intermediate cooling system containment isolation valve, IC-V-3
- planned maintenance on a nuclear service cooling water pump discharge check valve, NS-V-10C

The inspectors reviewed the work performed and reviewed the tests and results to verify that adequate post-maintenance tests demonstrated component operability.

b. Findings

No findings of significance were identified.

R22 Surveillance Testing

.1 Weekly Station Storage Battery Surveillance

a. Inspection Scope

On December 21, 2000, the inspectors observed electrical maintenance personnel perform the weekly station storage battery surveillance. The technical specification (TS) surveillance monitors the condition of the battery pilot cells.

b. Findings

The inspectors determined that AmerGen failed to establish sufficient controls to maintain safety-related battery room temperatures within design basis assumptions. The condition affected both station storage batteries.

On December 21, 2000, while conducting the weekly station storage battery TS surveillance in accordance with Surveillance Procedure (SP) 1301-4.6, the electrical maintenance technicians identified the battery room and pilot cell temperatures for both station storage batteries to be at 68°F. SP 1301-4.6 specified that battery cell temperatures shall be at least 70°F. The TMI-1 Battery Capacity Sizing and Voltage Drop Calculation (C-1101-734-5350-003) assumed that battery room temperatures are maintained in accordance with the Updated Final Safety Analysis Report (UFSAR) at 75±5°F.

The effect of lower temperatures is reduced battery capacity. The minimum required battery capacity is 85%. Battery capacity was measured in September 1999 at 101.6% for the A battery and 95.9% for the B battery. Engineering determined with battery temperatures at 68°F, battery capacity was reduced by an additional 1.6% due to the effects of the cell temperatures being below the minimum required value. System engineers determined that the battery would remain operable (above 85% capacity) with cell temperatures as low as 61°F. The system engineers considered the current battery capacity and age.

AmerGen determined the cause for the battery cell temperatures falling below the 70°F minimum to be a readjustment of the B battery room temperature controller (AH-TC-747) during a routine preventive maintenance activity completed on December 19, 2000. During conduct of the preventive maintenance, the instrument controls technicians identified the nominal output signal from AH-TC-747 to be high, and readjusted the signal back into the required band in accordance with the approved maintenance job order (JO 187289). The technicians then returned the temperature controller to its as-found setting of 70°F. The maintenance procedure did not specify an as-left setting for the temperature controller. With the setpoint at 70°F and the output signal readjusted back to its nominal value, the temperature controller did not respond adequately to lowering outside ambient temperatures to prevent the battery room temperatures from falling below the minimum value assumed in the design basis calculation.

The inspectors, using the significance determination process (SDP), determined AmerGen's failure to maintain battery room temperatures above the design basis limit to

be of very low safety significance (Green) based on the licensee's determination that both batteries continued to remain operable, even at the lower temperatures. The inspectors determined AmerGen's failure to establish adequate controls to ensure that battery room temperatures were maintained above the minimum value assumed in the design basis calculation is a violation 10 CFR 50 Appendix B Criterion III, Design Control. Because this violation is of very low safety significance and the problem was entered into the corrective action process (CAP reference 2000-1077), this violation is being treated as a non-cited violation, consistent with Section VI.A.1 of the Enforcement Policy, issued May 1, 2000 (65FR25368). **(NCV 05000289/2000-008-003)**

.2 Emergency Core Cooling System Leak Rate Monitoring

a. Inspection Scope

The inspectors reviewed AmerGen's controls for monitoring emergency core cooling system (ECCS) leakage into the auxiliary building. TS 4.5.4 limits the leakage from those portions of the decay heat, building spray, and make-up systems outside containment which are required to contain post accident sump recirculation fluid to 15 gallons per hour (gph). Limiting the leakage in these systems to less than 15 gph in part maintains off-site dose consequences for applicable design basis accidents to less than the 10 CFR Part 100 limits.

b. Findings

AmerGen auxiliary operators failed to follow procedure requirements for measuring and recording ECCS leakage outside containment. Senior reactor operators further failed to investigate ECCS leakage results recorded above technical specification (TS) limits.

Auxiliary operators perform weekly inspections of the decay heat and building spray pump vaults. The inspections are conducted in accordance with operations surveillance procedure OPS-S42, Reactor Building Spray/Decay Heat Removal Vault Entries/Inspections. OPS-S42 includes a step that requires collecting and measuring the leakage from the ECCS components (mainly pump mechanical seal leakage) that collects in the local pump vault floor drains.

On December 5, 2000, auxiliary operators performing OPS-S42 recorded the water leakage from the A decay heat removal pump (DH-P-1A) as approximately one-half gallon per minute (gpm) (30 gph). This recorded leakage exceeded the leakage limit of 15 gph listed in TS 4.5.4. The completed surveillance was reviewed that same day by a senior reactor operator, who did not identify that the recorded leakage value was in excess of the TS limit. The inspectors identified this reading on December 28, 2000, and brought it to the attention of operations department management.

Operations department management took immediate actions to have the leakage from DH-P-1A measured using a graduated cylinder. The leak rate was determined to be 40 milliliters per minute (0.6 gph). This value was consistent with previous leakage measurements from DH-P-1A and was well below the TS limit of 15 gph. Operations management subsequently determined the one-half gpm leak rate recorded on

December 5, 2000, was in error and resulted from the auxiliary operator "estimating" the leak rate by visual observation and not collecting and measuring the leakage as required by the operations surveillance procedure.

The inspectors used the SDP and determined the auxiliary operator's failure to follow procedural requirements for monitoring and recording ECCS system leakage to be of very low safety significance (Green) because actual ECCS leakage never exceeded the TS limit. The inspectors determined AmerGen's failure to follow the procedural requirements for collecting and measuring ECCS leakage is a violation of TS 6.8.1.b, Procedures and Programs, which requires that written procedures shall be established, implemented, and maintained for surveillance and test activities of equipment that affects nuclear safety and radioactive waste management systems. Because this violation is of very low safety significance and the problem was entered into the corrective action process (CAP reference 2001-0012), this violation is being treated as a non-cited violation, consistent with Section VI.A.1 of the Enforcement Policy, issued May 1, 2000 (65FR25368). **(NCV 05000289/2000-008-004)**

.3 Additional Surveillance Testing Inspections

a. Inspection Scope

The inspectors reviewed the following additional surveillance tests:

- Emergency Loading Sequence and High Pressure Injection Logic Channel/Component Test, Surveillance Procedure 1303-5.2
- Reactor Building and Isolation System Logic Channel/Component Test, Surveillance Procedure 1303-5.1
- Monitoring of Silt Buildup in River Water Screen House, Surveillance Procedure 1301-6.7

The inspectors observed portions of the surveillance testing activities and reviewed the test results against the procedure and technical specification requirements. The inspector sampled AmerGen's corrective action process for problems identified during past performance of the surveillances to ascertain the licensee's threshold for identifying and resolving problems.

b. Findings

No findings of significance were identified.

R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors walked down a temporary plant modification in the D vital bus control rod drive and reactor protection system interface cabinet. The temporary modification included monitoring equipment to support troubleshooting for voltage transients. The inspectors also reviewed the temporary modification documentation and evaluation.

b. Findings

No findings of significance were identified.

3. SAFEGUARDS

Physical Protection [PP]

PP1 Response to Contingency Events

a. Inspection Scope

The following activities were conducted to determine the effectiveness of the licensee's response to contingency events.

On December 12, 2000, a review was conducted of the licensee's defensive strategy, response time lines, target sets contingency drill scenarios and relevant implementing procedures. Upon completion of this review, on December 14, 2000, four table-top drills were conducted with security shift supervisors and response team leaders. The scenarios, including the adversary entry points and target selection, were made by the inspectors for each table-top drill.

A demonstration of firearms proficiency was observed on December 13, 2000. Three security officers fired a tactical stress course of fire that included firing from elevated positions, from behind barricades and at fixed and moving targets. A selected review of twenty firearms qualification training records was also performed.

A review of documentation associated with the licensee's drill and exercise program was conducted on December 13, 2000. This review included the documentation and critiques for contingency response drills conducted in the prior three quarters.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

OA1 Performance Indicator Verification

.1 Reactor Coolant System Activity

a. Inspection Scope

The inspectors examined reactor coolant system (RCS) dose equivalent iodine activity results for the previous year to verify that the RCS activity performance indicator (PI) was accurate. Portions of an RCS activity sample and analysis were also observed to verify that chemistry technicians appropriately followed procedures assuring accuracy in each sample used for the PI.

b. Findings

No findings of significance were identified.

.2 Reactor Coolant System Leakage

a. Inspection Scope

The inspectors examined RCS leakage surveillance results for the previous year to verify that the RCS leakage PI was accurate. An RCS leakage surveillance was also observed to verify that operators appropriately followed procedures assuring accuracy in each result used for the PI.

b. Findings

No findings of significance were identified.

OA6 Management Meetings

.1 Exit Meeting Summary

On January 8, 2001, the resident inspectors presented the inspection results to Mr. Warner and other members of licensee management. The licensee acknowledged the findings presented. The senior physical security inspector presented the physical security inspection results to members of licensee management on December 14, 2000. The licensee acknowledged the findings presented.

SUPPLEMENTARY INFORMATION

Persons Contacted

M. Warner, Vice President, TMI Unit 1
G. Gellrich, Plant Manager
D. Atherholt, Director - Operations
W. McSorley, Manager - Operations Support
O. Limpias, Director - Site Engineering
J. Telfer, Director - Radiation Health & Safety
B. Merryman, Director - Maintenance
E. Fuhrer, Manager - Regulatory Licensing
R. Goodrich, Security Manager
A. Miller, Regulatory Licensing

Items Opened, Closed, and Discussed

2000-008-001	NCV	Failure to Implement Compensatory Measures for an Inoperable Battery Room Fire Door
2000-008-002	NCV	Failure to Promptly Identify and Correct a Deficiency in a Turbine Driven Emergency Feedwater Governor Oiler
2000-008-003	NCV	Failure to Establish Adequate Controls and Ensure Battery Room Temperatures were Maintained Above the Design Basis Calculation Minimum Value
2000-008-004	NCV	Failure to Follow the Procedural Requirements for Collecting and Measuring Emergency Core Cooling System Leakage

Acronyms Used

ADAMS	Agencywide Documents and Management System
AmerGen	AmerGen Energy Company, LLC
CAP	Corrective Action Process
CFR	Code of Federal Regulations
CRO	Control Room Operator
DRS	Division of Reactor Safety
ECCS	Emergency Core Cooling System
ETT	Equipment Trouble Tag
gph	gallons per hour
gpm	gallons per minute
HPI	High Pressure Injection
IR	Inspection Report
NRC	Nuclear Regulatory Commission
PI	Performance Indicator
RCS	Reactor Coolant System
SCBA	Self-Contained Breathing Apparatus
SDP	Significance Determination Process
SP	Surveillance Procedure
SRO	Senior Reactor Operator
TDEFW	Turbine Driven Emergency Feedwater
TMI	Three Mile Island, Unit 1
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report

ATTACHMENT 1

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
• Initiating Events	• Occupational	• Physical Protection
• Mitigating Systems	• Public	
• Barrier Integrity		
• Emergency Preparedness		

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.