October 17, 2001

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

SUBJECT: THREE MILE ISLAND STATION, UNIT 1-NRC INSPECTION REPORT 50-289/01-06

Dear Mr. Warner:

On September 29, 2001, the NRC completed an inspection at your Three Mile Island Unit 1 facility. The enclosed report documents the inspection findings which were discussed on October 5, 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 one issue of very low safety significance (Green). This issue was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because the problem has been entered into your corrective action process, the NRC is treating this issue as a non-cited violation in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. 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, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Three Mile Island Unit 1 facility.

Since September 11, 2001, Three Mile Island Station Unit 1 has assumed a heightened level of security based on a series of threat advisories issued by the NRC. Although the NRC is not aware of any specific threat against nuclear facilities, the heightened level of security was recommended for all nuclear power plants and is being maintained due to the uncertainty about the possibility of additional terrorist attacks. The steps recommended by the NRC include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with local law enforcement and military authorities, and limited access of personnel and vehicles to the site.

The NRC continues to interact with the Intelligence Community and to communicate information to AmerGen Energy Company, LLC. In addition, the NRC has monitored maintenance and other activities which could relate to the site's security posture.

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).

Sincerely,

/RA/

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

Docket No: 50-289
License No: DPR-50

Enclosure: NRC Inspection Report 50-289/01-06
Attachment: Supplemental Information

cc w/encl Amergen Energy Company - Correspondence Control Desk
J. McElwain, Manager, Regulatory Assurance
G. Gellrich, Plant Manager
M. Gallagher, Director-Licensing
J.A. Benjamin, Licensing - Vice President, Exelon Corporation
TMI-Alert (TMIA)
D. Allard, PADER
M. Schoppman, Framatome

Distribution w/encl: Region I Docket Room (with concurrences)
J. Orr, DRP - NRC Resident Inspector
H. Miller, RA
J. Wiggins, DRA
J. Rogge, DRP
N. Perry, DRP
T. Haverkamp, DRP
D. Loveless, OEDO
E. Adensam, NRR
T. Colburn, PM, NRR
H. Pastis, Backup PM, NRR

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U.S. NUCLEAR REGULATORY COMMISSION

REGION 1

Docket No:	50-289
License No:	DPR-50
Report No:	50-289/01-06
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Three Mile Island Station, Unit 1
Location:	PO Box 480 Middletown, PA 17057
Dates:	August 12-September 29, 2001
Inspectors:	J. Daniel Orr, Senior Resident Inspector Craig W. Smith, Resident Inspector Ronald L. Nimitz, Senior Health Physicist, DRS Wayne L. Schmidt, Senior Reactor Inspector, DRS
Approved by:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

Three Mile Island, Unit 1
NRC Inspection Report 50-289/01-06

IR 05000289-01-06, on 08/12 - 09/29/2001, AmerGen Energy Company, LLC, Three Mile Island Unit 1, integrated resident inspector report, personnel performance during non-routine plant evolutions.

The inspection was conducted by resident inspectors, a senior health physicist, and a region-based senior reactor inspector. The inspection identified one Green finding, which was classified as a non-cited violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html. Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- **Green**. Auxiliary operators did not properly follow an operating procedure for starting a main condenser vacuum pump. This error challenged main condenser vacuum and locked out automatic operation of the turbine bypass valves. The control room operators did not properly follow an alarm response procedure for low main condenser vacuum. The control room operators' procedure errors unnecessarily maintained the turbine bypass valves locked out for an additional six-and-a-half hours.

  The safety significance of the degraded main condenser vacuum and inoperable turbine bypass valves was very low (Green) because operators were able to restore the main condenser vacuum and the turbine bypass valves were inoperable for less than the technical specification allowed outage time. The control room operators' failure to follow the low main condenser vacuum alarm response procedure as written was a violation of technical specification 6.8, "Procedures and Programs," which requires, among other requirements, that written procedures be implemented for applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2. Appendix "A" of Regulatory Guide 1.33 requires a procedure for loss of condenser vacuum. (Section 1R14)

B. Licensee Identified Violations

A violation of very low safety significance which was identified by AmerGen was reviewed by the inspectors. Corrective actions taken or planned by the AmerGen appear reasonable. This violation is listed in Section 4OA7 of this report.

Report Details

Summary of Plant Status

AmerGen Energy Company, LLC (AmerGen) operated Three Mile Island, Unit 1 (TMI) at 100 percent power until September 22, 2001. End-of-cycle coast down began on September 22, 2001, limiting the maximum power available. TMI was at 92 percent power on September 29, 2001.

1 REACTOR SAFETY

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

R04 Equipment Alignment

.1 Emergency Feedwater Complete System Walkdown

a. Inspection Scope

The inspectors performed a complete system walkdown for the emergency feedwater (EFW) system. The EFW system was selected because EFW is the fifth highest contributor to TMI's total core damage frequency based on a single system failure. Aspects of EFW that were reviewed to verify that the EFW system was correctly aligned and fully operable included position verification of major valves, switches, and circuit breakers, a corrective maintenance backlog review, a walkdown of equipment trouble tags, a corrective action review, and a system engineer interview. The inspectors referenced technical specifications and the updated final safety analysis report.

b. Findings

No findings of significance were identified.

.2 Partial Equipment Alignments

a. Inspection Scope

The inspectors conducted a partial system walkdown during planned maintenance on the decay heat removal system and its associated closed cooling water and river water systems. The inspectors also conducted a partial system walkdown on the high pressure injection/makeup and purification system while engineered safeguards actuation systems (ESAS) surveillance testing was in progress. The ESAS surveillance testing required several system configuration changes to always maintain available automatic high pressure injection. The decay heat removal and high pressure injection systems provide risk significant functions. The inspectors verified the system alignments were in accordance with operating procedures "Decay Heat Closed Cycle Cooling System," (1104-13); "Decay Heat River Water System," (1104-04); and "Makeup and Purification System," (1104-02), and that operating parameters were consistent with the plant operating condition. The decay heat removal and high pressure injection systems were also walked down following the maintenance activities to verify a proper return to service.

b. Findings

No findings of significance were identified.

R05 Fire Protection

a. Inspection Scope

The inspectors conducted fire protection inspections for the following plant fire zones:

- fuel handling building basement
- fuel handling building 305 foot elevation
- control building ESAS area
- control building relay room

The rooms and areas were selected based on enclosing or proximity to risk significant equipment. The inspectors conducted plant walkdowns and verified the areas were as described in the fire hazard analysis report. The plant walkdowns included observations of combustible material control, fire detection and suppression equipment operability, and compensatory measures established for degraded fire protection equipment.

b. Findings

No findings of significance were identified.

R06 Flood Protection Measures

a. Inspection Scope

The inspectors evaluated AmerGen's ability to cope with internal flooding in the heat exchanger vault. The heat exchanger vault contains numerous risk significant river water and closed cooling water equipment. The inspectors verified that TMI abnormal and emergency procedures "Nuclear Services Closed Cooling System Failure," (1203-20); "Reactor Coolant Pump and Motor Malfunction," (1203-16); "Nuclear Services River Water Failure," (1202-38); and "Loss of Intermediate Cooling System," (1202-17) could be implemented if a closed cooling water or river water system were necessarily secured to eliminate the internal flooding source. Operator inaccessibility and the effects of water damage to motor operator valves were also evaluated.

b. Findings

No findings of significance were identified.

R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed a simulator training session on September 6, 2001, for an operating crew consisting of licensed reactor and senior reactor operators. The inspectors observed abnormal transient procedure implementation, a controlled reactor shutdown and cooldown, and training for an intended plant modification.

b. Findings

No findings of significance were identified.

R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors verified AmerGen's implementation of the maintenance rule for the following areas:

- nuclear service closed cooling water system a(1) goals and corrective actions
- 'A' nuclear service closed cooling water pump oil leak following maintenance
- 'B' instrument air compressor unavailability performance monitoring

The aspects of maintenance rule implementation inspected included safety significance classification, a(2) performance monitoring or a(1) goal setting and corrective actions, and maintenance preventable functional failure determinations. The inspectors referenced: 10 CFR 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants;" NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Plants;" and AmerGen administrative procedure 1082, "NRC Maintenance Rule."

b. Findings

No findings of significance were identified.

R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed AmerGen's planning and risk assessments for the following risk significant maintenance activities:

- on line repairs to the makeup system deboration control valve
- 'A' decay heat removal system outage
- Reactor Building Emergency Cooling and Isolation System Logic Channel/Component Test (Surveillance Test 1303-5.1)

The inspectors reviewed the risk assessment of these maintenance activities with respect to 10 CFR 50.65(a)(4). The inspectors reviewed the online station risk

evaluation to assure that concurrent work would not negatively impact the overall safety of the facility. The inspectors referenced AmerGen administrative procedure 1082.1, "TMI Risk Management Program," and NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Plants."

b. Findings

No findings of significance were identified.

R14 Personnel Performance During Non-routine Plant Evolutions

a. Inspection Scope

The inspectors evaluated the initiating causes of a main condenser degraded vacuum condition. Control room logs and plant procedures for lowering condenser vacuum were reviewed, operators were interviewed, and AmerGen's corrective action condition report was evaluated. The inspectors also reviewed the follow-on operator errors that unnecessarily maintained the turbine bypass valves inoperable for an additional six-and-a-half hours.

b. Findings

The inspectors determined that auxiliary operators did not properly follow operating procedure 1106-15, "Main and Auxiliary Vacuum System." Control room operators in response to the degraded vacuum condition did not follow alarm response procedure N-1-6, "Main Condenser Vacuum Low." The safety significance of this finding is very low (Green) because an initiating event did not occur and the operators restored the turbine bypass valves (TBV) to automatic within the technical specification allowed outage time for inoperable TBVs. The control room operators' failure to follow N-1-6 as written was a violation of technical specification 6.8, "Procedures and Programs."

Equipment operators were attempting to start the 'A' main condenser vacuum pump (VA-P-1A) for a post-maintenance test. Procedure 1106-15 required the suction piping drained by manual operation prior to starting an idle main condenser vacuum pump. The auxiliary operators twice performed the draining sequence correctly, but on the third sequence of valve manipulations, an error was made and a suction path to the main condenser was established through the idle vacuum pump.

Control room operators were alerted to the field errors when a main annunciator panel alarmed. The control room operators entered main annunciator panel procedure N-1-6, "Main Condenser Vacuum Low." The auxiliary operators informed an off-shift senior reactor operator in the field that VA-P-1A had unexpectedly started. The auxiliary operators were confused; VA-P-1A was actually windmilling backwards from the open main condenser suction path. The off-shift senior reactor operator coordinated recovery actions with the main control room. VA-P-1A was isolated and the main condenser vacuum was restored.

About six-and-a-half hours later, a reactor operator performing rounds in a relay room noticed a status light indicating that the TBVs had been locked out from automatic operation. The TBVs provide a means of steam generator pressure control and decay

heat removal after a turbine trip. The control room operators reset the TBVs. The TBVs had automatically locked out as designed when main condenser vacuum earlier lowered to 23 inches vacuum. Procedure N-1-6 listed the automatic operation and required automatic actions verified.

This finding is more than minor because locking out the TBVs from automatic operation had an impact on safety. Automatic operation of the TBVs is considered in the safety analysis report for loss of electric power events. The safety significance of the inoperable TBVs was very low and only affected the mitigating systems cornerstone. This finding screened to Green in phase 1 of the significance determination process because the TBVs were inoperable for less than the technical specification allowed outage time. The control room operators' failure to follow N-1-6 as written was a violation of technical specification 6.8, "Procedures and Programs," which requires, among other requirements, that written procedures be implemented for applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2. Appendix "A" of Regulatory Guide 1.33 requires a procedure for loss of condenser vacuum. This technical specification violation is being treated as a non-cited violation because of the very low safety significance and because AmerGen has entered this procedure problem into its corrective action process (action request 00072497) (**NCV 50-289/01-06-01**).

R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability evaluations for the following degraded equipment issues affecting risk significant systems or components:

- ESAS relay buzzing identified subsequent to ESAS surveillance testing
- 'A' nuclear services river water pump discharge valve excessive stroke time identified during inservice testing
- 'A' motor driven emergency feedwater pump excessive packing leak identified during heat sink protection system testing
- 'A' control building ventilation system booster fan failure

The inspectors verified the degraded conditions were properly characterized, the operability of the affected systems was properly justified, and no unrecognized increase in plant risk resulted from the equipment issues.

b. Findings

No findings of significance were identified.

R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance tests performed by AmerGen in conjunction with the following planned or emergent work activities on risk significant equipment:

- 'A' decay river water pump discharge valve dynamic testing
- 'A' atmospheric dump valve emergent repairs to correct excessive stroke time identified during inservice testing
- 'B' diesel generator air start compressor pressure switch replacement
- 'A' and 'B' atmospheric dump valve control loop calibration

The inspectors verified that the post-maintenance test procedures and test activities were adequate to verify operability and functional capability prior to the affected systems being returned to service.

b. Findings

No findings of significance were identified.

R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the following surveillance activities. The surveillances were selected based on contribution to plant risk.

- High Pressure Injection/Low Pressure Injection Analog Channel (Test 1303-4.19)
- Emergency Loading Sequence and High Pressure Logic Channel/Component (Test 1303-5.2)

The inspectors observed portions of the selected surveillance tests and verified, based on the test results, that the systems met technical specification and procedural requirements. The inspectors reviewed AmerGen's corrective action process for problems identified during previous performances of the tests to determine if problems involving surveillance testing were being identified and resolved at an appropriate threshold.

b. Findings

No findings of significance were identified.

R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed two risk significant temporary modifications to the 'A' motor driven emergency feedwater pump. The modifications provided added protection against water intrusion into the pump outboard bearing necessitated by excessive pump packing leakoff identified during routine surveillance testing. The inspectors reviewed the temporary modifications and associated 10 CFR 50.59 screening against the system design basis documentation. The inspectors verified the installation of the modifications was consistent with the written documentation and that there were no adverse affects on system operability.

b. Findings

No findings of significance were identified.

2 RADIATION SAFETY

Occupational Radiation Safety [OS]

OS1 Access Control to Radiologically Significant Areas

a. Inspection Scope

The inspector reviewed the following documents and conducted the following activities to determine the effectiveness of access controls to radiologically significant areas:

- The inspector toured accessible areas of the radiological controlled area and physically inspected and challenged five locked High Radiation Area (HRA) access points to determine if access controls were sufficient to preclude unauthorized entry.
- The inspector made independent radiation level measurements within accessible radiological controlled areas (RCAs) at the station to: 1) verify areas expected to exhibit radiation levels in excess of 100 mR/hr were posted and controlled as HRAs or locked as appropriate, and 2) confirm posted survey data.
- The inspector reviewed radiological controls planning and preparation for upcoming fuel pool diving activities including use of accredited dosimetry.
- The inspector reviewed a selection of self-assessments and licensee identified findings (listed below) to determine if findings were properly entered into the corrective action program, evaluated, and corrective actions were initiated.
    - Radiological Health and Safety Corrective Action Quarterly Report (First Quarter 2001)
    - TMI Continuous Assessment Report (April 1 - June 30, 2001)
    - Self Assessments (2001) - 1026, 1030, 1031, 1038, and 1085
    - Corrective Action Program (T2001) - 24, 32, 38, 195, 222, and 322
    - Radioactive Material Control Status

The review in the above areas was against applicable licensee procedures, 10 CFR 20, and applicable technical specifications.

b. Findings

No findings of significance were identified.

OS2 ALARA Planning and Controls

a. Inspection Scope

The inspector reviewed the adequacy and the effectiveness of AmerGen's program to reduce occupational radiation exposure to as low as is reasonably achievable (ALARA). The inspector evaluated ALARA planning and preparation for radiological work tasks to be conducted during the 2001 refueling outage (14R). Tasks reviewed included radiation shielding, reactor refueling, steam generator work, scaffolding construction, and reactor vessel head penetration work. The purpose of this review was to evaluate the level of planning and preparation for the activities. The inspector also attended an Outage Planning meeting on August 23, 2001. The following documents were reviewed:

- 13 Refueling Outage Report and Early Boron Evaluation
- Five year ALARA Plan
- Business Plan (ALARA Initiatives)
- TMI Unit 1 Performance and Goals
- Two and Three Year Average Dose Per Unit
- Station ALARA Council Minutes (August 15, 2001, August 17, 2001 [draft])
- Source Term Reduction Program including shutdown chemistry initiatives
- ALARA Plans for tasks and licensee bench marking initiatives

The evaluation of licensee performance in this area was against criteria contained in applicable procedures, 10 CFR 20, and applicable technical specifications.

b. Findings

No findings of significance were identified.

OS3 Radiation Monitoring Instrumentation

a. Inspection Scope

The inspector selectively reviewed elements of the radiation monitoring and instrumentation program as described below:

- The inspector reviewed the calibration and checking of radiation monitoring instruments used by radiological controls personnel during job coverage surveys and work associated with entry into the reactor building (containment) on August 10, 2001, to determine if properly calibrated and checked instrumentation was used.
- The inspector reviewed procedure guidance for actions to be taken upon identification of radiological survey instruments that failed source checks.
- The inspector evaluated calibration sources to determine if the sources were appropriate for radiation types and energies encountered within the facility.

- Calibration records for the following instruments were reviewed to evaluate the adequacy of calibration and the conformance with applicable calibration procedures and programs:
  - RSO-50 (Sn. B247Y)
  - SAC-4 (Sn. 394)
  - ASP-1 (Sn. 710276)
  - RM-1 (Sn. 315)
  - APTEC (Sns. 2891, 313)
  - PCM-1B personnel contamination monitors (Sns. 161and 744)
  - PM-7 personnel contamination monitor (Sns. 445, 321)
  - electronic personnel dosimeters PD-3 (Sns. 1636, 1581, 1488, 1216)
  - electronic personnel dosimeters PDE-4 (Sns. 1733, 1732, 1701)
  - personnel air samplers (Sn. 2097, 2234)
  - portable air monitor AMS-3 (Sn. 384, 782)
  - portable air monitor AMS-4 (Sn. 452, 133)
  - whole body counter, Fastscan (Sn. 96-5190)
- The inspector reviewed the use and testing of self-contained breathing apparatus (SCBA) to determine if adequate quantities of such devices were available, filling stations were available, and appropriate personnel had been trained in the use of the devices including the changing of air bottles. The inspector reviewed SCBA training and qualification records for the August 30, 2001, reactor operations 'B' shift to determine the shift crew's SCBA use qualification status.

The review was against criteria contained in applicable licensee procedures, 10 CFR 20, applicable technical specifications, and industry standards.

b. Findings

No findings of significance were identified.

4 OTHER ACTIVITIES

OA1 Performance Indicator Verification

a. Inspection Scope

The inspectors verified data submitted by AmerGen for the Emergency Diesel Generator Unavailability performance indicator. The inspectors reviewed operating logs, maintenance rule records, and the corrective action process database to verify the accuracy and completeness of the reported unavailability data. Records were reviewed for reported performance indicator data covering the last two quarters of 2000 and the first two quarters of 2001.

b. Findings

No findings of significance were identified.

OA6 Management Meetings

Exit Meeting Summary

On October 5, 2001, the resident inspectors presented the inspection results to members of AmerGen management led by Mr. Mark Warner. AmerGen acknowledged the findings presented. AmerGen did not indicate that any of the information presented at the exit meeting was proprietary.

OA7 Licensee Identified Violations

The following finding of very low safety significance was identified by AmerGen and is a violation of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a non-cited violation (NCV):

- **NCV 50-289/01-06-02**. 10 CFR 20.1703 requires, in part, that the licensee implement and maintain a respiratory protection program that includes written procedures regarding maintenance and repair of respiratory protective equipment. On June 16, 2001, the licensee determined that it had failed to replace rupture discs in accordance with specified guidance for repair and maintenance of self-contained breathing apparatus. The issue involving this matter was addressed by various corrective actions and entered into the corrective action process (CAP Nos. T2001-481, 0331, and 0606). This issue is being treated as a Non-Cited Violation.

If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. 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, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Three Mile Island Unit 1 facility.

ATTACHMENT
SUPPLEMENTAL INFORMATION

a. Key Points of Contact

D. Atherholt, Shift Operations Superintendent
G. Gellrich, Plant Manager
O. Limpias, Director - Site Engineering
D. McDermott, Director, Maintenance
J. McElwain, Manager, Regulatory Assurance
S. Queen, Senior Manager, Plant Engineering
J. Robertson, Plant Operations Director
M. Warner, Vice President, TMI Unit I

b. Items Opened, Closed, and Discussed

Opened and Closed

50-289/01-06-01	NCV	Inoperable Turbine Bypass Valves
50-289/01-06-02	NCV	Failure to Repair and Maintain Respiratory Protective Equipment in Accordance with 10 CFR 20.1703

c. List of Acronyms

ADAMS	Agencywide Documents and Management System
ALARA	As Low As is Reasonably Achievable
AmerGen	AmerGen Energy Company, LLC
CAP	Corrective Action Process
CFR	Code of Federal Regulations
DRS	Division of Reactor Safety
EFW	Emergency Feedwater
ESAS	Engineered Safeguards Actuation System
HRA	High Radiation Area
IR	Inspection Report
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
NUMARC	Nuclear Management and Resources Council
RCA	Radiological Controlled Area
SCBA	Self-Contained Breathing Apparatus
SDP	Significance Determination Process
TBV	Turbine Bypass Valves
TMI	Three Mile Island, Unit 1