

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

THREE MILE ISLAND

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/15/2000	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>INADVERTENT START OF EMERGENCY FEEDWATER PUMP</b>  The safety related turbine driven emergency feedwater pump unexpectedly started, due to an inadequately reviewed special temporary procedure to reduce seat leakage past the low pressure steam admission valve. No equipment damage occurred. AmerGen addressed two minor steam trap configuration issues identified by NRC during a subsequent system walkdown.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>LOSS OF OFFGAS RADIATION MONITOR FLOW</b>  An auxiliary operator properly identified a no flow condition and restored flow to both condenser offgas radiation monitors, within the Offsite Dose Calculation Manual (ODCM) allowed out-of-service time. However, poor control room communications, or a lack of understanding of ODCM requirements, caused the shift manager not to be informed of the no flow condition or the corrective actions taken for over two hours. The shift manager and AmerGen management took appropriate actions to ensure that condensation in the sample lines did not cause a repeated loss of flow condition, however a specific root cause for the abnormal buildup of condensation in the process sample lines could not be determined.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>YEAR 2000 ROLLOVER</b>  AmerGen developed comprehensive contingency and augmented staffing plans in preparation for the Year 2000 (Y2K) rollover. Operations department management held briefings with the on-shift operating crew and augmented staff personnel, thoroughly and clearly detailing management expectations, prior to the rollover. AmerGen experienced no abnormal events or unexpected equipment response during the Y2K rollover.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>OPERATOR PERFORMANCE FOLLOWING LOSS OF AUXILIARY TRANSFORMER</b>  The plant electrical system responded as designed to the trip of the non-safety related A auxiliary transformer and partial loss of offsite power. Operators responded well to the annunciated alarms and loss of injection flow to the reactor coolant pump seals.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>PROBLEM IDENTIFICATION</b>  Examples were identified that indicate material non-conformance reports were not well integrated into the Corrective Action Program as they focus on material defects with the result that human performance issues have not always been addressed. The team observed occasional deficiencies with initial operability and reportability determinations that were incomplete and did not include an appropriate technical review.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>SELF-ASSESSMENT/OPERATING EXPERIENCE</b>  Departmental self-assessments varied in quality and depth. While engineering self-assessments were generally probing and self-critical, operation and maintenance self-assessments were not.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>PROBLEM IDENTIFICATION</b>  Overall, GPUN appropriately identified problems and entered the deficiencies in the corrective action process as required with one exception related to operating a decay heat removal pump in a manner inconsistent with approved procedures resulting in a non-cited violation. Deficiencies entered into the corrective action system were properly classified and prioritized.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>ROOT CAUSE EVALUATION</b>  Appropriate attention was focused on investigating problem causes commensurate with the level of risk, and the detail and accuracy of the analyses were acceptable.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>CORRECTIVE ACTIONS</b>  Corrective actions were effective in focusing on resolution of the identified root cause and prevention of significant problem recurrence. Corrective actions were generally completed in a timely manner consistent with the safety significance of the issue.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>TRENDING/EXTENT OF CONDITION</b>  Overall, problems were being identified and captured in one of the many tracking database systems at the site and the Correction Action Program system was appropriately utilized to capture trend results. Most extent of condition reviews were generally effective in identifying associated concerns and implementing appropriate correction actions.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>SELF-ASSESSMENT/OPERATING EXPERIENCE</b>  Quality assurance assessments supplied by Nuclear Safety Assessment and the Independent Onsite Safety Review Group provided excellent review of important areas. Operating experience information was of a broad scope, was appropriately tied into the Corrective Action Program, and this program area was annually assessed.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/08/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>RESOLUTION OF NON-CITED VIOLATIONS</b>  There were no identified deficiencies relative to the disposition of non-cited violations.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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12/08/1999	1999009-01	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	<b>FAILURE TO IMPLEMENT DECAY HEAT SYSTEM PUMP OPERATION PROCEDURES</b>  Operators used a safety-related decay heat removal pump in a manner inconsistent with existing procedures to lower the reactor vessel level to the bottom of the reactor coolant system hot leg. There was no fuel in the reactor vessel at the time. This failure is a violation of Technical Specification 6.8.1., pursuant to Regulatory Guide 1.33, Section 9.d.(4).
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/04/1999	1999010	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: Ter:	<b>MINOR OPERATOR PROCEDURE USAGE VIOLATION DURING VENTING OF CORE FLOOD TANKS</b>  Operators failed to follow administrative procedural requirements in two instances during the conduct of an evolution to vent the "A" core flood tank on November 20. Although no valves were found out of position as a result, this issue illustrated a lack of formality in the conduct of evolutions and weaknesses in the processes in place to prevent mispositioning events. This was considered a minor violation.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/14/1999	MA3950	Pri: OPS Sec:	NRC	LIC	Pri: 1C Sec: Ter:	<b>DELAY IN SUBMITTING AMENDMENT REQUEST TO ADD OPERABILITY AND SURVEILLANCE REQUIREMENTS F</b>  In reference to License Amendment 216, GPUN did not submit this amendment request until nearly four years after the NRC request dated December 27, 1994.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	Pri: OPS Sec:	NRC	MV	Pri: 1C Sec: Ter:	<b>OVERTIME WORK CONTROLS</b>  GPUN established an outage shift manning schedule without sufficient contingency to allow for emergent work and job delays, thereby causing overtime usage to exceed the working hour guidelines contained in NRC Generic Letter (GL) 82-12, "Nuclear Plant Staff Working Hours." A minor violation was identified in GPUN's implementation of the technical specification required procedure for controlling plant staff overtime.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	Pri: OPS Sec:	NRC	NEG	Pri: 1B Sec: Ter:	<b>EXTENDED TIME AT HIGH RISK MID-LOOP CONDITION</b>  Although it had no safety consequence in this instance, GPUN did not immediately begin work to install the once through steam generator cold leg nozzle dams after the initial reactor coolant system (RCS) draindown to mid-loop with fuel still loaded in the reactor vessel. This work was delayed for approximately one shift, due to scheduling difficulties. The risk in this high decay heat, limited RCS inventory condition could have been minimized by limiting the time in this condition.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>PROCEDURE USAGE WEAKNESSES</b>  Two procedural use weaknesses were noted. First, plant administrative procedures allowed re-sequencing of proceduralized steps with shift supervisor (SS) authorization, but did not specify a method for documenting such authorization. During the reactor coolant system refilling, the SS authorized the evolution to continue without filling the letdown piping as sequenced by the procedure, but there was no documentation of a review to ensure that this would not cause a problem later on in the filling operation. Second, administrative procedures did not specify the need to document reactivity change calculations. Engineering personnel and the SS completed calculations for boron concentration changes without documenting them on the proceduralized form.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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10/23/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>SHUTDOWN EVOLUTION</b>  The shutdown evolution was well controlled and conducted in a safe manner. Operations management directly supervised the conduct of the evolution and provided operational experience feedback to the operating crews.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>OPERATOR OUTAGE PERFORMANCE</b>  The operators properly controlled plant conditions including available decay heat removal sources and reactor coolant system water levels during the outage. The movement of reactor fuel was performed well and in accordance with Technical Specification requirements.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>FAILURE TO FOLLOW SOLUBLE BORON CONTROL PROCEDURE</b>  In a review of a previously open issue from 1989, GPUN did not meet proceduralized requirements on the availability of the boric acid mix tank as an emergency boration path in two cases. These were issues of low safety significance since the borated water storage tank was always operable as an emergency boration path. GPUN took appropriate actions to correct procedures and to fix the degraded boric acid piping heat tracing.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008-03	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>INABILITY TO REMOTELY CLOSE B MAIN STEAM ISOLATION VALVE</b>  On October 19 during plant startup, GPUN personnel could not remotely operate the B main steam isolation valve (MSIV) from the control room and operated it locally without completing a technical specification required procedure change. This placed the unit in a situation where it was outside of the design basis. Management oversight was deficient in that startup was allowed to continue without an associated operating procedure change or an engineering review of this degraded condition. The degraded condition of the MSIV was subsequently determined to not be risk significant.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
08/28/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>ESAS RELAY FAILURE</b>  A control room operator appropriately responded to an indication of an overheated and smoking safety-related relay in the engineered safeguards actuation system. The operability evaluation for the degraded relay was delayed because operators did not enter it into the corrective action program in a timely manner. Additionally, the operability evaluation was based solely on previous experience with less severe relay degradation and did not consider further testing as a means to verify operability of the degraded relay. GPUN subsequently replaced the relay and verified operability of the new relay through post-maintenance testing.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 3B	<b>SEVERAL LOW SAFETY SIGNIFICANCE OPERATOR EQUIPMENT MIS-POSITIONING EVENTS</b>  GPUN identified four human performance errors involving plant operators. While non had any safety significance, they represented a declining trend in operator performance. GPUN entered the events into its corrective action program and initiated a root cause evaluation.
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07/17/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>QUESTIONABLE GUIDANCE PROVED TO OPERATORS FOR LOW SYSTEM GRID VOLTAGE CONDITIONS</b>  Operators responded appropriately to a sustained low system grid voltage condition. Additionally, the operators were not aware that one of the meter indications, referenced in the abnormal operating procedures for monitoring system grid voltage, provided an erroneous reading.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>PROPER PLANT AND OPERATOR RESPONSE TO A LOSS OF B AUXILIARY TRANSFORMER AND DEGRADE GR</b>  The plant electrical system responded as designed to the loss of the B auxiliary transformer. The A emergency diesel generator automatically fast started and loaded within 10 seconds as designed. Operators responded appropriately to the annunciated alarms.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>OPERATOR RESPONSE TO LOSS OF THE B VITAL 120 VOLT BUS</b>  The reactor operators properly responded to the loss of the B vital 120 volt bus. Risk documents appropriately addressed the added risk for a reactor trip and engineered safety actuation if the alternate power supply was lost.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>INADEQUATE OPERABILITY ASSESSMENT</b>  The May 13 initial operations corrective action process operability assessment for the reactor building emergency cooler (RBEC) high cooling coil differential pressure was inadequate. Further, by May 14 GPUN had not assessed the possibility that the RBEC performance could affect the planned reactor building spray system outage.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>ROUTINE OPERATOR PERFORMANCE</b>  The shift operating crews performed routine activities very well. Operators also responded properly to annunciated alarms.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>USE OF RISK DOCUMENTS</b>  Risk documents prepared to support work provided appropriate insight and areas of caution. Shift supervision used the risk documents to perform good pre-job briefings.
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06/05/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>PLANT REVIEW GROUP REVIEW OF REACTOR BUILDING EMERGENCY COOLER</b>  The plant review group (PRG) performed the June 4 assessment of the reactor building emergency cooler (RBEC) degradation well. Further, the associated justification for continued operation discussion and the report made to the NRC for a condition outside the design basis were suitable. GPUN management appropriately questioned the May 17 PRG judgement that the RBECs were fully operable.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>INCORRECT DIESEL GENERATOR LUBRICATING OIL</b>  A plant operator added an incorrect lubricating oil to the "A" emergency diesel generator (EG-Y-1A) lubricating oil sump while the machine was operating. A subsequent evaluation found EG-Y-1A remained operable with no corrective actions required to flush the incorrect lubricating oil from the system.
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04/24/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>INTEGRATED CONTROL SYSTEM MALFUNCTIONS</b>  Repeated ICS malfunctions continue to be an operational challenge.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>INTEGRATED CONTROL SYSTEM MALFUNCTIONS</b>  Control room operators responded well to an integrated control system malfunction.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	WK	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>ON-LINE REPAIRS TO SECONDARY PLANT CONTROLLER</b>  GPUN conducted successful on-line maintenance to replace the pneumatic positioner for the "A" heater drain control valve that corrected a problem with secondary plant flow oscillations. While conducting the repairs, maintenance technicians identified that the replacement positioner was not properly configured. In one stance, communications to the control room during the troubleshooting efforts were not timely.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
03/13/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>ICS MALFUNCTIONS</b>  Integrated control system difficulties represent a challenge to perators, and as such warrants your continued attention. (Cover Letter)
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03/13/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>CONTROL ROOM STAFF</b>  The control room staff operated the unit safely; conducting required surveillance testing in a safe manner, including emergency safeguards actuation system testing and providing appropriate response to observed equipment malfunctions, including an integrated control system demand fluctuation.
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03/13/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>RESPONSE RAD ALARM</b>  Control room operators responded properly to a momentary increase in condenser offgas activity, as indicated by an "alert" radiation monitor alarm.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>CONTROL ROOM STAFF AND ACTIVITIES</b>  The control room staff operated the unit safely, properly responding to several equipment failures. Shift supervision appropriately evaluated operability for the failed equipment.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>OPERATOR RESPONSE TO CONTROL SYSTEM FAILURES</b>  The control room operators responded well to two separate failures of the integrated control system (ICS), taking effective actions to return the unit to normal steady state conditions.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>MINOR PROCEDURAL VIOLATIONS WITH REMOVING FIRE SERVICE HEADER FROM SERVICE</b>  Two lapses were identified in the planning, conduct, and coordination of fire protection maintenance activities in conjunction with AmerGen removing from service the Intermediate Building fire service header for planned maintenance. The risk of the maintenance was low because manual actions could have restored the system. The failure to follow approved fire protection and risk assessment procedures constituted a violation of minor significance not subject to formal enforcement action.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>AUXILIARY TRANSFORMER LOSS</b>  The cause of the transformer trip was an electrical short, caused by moisture intrusion, in the non-safety related fault pressure trip circuit cabinet. The moisture intrusion resulted from a lack of cabinet weatherproofing following a modification made during the Fall 1999 refueling outage.
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<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/04/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>MINOR VIOLATION IN THE INSTALLATION OF WIRING ON A REACTOR TRIP BREAKER</b>  GPUN identified a loose wire in the "B" control rod drive alternating current reactor trip breaker control circuit that resulted in a loss of power to the shunt trip device for that breaker during routine surveillance testing. The condition was immediately corrected. The loose wire resulted from a poorly made electrical connection during a modification to the breaker control circuit during 13R Refueling Outage. The failure to identify the poorly made connection during the modification process or through appropriate post-modification process was a minor violation.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/04/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>MINOR MAINTENANCE PROCEDURE USAGE VIOLATION DURING MAKE-UP PUMP OVERHAUL</b>  GPUN identified several instances where work steps performed during the overhaul of MU-P-1B in 13R Refueling Outage were not performed in accordance with the vendor technical manual, as required by the plant maintenance procedure referenced in the job order work package. The failure to adhere to the procedure requirements was a minor violation. Upon returning the pump to service, the pump shaft mechanical seals were found to be leaking; however, the leakage rate was acceptable by plant technical specifications.
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12/04/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	WK	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>WEAKNESSES IN INTEGRATED CONTROL SYSTEM PREVENTIVE MAINTENANCE TRACKING</b>  GPUN classified the Integrated Control System (ICS) in its NRC Maintenance Rule program as needing improvement. The corrective actions relied on the existing preventive maintenance program for improving system performance. The scheduled on-line preventive maintenance for the ICS was not completed during the last cycle of operation. This was a weakness in GPUN's implementation of its NRC Maintenance Rule program for a system designated as needing improvement. The system engineer was aware of the schedule delays and documented in an engineering evaluation justification for extending the completion date of the on-line preventive maintenance into the next operating cycle. Some weaknesses were identified in the work package that implemented the on-line replacement of ICS modules.
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10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>REACTOR COOLANT PUMP OVERHAUL AND SEAL LEAKAGE</b>  The C reactor coolant pump overhaul was performed satisfactorily. System Engineering provided good support and direction to the maintenance technicians performing the work. GPUN's evaluation of the as-found condition of the degraded fasteners on the RC-P-1C main flange seal was thorough and identified no concerns over past operability. GPUN's actions to repair the cause of the main flange seal leakage were appropriate. Visual inspections of the other reactor coolant pumps identified no other leaking main flange seals. Some minor housekeeping and radiological control issues were identified during the conduct of the maintenance that contributed to several personnel skin contaminations.
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10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>BENT VALVE STEM DURING TESTING</b>  GPUN responded appropriately to a bent valve stem on the A decay heat injection valve that occurred when the motor operator torque switch failed to actuate during testing. Plant management delayed reloading the core from the spent fuel pool until repairs to the valve were completed. Inspections on the valve body to characterize the extent of damage were appropriate. At the end of the inspection period, GPUN was conducting a root cause evaluation to determine the exact cause for the failed torque switch.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>EMERGENCY SAFEGUARDS RELAY REPLACEMENT</b>  Replacement of the engineered safety actuation system relays in Cycle 13 refueling outage was performed well. The maintenance technicians were knowledgeable of the tasks being performed. The job order and engineering work package provided adequate instruction to the workers.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>NONDESTRUCTIVE EXAMINATION PROGRAM</b>  GPUN conducted the observed nondestructive examination activities in accordance with technical specifications using appropriate procedures, techniques, and with qualified and certified personnel.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>STEAM GENERATOR TUBE INSPECTIONS</b>  GPUN examined the once through steam generator tubes with eddy current techniques consistent with current industry practice. GPUN had a well-defined process for replacing Inconel 600 rolled mechanical tube plugs with Inconel 690 plugs.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>REACTOR BUILDING EMERGENCY COOLERS</b>  GPUN took appropriate actions to restore the reactor building emergency coolers to above the 25,000 cubic feet per minute (cfm) air flow per cooler in slow speed to ensure that they met their design basis assumptions and that the coolers were operable and no longer in a degraded state.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
08/28/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>DECAY HEAT PUMP VIBRATIONS</b>  Surveillance testing of the A decay heat removal pump identified vibration levels in the American Society of Mechanical Engineers Code alert range during the last two surveillance runs conducted on July 1 and August 10. Prior to the August 10 surveillance, GPUN changed the surveillance procedure to a displacement-based acceptance criteria for pump vibrations to more accurately reflect actual pump operating conditions. Initially, Inservice Testing Engineering provided inadequate information to the Plant Review Group to support the proposed change to the surveillance procedure acceptance criteria. GPUN attributed the increased pump vibrations to flow induced vibrations and not to degraded pump performance.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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08/28/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>ESAS RELAY FAILURE ROOT CAUSE</b>  GPUN continued to pursue a resolution of the ESAS relay failures. GPUN's root cause of the failures was thorough, and the assigned corrective actions were appropriate for resolving the apparent cause of the relay failures.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
08/28/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>OUTAGE PREPS</b>  GPUN conducted the installation of temporary equipment in the preparation for the refueling outage generally well. GPUN management took immediate corrective actions and emphasized to the work groups involved the importance of following the proceduralized scaffold erection and temporary electrical cable installation policies following identification of two minor isolated issues.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>POST-MAINTENANCE TESTING</b>  GPUN properly conducted and documented the post-maintenance testing (PMT) on several maintenance activities that were reviewed. A minor issue was identified where supervisors could be more attentive to dating entries that changed PMT requirements prior to the testing being performed.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>WELL CONTROLLED RECEIPT OF NEW FUEL</b>  The receipt of new fuel was well controlled and coordinated by Maintenance and Operations. The maintenance supervisor provided good oversight of the evolution. The procedural guidance was well written.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004-12	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b>	<b>2B EMERGENCY FEEDWATER PUMP UNKNOWINGLY INOPERABLE FOR GREATER THAN THE TECHNICAL SPE</b>  GPUN identified in May 1999 that the 2B EFW pump outboard bearing had failed. GPUN took appropriate actions to repair the pump and to ensure that similar failures had not occurred on the other two EFW pumps. The inspectors found that GPUN's LER 99-004-00 on this event provided accurate information and assigned appropriate corrective actions. However, GPUN and the NRC determined that the pump was unavailable to perform its safety function, due to the failed bearing, for longer than the TS allowed out-of-service time of 72 hours. The NRC staff considered this TS violation for escalated enforcement in accordance with the NRC enforcement policy and found that GPUN could not have reasonably predicted the failure of the 2B EFW pump bearing prior to its actual failure.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>EMERGENCY FEEDWATER PUMP COMMON CAUSE REVIEW</b>  The common cause evaluation was effective at assuring that the two other emergency feedwater pumps did not have similar bearing damage. Visual inspection of the bearing showed no damage.
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06/05/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SINGLE BATTERY CELL CHANGE-OUT</b> GPUN properly planned and completed a single cell change-out on the A battery, while appropriately limiting the battery out-of-service time to a minimum.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>DECAY HEAT REMOVAL/BUILDING SPRAY OUTAGE</b> The maintenance department conducted a well-planned outage on the A decay heat removal train and the A building spray system.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	WK	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>DIESEL GENERATOR INSPECTION FME ISSUES</b> GPUN completed the required annual inspections on both emergency diesel generators in accordance with the manufacturer's recommendations as required by the plant's Technical Specifications. Workers exhibited a lack of attention to detail for foreign materials exclusion controls during the conduct of the inspections.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
03/13/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>MAINTENANCE ACTIVITIES</b> GPUN performed observed maintenance activities well including nuclear river pump (NR-P-1A) preventive maintenance and modification activities; including proper post-maintenance testing and inservice testing.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
03/13/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>SURVEILLANCE TESTING</b> GPUN completed normal surveillance activities properly including the observed monthly emergency diesel generator testing.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
03/13/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>FAILED AIR BOOSTER</b> Maintenance, with assistance from engineering, diagnosed and replaced the failed air booster on the letdown containment isolation valve (MU-V-3). There was good coordination with operations to ensure the safety related functions of the valve remained operable.
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03/13/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>CIRCUIT BREAKER DEFICIENCIES</b> Maintenance technicians identified and corrected deficiencies with the fit-up of Westinghouse Model DB-25 circuit breakers into the breaker cubicles. Maintenance technicians effectively used the corrective action process to identify the issue for further resolution.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>USE OF CORRECTIVE ACTION PROCESS</b> GPUN used the corrective action process (CAP) to properly document equipment failures and problems as part of the maintenance rule.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>QUARTERLY MAINTENANCE RULE REPORT</b> The quarterly maintenance rule report for the last quarter 1998 provides good information on the status of systems that required enhanced monitoring. No risk significant maintenance preventable functional failures (MPFFs) occurred during that period.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>DAILY TRENDING OF CORE DAMAGE FREQUENCY</b> Daily trending of the core damage frequency (CDF) appeared useful in planning and identifying areas where the cumulative effects of out of service equipment can be minimized.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>OBSERVED MAINTENANCE ACTIVITIES</b> GPUN conducted observed maintenance and surveillance activities well, in accordance with approved plant procedures.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>EMERGENCY VENTILATION SYSTEM TESTING</b> GPUN met their approved commitments, described in NRC safety evaluation report for the TS Amendment 122 for the testing the of the fuel handling building (FHB) emergency safety feature ventilation system and for ensuring FHB operability prior to refueling operations.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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01/15/2000	1999011	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	MV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>PRESSURIZER SEISMIC DESIGN</b> GPUN's failure to correctly translate the updated final safety analysis report seismic design requirements into the pressurizer support design was an isolated case and constituted a violation of minor significance not subject to formal enforcement action.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>SAFETY EVALUATION FOR CHANGES IN BUILDING SPRAY SYSTEM OPERATION</b> The safety evaluation and abnormal transient procedure changes prepared to support securing the building spray system, at the point of borated water storage tank depletion and low pressure injection swapover to the reactor building recirculation sump, adequately addressed the changes in containment pressure and temperature response and appropriately considered single failures.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>MAXIMUM HYPOTHETICAL ACCIDENT DOSE CALCULATION</b> GPUN did not consider a single failure in their analysis of the maximum hypothetical accident offsite dose calculations, assuming that two coolers would be operating at 29,000 cubic feet per minute (cfm) each following a loss of coolant accident with fission product release to the reactor building. The assumption of only a single reaction building emergency cooler at 29,000 cfm resulted in an increased off-site dose, which was still within the 10 CFR 100 limits, as noted in the NRC Correction Letter to Technical Specification Amendment 215, dated October 14, 1999.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>EMERGENCY FEEDWATER FLOW TESTING</b> GPUN properly analyzed the emergency feedwater system and completed calculations and testing to ensure its operability to meet the design basis requirements as outlined in the Updated Final Safety Analysis Report (UFSAR). Specifically, GPUN used the technical specification required loss of feedwater testing requirements and appropriately identified and dispositioned a deficiency in the UFSAR concerning the seismic accident response requirements and the small break loss of coolant analysis.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	URI	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>DECAY HEAT EXCHANGER OPERABILITY REVIEW BASED ON TESTING RESULTS</b> An unresolved item was opened to review the calculation methods and engineering assumptions used to ensure the operability of the A and B decay heat removal heat exchangers following identification of degraded performance of the B heat exchanger during Cycle 13 refueling outage.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
08/28/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>SYSTEM ENGINEERING</b> System Engineering performed well in the analysis of decay heat removal pump vibration issues and in the testing and analysis of the control room emergency ventilation system.
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08/28/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	<b>ENGINEERING SAFETY EVALUATIONS</b>  The procedures supporting the 10 CFR 50.59 and Updated Final Safety Analysis Report updating processes were acceptable, providing comprehensive guidance and detailed responsibilities for implementing the requirements of 10 CFR 50.59 and 10 CFR 50.71(e).
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	<b>PROPER EVALUATION OF REACTOR BUILDING FAN COOLER DEGRADED CONDITIONS</b>  GPUN took appropriate actions with a justification for continued operation to ensure that the reactor building coolers could perform their design function with degraded air flows by establishing lower than design cooling water temperature limits.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004-13	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	<b>DISCOVERY OF A CONDITION OUTSIDE THE UFSAR DESIGN BASIS FOR CONTROL ROOM HABITABILITY</b>  On March 10, 1999, GPUN identified a manual flow balancing damper in the outside air supply duct for the CBEVS failed shut. GPUN took immediate corrective actions to clamp open the failed flow balancing damper and satisfactorily tested the control building envelope to verify a positive pressure could be established. In LER 99-003-00, GPUN committed to implementing long-term corrective actions to inspect the CBEVS to verify its physical conditions and to review the system's compliance with its design requirements. A supplement to the LER will be submitted to describe any required system modifications. The inspectors verified, through in-plant review and interviews with GPUN staff, the assigned corrective actions were appropriate.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004-14	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	<b>OPEN FLOOD PATH BETWEEN TURBINE BUILDING AND CONTROL BUILDING</b>  On May 13, 1999, GPUN identified (LER 99-005-00) that two plant modifications made in 1983 and 1990 created an open flood path from the turbine building to the control building through secondary sample lab drain system. This condition was contrary to UFSAR design basis description which requires, in part, that all potential flood paths are sealed. GPUN took immediate corrective actions to revise the flood emergency procedure to provide direction to the operators to seal the drains. Long-term corrective actions planned include permanent plant modifications to seal floor drains that have no function during normal operation, a review of previous modifications to the drain system for similar conditions, and a comprehensive walk-down of the plant to ensure openings above the probable maximum flood level are sealed. The inspectors verified, through in-plant review and interviews with GPUN staff, the assigned corrective actions were appropriate.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/29/1999	MA4301	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: Ter:	<b>GPUN INFORMATION TO JUSTIFY THE 20 % OTSG TUBE PLUGGING WAS NOT STRAIGHT FORWARD AND CHA</b>  Several requests for additional information were required as well as resolution of emergent issues having potential effect on GPUN analyses before the NRC could complete its review. The responses to the requests for information were less timely than would be expected given GPUN's requested schedule. This indicates the review was not as straightforward as indicated in their submittal.
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07/29/1999	MA5185	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: Ter:	<b>GPUN PROPOSED A TS AMENDMENT THAT IF APPROVED, WOULD OVERRIDE THE 50.54 (X) REPORTING AND</b>  By letter dated April 1, 1999, GPUN submitted an application for license amendment for TMI-1 requesting, in part, a proposed change to TS 3.1.12.3 to add a condition to the limiting condition for operation that would allow continued high pressure injection (HPI) operation without violating the TSs, if HPI is operating during an emergency cooldown. GPUN's basis for that proposed change was that the administrative controls established to reduce the possibility of a low temperature overpressure event were never intended to limit the use of HPI to mitigate a design basis accident.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/29/1999	MA3845	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: Ter:	<b>GPUN PROVIDED INVALID DATA FOR STAFF REVIEW FOR A TS AMENDMENT ON CHANGES TO THE ATMOSP</b>  TS amendment 210 approves a revision to the TMI-1 UFSAR for use of revised atmospheric dispersion factors (obtained by utilizing recent meteorological and population data). The GPUN review was not as straightforward as indicated in their initial submittal in that some of the data provided was not valid as discussed previously.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/29/1999	MA3845	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: Ter:	<b>THREE GPUN TS CHANGE REQUESTS DID NOT PROVIDE CLEAR BASES TO SUPPORT ACCELERATING NRC S</b>  This request, with others, was identified as required to be completed in order to support the sale and license transfer of TMI-1 to AmerGen. Neither the GPUN December 3, 1998 application for that request, nor the November 25, 1998 application related to this request provided a basis for a higher priority accelerated review to support the April 15, 1999 proposed transfer date. The NRC consented to support the requested schedule; however, the information may be used as a PIM entry. These amendments modified the OTSG tube inspection criteria for the upcoming outage (TS 209) and allowed changes to the atmospheric dispersion assumptions for radiological dose consequences (210) TS CR 279.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>ACCEPTABLE CALCULATION PROCESS</b>  The calculations were sufficiently detailed, consistent with their intended purpose, and acceptably controlled. The revised calculation procedure provided sufficient guidance for the correct administration and control of the calculation results.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>ELECTRONIC TASK TRACKING SYSTEM WAS EFFECTIVE</b>  The electronic task tracking system was effectively used to track action items.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>COMPREHENSIVE ENVIRONMENTAL QUALIFICATION SELF-ASSESSMENT</b>  The licensee's assessment of the TMI environmental qualification program was a comprehensive effort and provided a good insight on the qualification status of the equipment evaluated. Also, the licensee's review and resolution of the identified findings was acceptable. The licensee planned to issue a CAP to address extent of condition.
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<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>APPROPRIATE SYSTEM DESIGN BASIS REVIEWS</b>  The licensee's review for consistency of the UFSAR, the Technical Specification bases, the System Design Basis Documents (SDBD), and the as-built drawings was appropriate. The content of the SDBDs reviewed was comprehensive with interim system design changes properly posted against the SDBD. The referencing of supporting documents was acceptable.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING IMPROVING</b>  The team determined that the engineering organization provides acceptable support to plant operations. We found that you are addressing previously identified weaknesses in the various engineering program areas. We noted that your ongoing efforts to better define the design bases, to improve documentation, and to strengthen the quality and effectiveness of Engineering are producing positive results.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ACCEPTABLE RESPONSE TO PLANT EVENT</b>  Evaluation of plant events was acceptable. Also acceptable were the threshold for problem identification and the timeliness for resolving engineering issues. The licensee was proactively addressing relay coil failures in the Engineered Safety Features System and had engaged an independent laboratory to conduct a root cause analysis of the failure. Potentially defective relays were being conservatively replaced.
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05/28/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>GOOD COMMUNICATION BETWEEN ENGINEERING AND PLANT STAFF</b>  Communication among engineering and plant organizations was good.
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05/28/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>EFFECTIVE SELF-ASSESSMENTS AND AUDITS</b>  The engineering self-assessment and the NSA audits were an effective element of the TMI self-assessment process. They were broad in scope and addressed most engineering programs. Recommendations were appropriate for the findings. Management was actively involved in ensuring that the findings and recommendations were addressed in a timely manner.
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<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
05/28/1999	1999005-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>INADEQUATE BATTERY TEST ACCEPTANCE CRITERIA</b>  The battery surveillance test procedure incorrectly specified the minimum battery voltage at the end of the duty cycle to be 105 Vdc. As identified in the battery sizing calculation, this voltage would not be sufficient to ensure operability of the inverters. Based on the results of an earlier test and the available battery load capability margin, the licensee declared the inverters operable, but did not provide sufficient justification. The licensee confirmed operability by calculation during the inspection. However, the incorrect surveillance test procedure acceptance criteria resulted in a non-cited violation.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>REVIEW OF OUTAGE MODIFICATIONS</b>  Several modification packages that GPUN plans to install during the upcoming refueling outage were well prepared. These modifications will address potential pressure locking on decay heat removal valves and provide a high temperature isolation in the event of a makeup system letdown line break inside the auxiliary building.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>GOOD SYSTEM ENGINEER PERFORMANCE IN IDENTIFYING REACTOR BUILDING EMERGENCY COOLER DEGRADATION</b>  System engineering and engineering in general performed well in identifying the degraded reactor building emergency coolers. Engineering was persistent in their review of data and industry information, and in the completion of preliminary calculations to assess the extent of the degradation and to support the justification for continued operation.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING REVIEW MEETING</b>  The engineering review meeting provided a good forum for engineering to discuss and remain aware of ongoing problems, and gave management a chance to get an overview of issues and to provide unified guidance on further actions to be taken.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	STR	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING SUPPORT</b>  System, component, and quality verification engineers provided excellent support during emergency feedwater pump corrective maintenance, battery cell replacement, ESAS relay work, and the decay heat removal and building spray outages.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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06/05/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	Self	WK	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>EMERGENCY FEEDWATER SUCTION TEMPERATURE DESIGN DEFICIENCY</b>  The high suction temperatures that occurred during emergency feedwater (EFW) post-maintenance testing caused engineering to identify a possible design deficiency with respect to the influence of the condensate system on EFW pump suction temperature. GPUN properly evaluated operability and was performing re-analysis of the suction temperature limits.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>CONDENSER OFFGAS RADIATION ALARM</b>  In response to repeated momentary alarms from the condenser offgas radiation alarm (RM-A-5), GPUN raised the alarm setpoint to reduce operator distraction while still providing adequate warning of an increasing primary to secondary leak rate.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING SUPPORT</b>  The engineering department continued to provide good support to plant operations and maintenance activities.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>THERMO-LAG FIRE BARRIER FOUND OUTSIDE APPROVED JOINT DESIGN ARRANGEMENT</b>  The inspectors reviewed LER 98-06-00, dated July 17, 1998, to verify GPUN completed a comprehensive evaluation and took adequate corrective actions in response to a Thermo-lag fire barrier found incorrectly configured. The root cause evaluation was thorough, and the corrective actions (both immediate and long term) were appropriate. This in-office review of the LER concluded that the LER properly addressed the requirements of 10 CFR 50.73. This improperly configured Thermo-lag fire barrier constitutes a violation of the fire protection program. This Severity Level IV Violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy, and is addressed in the corrective action plan as CAP T1998-0489.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4C <b>Sec:</b> 4A <b>Ter:</b>	<b>INOPERABLE INTAKE SCREEN AND PUMP HOUSE FLOOR DRAIN CHECK VALVES DUE TO LACK OF PREVENT.</b>  The inspectors reviewed LER 98-007-00, dated August 14, 1998, to verify GPUN completed a comprehensive evaluation and took adequate corrective actions in response to finding degraded floor drain check valves in the Intake Screen and Pump House. The inspectors performed an in-office review of the LER, and inspected the areas around the floor drains. The root cause evaluation was thorough, and the corrective actions appropriately addressed the root causes. The LER properly addressed the requirements of 10 CFR 50.73. This failure to maintain the floor drain check valves operable constitutes a violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Actions, since this condition adverse to quality was not promptly identified and corrected. This Security Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy, and is addressed in the corrective action program as CAP T1998-0595.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

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03/13/1999	1999001	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING SUPPORT TO OPERATIONS</b> Engineering provided sound technical advice to operations and maintenance during the on-line repairs to MU-V-3. The supporting temporary modification and safety evaluation were well prepared. Engineering closely followed the issues identified concerning the fit-up of the Westinghouse Model DB-25 circuit breakers and provided good input to maintenance and operations concerning operability of the breakers.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>CONDUCT OF ENGINEERING DESIGN ACTIVITIES</b> The methodology and detail of the updated voltage regulation study demonstrated conformance of the electrical distribution system with the UFSAR design basis. However, outstanding issues identified as a result of the calculation required additional review of corrective actions documented in the CAP.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ENGINEERING SUPPORT TO OPERATIONS</b> Site engineering personnel responded well to several equipment failures including the ICS module and the DR strainer clogging.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>EFFECTIVE SOLID RADWASTE PROGRAM</b> The solid radioactive waste management program continued to be effective based on proper implementation of the program by knowledgeable personnel, the existence of appropriate procedures and controls, and the acceptable condition of facilities and equipment.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>EFFECTIVE RADWASTE TRANSPORT</b> The program to transport low level radioactive waste and other radioactive materials was effective. The shipping manifests and supporting documentation were properly prepared. Radiation and contamination limits were met. Waste was properly classified, and shipments were properly typed as to their Department of Transportation class.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>EFFECTIVE RADWASTE TRANSPORT TRAINING</b> The Nuclear Regulatory Commission and Department of Transportation training and retraining requirements for the personnel involved in solid radioactive waste management and the shipment of radioactive waste and materials were implemented in an effective manner. The lesson plans, training materials, and training records were readily available, appropriate, well organized, and well documented.
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01/15/2000	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>EFFECTIVE RADWASTE QUALITY ASSURANCE AUDITS</b>  Quality assurance activities were effective. The audit performed as required by technical specifications was appropriate in scope and depth. The Monitoring Reports were appropriately detailed and comprehensive in that they covered the full scope of each monitored evolution.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/15/2000	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PLAN CHANGE ADEQUATE</b>  Based on a limited review of the security program changes, as described in the plan revision, no Nuclear Regulatory Commission approval of these changes is required, in accordance with 10 CFR 50.54(p). These changes will be subject to future inspection to confirm that the changes, as implemented, have not decreased the overall effectiveness of the security plan.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
12/04/1999	1999010	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	WK	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>POOR WORK PRACTICE ON CONTROL OF ALARMING DOSIMETERS FOR RADIATION WORK PERMITS</b>  Plant management identified a poor work practice concerning the use of electronic pocket dosimeters. This poor work practice could result in inaccurate dosimetry records and individuals not being aware of their personal dose history. GPUN management took actions to stop this poor work practice.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	MV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>AIR SAMPLING EQUIPMENT MAINTENANCE</b>  Failure of technicians to adequately maintain air sampling equipment by properly inspecting and replacing O-rings in air monitors resulted in a minor violation.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>OUTAGE RADIOLOGICAL CONTROLS AND HOUSEKEEPING</b>  GPUN implemented generally acceptable radiological controls and housekeeping during the outage. Minor deficiencies in contaminated area control and posting requirements were noted. Considerable GPUN management involvement was required to establish an acceptable level of reactor building cleanliness control. GPUN personnel acknowledged the minor issues identified and quickly corrected them.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>OUTAGE CONTAMINATION CONTROL</b>  The overall planning, preparation, and use of various radiological controls were generally effective in minimizing dose and limiting the spread of contamination when performing outage-related tasks.
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10/23/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>OUTAGE RADIOLOGICAL CONTROLS</b>  Radiological controls were adequately implemented as evidenced by an experienced staff implementing procedures to minimize external and internal exposure by appropriately monitoring personnel dose, adequately controlling access to radiologically controlled areas, and implementing detailed radiation work permits.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
10/23/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>RADIATION PROTECTION PROGRAM</b>  GPUN adequately monitored the implementation of the radiation protection program, worker practices, and procedural compliance through various management controls, including audits, departmental self-assessments, and routine observations. Prompt actions were taken to evaluate and correct factors that could degrade performance.
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08/28/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>FIRE DOOR</b>  A fire door to the C make-up pump cubicle was found open and unattended. The C make-up pump was out of service at the time of the discovery. There was minimal threat from a fire that initiated either inside or outside the make-up pump cubicles spreading to safety-related equipment.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>GOOD CONTROL OF HOT WORK</b>  The licensee established good administrative controls for hot-work activities. The hot-work activities were accomplished in accordance with approved procedures and the associated hot-work permits. Proper controls of combustible materials were in place. Good control of hot-work activities, impairments, and transient combustibles were evident.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>GOOD FIRE PROTECTION EQUIPMENT CONDITION</b>  Fire protection equipment conditions and housekeeping in the observed areas were good. Roving fire watches were knowledgeable of station procedures for reporting fires, fire watch duties, and responding to fires. Eight hour emergency light operation and illumination patterns were good.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>GOOD CONDITION OF FIRE PENETRATION SEALS</b>  Fire penetration seals were in good condition and the "as-built" condition met the test criteria outlined in the vendor's test report for operational performance.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>GOOD CONDITION OF FIRE MAIN LOOP</b>  The fire main loop was in good repair, and capable of providing the necessary water supply for fire fighting needs at the facility. The fire pumps were well-maintained and ready for service.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>FIRE DETECTION SYSTEM</b>  The incipient fire detection system could provide improved detection capabilities for the eight fire zones it monitors in the control building. The licensee had appropriate compensatory measures in place for the system in the event that it failed or was removed from service for surveillance purposes.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>FIRE PROTECTION PROCEDURES</b>  Fire protection procedures met the requirements for fire protection program implementation, contained sufficient detail, and were technically sound.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>FIRE BRIGADE TEAM</b>  Performance by the fire brigade team during a fire drill was very good. All expectations of the fire drill were met.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>FIRE PROTECTION TRAINING PROGRAM</b>  The training program complied with NRC requirements for preparing fire brigade members to combat fires. Fire brigade members reviewed were current on all required training and annual physical examinations.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 1C <b>Ter:</b>	<b>GPUN CONTINUED TO TAKE APPROPRIATE ACTIONS TO ADDRESS THERMO-LAG</b>  The inspector concluded that appropriate compensatory actions were in place for reviewed areas where the Thermo-Lag had not been upgraded. The inspector also concluded that the as-installed configuration of the Mecatiss wrap in fire zone AB-FZ-3 was consistent with the installation drawing. Engineering packages to upgrade five barriers in fire zones AB-FZ-5, AB-FZ-7 and FH-FZ-2 had been completed. No evidence was found that indicated that the licensee would not meet the intent of the confirmatory letter. Additionally, the inspector concluded that the licensee's instituted database to control and track Thermo-Lag mitigation efforts was a valuable tool.
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07/17/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>TIMELY AND EFFECTIVE FIRE PROTECTION AUDITS</b> The fire protection quality assurance audits appropriately reviewed fire protection program attributes and compliance with program requirements. The fire protection audit findings were appropriately addressed and timely corrective actions had been taken for identified deficiencies.
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06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>TECHNICAL SUPPORT CENTER SIZE CHALLENGES THE COMFORT OF RESPONDERS</b> The licensee identified that the Technical Support Center size was a challenge in meeting the comfort needs of responders.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>VERY GOOD OVERALL EMERGENCY RESPONSE ORGANIZATION PERFORMANCE</b> Overall licensee performance during this exercise was very good as the Emergency response Organization demonstrated that it could implement the emergency plan. The emergency response facilities were staffed and activated in a timely manner. Good command and control were demonstrated by all of the facility leads. There were good communications observed within and among the facilities. Event classifications were accurate and timely. Offsite notifications were all made within the 15 minute requirement. News releases and press briefings were accurate and timely.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>GOOD ASSESSMENT OF PLANT CONDITIONS; GOOD ANTICIPATION OF POTENTIAL DEGRADATION</b> There was very good assessment of plant conditions. Mitigation strategies were quickly developed and implemented. The licensee addressed current simulated problems well while anticipating potential plant degradation issues.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>PROPER UPGRADES, PROTECTIVE ACTION RECOMMENDATIONS, AND DOSE ASSESSMENTS</b> The licensee performed proper classification upgrades and protective action recommendations. Dose projection and dose assessment activities were well coordinated between the Emergency Control Center and Emergency Operations Facility.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>WELL EQUIPPED AND CAPABLE FACILITIES</b> Facilities were well equipped and capable of supporting emergency response organization activities.
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06/11/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>THOROUGH, SELF-CRITICAL DRILL CRITIQUE</b>  During the critique, the licensee methodically reviewed the exercise objectives for each facility and identified issues in addition to the ones identified by the inspectors. Positive and negative items were noted. Overall, the critique was thorough and appropriately self-critical and was assessed as very good.
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06/05/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>SECURITY TOUR</b>  Security officers maintained good controls over personnel access to the protected area. Further, on routine evening tours the protected area lighting came on at dusk and provided suitable visibility.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>GOOD RADIATION PROTECTION</b>  The radiological control technician support during the observed portions of the decay heat removal outage was very good. The technicians provided realtime monitoring making the jobs go smoothly. Good contamination control techniques were used, and the workers were advised on the use of protective clothing and catch containment.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
06/05/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	Self	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>REPAIR TO WASTE EVAPORATOR CONDENSATE STORAGE TANK LINE</b>  GPUN completed necessary repairs to return the waste evaporator condensate storage tank discharge line to service. Observed work in the field was conducted properly. Radiological control technicians properly controlled the work areas to ensure no unmonitored released occurred.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PROGRAM IMPLEMENTATION</b>  GPUN conducted security and safeguards activities in a manner that protected public health and safety in the areas of access authorization, alarm stations, communications, and protected area access control of personnel, packages and vehicles. This portion of the program, as implemented, met commitments and NRC requirements.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PROGRAM IMPLEMENTATION</b>  Security's protected area assessment aids, protected area detection aids, and personnel search equipment were well maintained and reliable, and were able to meet commitments and NRC requirements.
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<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PROGRAM IMPLEMENTATION</b>  Security force personnel were trained in accordance with the requirements of the Training and Qualification Plan, and training documentation was properly maintained and accurate.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PROGRAM IMPLEMENTATION</b>  The level of management support was adequate to ensure effective implementation of the security program as evidenced by adequate staffing levels and allocation of resources to support programmatic needs.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
04/24/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>SECURITY PROGRAM IMPLEMENTATION</b>  Audits of the security program were comprehensive in scope and depth, and findings were reported to the appropriate level of management. The self-assessment program was effectively implemented to identify and resolve potential weaknesses.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
03/13/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>LEAK IN RAD WASTE DISCHARGE LINE</b>  The GPUN Department of Environmental Affairs properly identified the possibility of a leak from the waste evaporator condensate storage tank (WECST) discharge line using monitoring well grab sample analysis results. GPUN took appropriate actions to assess the possibility of a leak from the buried normal liquid radioactive waste discharge line from the WECST.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						
01/30/1999	1998009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>ROUTINE PLANT HOUSEKEEPING</b>  Plant housekeeping remained good. No negative radiological conditions were identified during routine plant tours.
<b>Dockets Discussed:</b> 05000289 Three Mile Island 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

## Legend

### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.