

May 29, 1998

Mr. J. Langenbach
Vice President and Director
Three Mile Island
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Route 441 South
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SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - THREE MILE ISLAND

On April 29, 1998, the NRC staff completed the semiannual Plant Performance Review (PPR) of Three Mile Island. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for Three Mile Island involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period October 1997 through March 1998. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC Systematic Assessment of Licensee Performance (SALP) and senior management meeting (SMM) reviews.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and GPU Nuclear. The PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the Three Mile Island PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. Resident inspections are not listed due to their ongoing and continuous nature.

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Mr. J. Langenbach

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We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (610) 337-5358.

Sincerely,

Original Signed By:

Michele G. Evans, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket Nos. 50-289, 50-320
License Nos. DPR-50, DPR-73

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

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Mr. J. Langenbach

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THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
3/21/98	Positive	IR 98-01	L	OPS	5B	Senior GPUN management, after a timely review of the submitted Licensee Event Report (LER) on the missed spent fuel pool (SFP) samples, concluded that a revised report containing a more comprehensive description of the issue and broad based corrective actions was necessary. (Enforcement Discretion per VII.B.1 of the Enforcement Policy)
	NCV	NCV 98-01-01			5C	
	LER	LER 98-002				
3/21/98	Negative	IR 98-01	N	OPS	5B	GPUN focused the initial root cause analysis and associated corrective actions too narrowly, concerning a missed SFP sample. GPUN concluded that the primary cause for the missed sample was a missing operator aid plaque. However, the auxiliary operator informed the control room, as required by procedure and the operator aid, when the water addition was stopped. The inspectors determined that the shift operating crew did not coordinate the performance of the required SFP sample after the routine water addition.
	LER	LER 98-002			5C	
3/21/98	Positive	IR 98-01	L	OPS	5A	A diligent review by the chemistry department resulted in the discovery that a Technical Specification (TS) required SFP boron concentration sample was missed. GPUN promptly initiated a corrective action process form to document and correct the error, and reported the missed surveillance as required.
	LER	LER 98-002			5C	
3/21/98	Strength	IR 98-01	N	OPS	5A	Plant management and operations' sensitivity to small changes in the reactor coolant system (RCS) leakage calculations and associated plant indicators led to the discovery and isolation of two small leaks in the Reactor Building. The aggressive response to the leakage indications has resulted in an RCS leakage well below the TS limit.
					5B	
					5C	
1/24/98	Positive	IR 97-10	N	OPS	1C	GPUN implemented the licensed operator requalification training program well for those areas reviewed. Annual licensed operator exams were administered appropriately; operators performed well and management had extensive involvement in the exam process.
1/24/98	Positive	IR 97-10	N	OPS	1C	The human performance review board (HPRB) meeting provided an objective assessment of the corrective action process (CAP). The meeting included the site Vice President, site directors, and key managers. The HPRB initiative demonstrated management's support for the CAP process and expectations to improve the current program.
					5A	
1/24/98	Positive	IR 97-10	N	OPS	1C	The routinely scheduled management meetings (operations and maintenance (6:30am), maintenance (8:00am), and plan of the day (3:00pm)) provided good platforms for discussion of current issues and future plans.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/24/98	Positive	IR 97-10	N	OPS	5A 5B	The nuclear safety and compliance committee (NSCC) identified important performance issues and effectively communicated them to the board of directors. The GORB also identified several underlying issues and initiated appropriate action items. However, the GORB failed to recognize and act on some key issues (i.e. emergency preparedness, qualified component list reclassification, and motor operated valve programs) indicating inconsistent performance by GORB subcommittees. Reasonable actions were proposed to improve GORB/CPUN interfaces and performance.
1/24/98	Negative	IR 97-10	N	OPS	5A	Operational experience (OE) program performance was mixed with some signs of improvement. Internal and external oversight groups raised several concerns regarding ineffective use of industry experience. Several actions to address those concerns were recently implemented. The OE and vendor documents departments typically notify the correct station personnel of potential industry concerns for resolution. Resolution thoroughness and response detail varied widely and in some instances were insufficient for reviewers to do an independent closeout. Inadequate detail and resource constraints resulted in poor assessment of a station blackout diesel generator issue. Senior management recognized that proper OE implementation requires more resources and intends to add one full time individual to help coordinate the OE program.
1/24/98	Negative	IR 97-10	N	OPS	5A	The GPUN organization has been slow to formalize a line self assessment program.
1/24/98	Negative	IR 97-10	N	OPS	5C	In several instances GPUN line organizations failed to take sufficient action to preclude recurrence of known problems.
1/24/98	Positive	IR 97-10	N	OPS	5B	NSA audits and recommendations have been good.
1/24/98	Weakness	IR 97-10	N	OPS	5C	The actions taken to resolve several larger CAP issues were not properly managed due to higher station priorities and a perceived lack of resources by the plant staff. Poor initial problem scoping and unrealistic corrective action schedules made it difficult for the organization to correct problems in a timely manner. Several significant engineering problems such as previously identified service water cooling system deficiencies, calculation program controls, inservice testing program scope, and configuration control weaknesses remain only partially corrected. In several instances, causal analyses were narrowly focused and may have fixed only the immediate problem, and not the root cause.
1/24/98	Negative	IR 97-10	N	OPS	5B 5C	Problem resolution backlog has increased, assignment of action due dates and aggregate CAP timeliness assessment have been inconsistent, and CAP extension/escalation processes have not been consistently applied. There are multiple corrective action processes in use at TMI, which at times, makes it difficult for management to track overall implementation and to quantify needed resources. The engineering task tracking system (ETTS) was not effectively used as an action tracking and resource planning tool.

THREE MILE ISLAND I PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/24/98	Positive	IR 97-10	N	OPS	5A 5B 5C	Corrective action programs at TMI are improving. The new CAP, implemented in March 1997, has lowered problem identification threshold. The corrective action processes were generally understood and properly used by station personnel. Resolution of failure to meet maintenance rule (MR) performance criteria for the high pressure injection (HPI) system was excellent. Response to daily issues, including potential plant challenging problems was also good.
1/24/98	Positive	IR 97-10	N	OPS	5B 5C	The General Office Review Board (GORB) conducted a very detailed meeting in December 1997 covering a broad range of topic areas, with specific issues in each area. Separate sub-committee meetings were a good use of time and allowed more detailed questioning and probing of the TMI staff, prior to presentations to the entire GORB. Site management from engineering, operations, the PRG, and nuclear safety assessment (NSA) gave good presentations of current issues, which the GORB properly questioned and analyzed.
1/24/98	Strength	IR 97-10	N	OPS	5B 5C	The plant review group (PRG) thoroughly reviewed several plant issues including: failure of an NI lower detector, identification of a possible out of design basis issue with the RBECs, maintenance on the RR-V-4 valves in a hot shutdown condition, and the impacts of a MU leak while at power.
1/24/98	VIO	IR 97-10 VIO 97-10-01	N	OPS	1C, 3B 4B	GFUN conducted a leak test of the reactor building emergency coolers (RBECs) without having a properly reviewed procedure in place. The use of the inservice test (IST) procedure to close the reactor river (RR) cooling water RR-V-3 valves was an intent change to the procedure which did not receive prior review or approval before implementation. This is a Violation of Technical Specifications (TS) 6.5.1.1 and 6.8.2 which requires that intent changes to procedures be reviewed prior to implementation.
1/24/98	Positive	IR 97-10	N	OPS	1A 3A	Operators responded well in the identification of the makeup (MU) system leak in November 1997, to the failure of the power range nuclear instrument (NI) -7 lower detector, and to a clogged strainer for the 'A' decay river (DR) cooling water pump. Operators conducted the unit shutdown, to repair the MU leak, well. The control of reactor coolant system (RCS) level in the mid-loop range, to allow repairs to the B reactor coolant pump (RCP) seal, was appropriate, as was RCS refilling, and unit restart.
1/24/98	Positive	IR 97-10	N	OPS	5A	IOSRG identified and reported good issues, which were properly resolved.
11/1/97	Positive	IR 97-09	N	OPS	1C	Operations department and training management continue to coordinate licensed operator requalification classroom, simulator, and on-the-job training well, providing intensive precutage training. In addition, all operators involved with the core offload and reload completed on-the-job training and a qualification card that contained refueling operation tasks from the job task analysis.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/1/97	VIO	IR 97-09 EA 97-533 - 02014 EEI 97-09-02	N	OPS	3B 3A	During the RCS filling operations a shift supervisor (SS) displayed a poor procedure compliance standard. The SS directed the plant operators to increase the fill rate, from a flow path not included in the applicable operating procedure. This resulted in an excessive flowrate and led to the overflow of approximately 50 gallons of RCS water out of the control rod drive mechanism (CRDM) vent openings. This appeared to be a violation, based on failure to follow approved station operating procedures. VIO EA 97-533-02014 issued 1/27/98 closed EEI 97-09-02 (Violation of TS 6.8.1)
11/1/97	Positive	IR 97-09	N	OPS	1A 3A	Generally, GPUN conducted the 12R refueling outage well. Operators, despite several lapses, displayed excellent control of plant and equipment conditions, including draining to mid-loop and in refilling the reactor coolant system (RCS) and in unit restart activities.

THREE MILE ISLAND I PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
3/21/98	Positive	IR 98-01	N	MAINT	2B 3A 3C	Maintenance technicians demonstrated consistent use of the foreign material exclusion barriers throughout the intermediate closed cooling heat exchanger and pump motor bearing replacement work activities. All heat exchanger and connected pipe openings were properly covered throughout the maintenance outage.
1/24/98	Positive	IR 97-10	N	MAINT	2B	GPUN used good tracking systems and monitoring of unavailability to identify systems structures and components (SSCs) that needed additional attention under the NRC's MR. Further, the CAP process and routine meetings and planning appeared to allow identification for equipment problems and the trending and tracking of planned on-line maintenance effects on unavailability. Tracking, identification and planning for improvements on SSCs in the a(1) criteria appeared good.
1/24/98	Positive	IR 97-10	N	MAINT	3A 2B 3B	Surveillance test performance for the power range NI calibrations, emergency diesel generator runs, ES logic, control rod movement and the reactor protection system (RPS) was excellent. In particular, the RPS weekly tests were performed after the required documentation was revised to address the bypassed 'C' RPS logic channel.
1/24/98	Positive	IR 97-10	N	MAINT	3A	The electrical maintenance technicians' performance, supervision oversight and coordination of REBC isolation valves RR-V-4C/D preventive maintenance and MOVATS testing were excellent. The system engineer manager provided excellent support throughout the testing.
11/1/97	Positive	IR 97-09	N	MAINT	4B	The eddy current inspection program was well planned and organized, and could determine the integrity of the once through steam generator (OTSG) tubes, according to the ASME Code, Section XI and TS.
11/1/97	Positive	IR 97-09	N	MAINT	3A 4B	GPUN conducted inservice inspection (ISI) activities at TMI following the American Society of Mechanical Engineers (ASME) Section XI, 1986 Edition and 10 CFR 50.55a(g). The flow accelerated corrosion (FAC) program was thorough, effective, and capable of predicting the depletion of piping wall thickness.
11/1/97	Negative	IR 97-09 URI 97-09-04	N	MAINT	4C 4B	The appropriateness of testing an emergency diesel generator (EDG), following simulated loss of offsite power (LOOP) and loss of coolant accident (LOCA) conditions, with the output breaker in the pull-to-lock position was an Unresolved Item. (URI 97-09-04)
11/1/97	Positive	IR 97-09	L	MAINT	5A 5B	The nuclear safety assessment group (NSA) reviewed PMTs conducted during 12R on safety-related equipment, on a sampling basis, because of the PORV root cause analysis. This assessment was very comprehensive and appropriately expanded after a few minor documentation problems were found. Plant management's decision to evaluate and resolve the minor PMT issues before plant restart was prudent.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/1/97	VIO SL-III	IR 97-09 EA 97-533-01013 EEI 97-09-03 LER 97-10	L	MAINT	3A 4B	The pressurizer PORV was inoperable for the two-year operating cycle from October 1995 to September 1997 due to a wiring error and the failure to do a post-maintenance test (PMT) after the valve replacement in the September 1995 refuel outage. This issue involved the unavailability of the PORV during plant depressurization situations as directed by the emergency operating procedures and the calculated increase in core damage frequency (4.18E-5/year to 4.85E-5/year). This appeared to be a violation of TS IST requirements. VIO EA 97-533-01013 issued 1/27/98 closed EEI 97-09-03. (Violation of TS 4.2.2)
11/1/97	Positive	IR 97-09	L	MAINT	2A 4A	GPUN responded proactively to the generic makeup (MU) system high pressure injection (HPI) thermal sleeve cracking issue at Babcock and Wilcox (B&W) plants. After finding two cracks in the 'B' thermal sleeve, plant management decided to complete a visual internal inspection of the remaining three sleeves, detecting no additional flaws. Replacement of the 'B' thermal sleeve was well conducted and supervised.
11/1/97	Positive	IR 97-09	N	MAINT	2A 4A	Plant management's decision to replace the remaining 31 old design thermal barriers during the 12R refuel outage with the new design displayed a clear commitment to resolve the slow CRDM drop time issue. All control rod drop times were less than the TS limit when tested before the plant startup.
11/1/97	Negative	IR 97-09	L	MAINT	3A 4C	Maintenance rework was required for the pressurizer power operated relief valve (PORV), following identification of a miswired operating solenoid valve and repeatedly on the 'A' DH pump following seal replacement. The rework on the 'A' DH pump resulted in an extended time with only the 'B' DH pump operable for core heat removal.
11/1/97	Positive	IR 97-09	N	MAINT	3A	Routine outage meetings provided good insight into upcoming work activities and equipment problems. For the 12R outage, order activities observed, the work packages contained the needed planning information and the workers properly documented the completed work. GPUN used lessons learned from the prior refuel outages and other plants to prevent recurring problems.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
3/21/98	NCV Positive LER	IR 98-01 NCV 98-01-02 LER 98-001	L	ENG	3B 4A 5C	The questioning attitude of a system engineer resulted in the reversal of a 1993 plant review group (PRG) operability determination for the emergency core cooling system (ECCS) flow transmitters. The 1993 PRG incorrectly determined that the ECCS system remained operable when the associated flow instruments were out of service for maintenance. GPUN reported the issue to the NRC and took comprehensive corrective actions once the issue was noted. (Enforcement Discretion per VII.B.1 of the Enforcement Policy)
1/24/98	Positive	IR 97-10	N	ENG	4B 5C	The calculations and testing completed on the MU system injection piping for a small break loss of coolant accident (SBLOCA) adequately determined the minimum MU tank levels for NPSH. The testing proved actual system performance within the bounds of the calculations. However, there were differences in the methodologies employed in system resistance modeling. Also, a weakness was found in the test procedure and the safety evaluation (SE) since the as tested conditions did not match the calculation condition; this did not invalidate the test results. However, GPUN committed to update the SE to include an evaluation of the test conditions and results versus the calculated condition.
1/24/98	Positive LER	IR 97-10 IR 96-06 LER 96-01	N	ENG	4A	The GPUN response to the generic Westinghouse breaker seismic concern was comprehensive and effective. The licensee event report provided a detailed description and assessment of the event. The root cause analysis was thorough and the implementation of the associated corrective action was timely.
1/24/98	Positive URI	IR 97-10 URI 97-10-03	L	ENG	4B 3A	Engineering performed well in identifying the issue of a difference between the GL 96-06 submittal and the updated final safety analysis report (UFSAR), and getting the issue to the site for PRG review. However, this instance raised questions over the adequacy of the review and the understanding of possible plant impacts as a result of the GL 96-06 submittal. This is an Unresolved Item pending review to determine if GPUN violated any NRC requirements with respect to the control of the RBEC design.
1/24/98	Positive	IR 97-10	N	ENG	4A	Overall, engineering provided good support for plant operations including: questioning the need for the emergency core cooling system (ECCS) flow instruments to meet system operability, review of the MU leak; development of a temporary modification to the RCP oil leak collection system to allow remote (outside the D-ring) pumpdown; review of the NI-7 lower detector failure and in support of the replacement of the B RCP seal package.
1/24/98	Negative	IR 97-10	N	ENG	4B 3A	An engineering safety evaluation written in 1993 addressed the potential safety issue associated with the high temperature effects on the concrete for the primary containment. However, the engineering processes did not result in a revision to the UFSAR to reflect the increased concrete temperature limit as noted in the safety evaluation.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/1/97	Positive	IR 97-09	N	ENG	4A	Engineering developed and maintenance installed a modification to improve the closing capabilities of MU-V-3 the RCS letdown outboard isolation valve. The modification installed an air to close function on this air operated valve, increasing the ability of the valve to close under system flow and differential pressure. The modification package was detailed and well developed and the PMT appeared complete.
11/1/97	Positive	IR 97-09	N	ENG	4A 1A	Based on a detailed system review, GPUN has maintained the core flood (CF) system in good material condition. Engineering maintained the design basis following 10 CFR 50.46. The design basis document (DBD) was "easy to use" and thorough in describing the design basis. Documents were found consistent with the applicable sections of the DBD, updated final safety analysis report (UFSAR), TS, IEEE standards, procedures, system drawings and system layout. Adequate procedures were in place to operate the CF within its design basis.
11/1/97	Positive	IR 97-09	L	ENG	3A	The PORV problems were recognized due to the diligent review and questioning attitude of an electrical engineer. The engineer recognized and pursued the connection between the PORV problem found in the current refuel outage and the possibility of the same problem existing with the previously installed PORV.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
3/21/98	Positive	IR 98-01	N	PS	2B 3C 5A	The plant continues to strive toward lower dose to plant workers by flushing system hot spots. Plant housekeeping has improved since the refuel outage with the exception of the emergency diesel generators.
3/21/98	Positive	IR 98-01	N	PS	3A 3B 3C	The central and secondary alarm station (CAS and SAS) operator performance was professional and responsive to ensure that control was maintained for the vital and protected areas of the plant. The necessary CAS and SAS support equipment was reliable and well maintained.
1/24/98	Positive	IR 97-10	N	PS	1C 3A	The licensee maintained and implemented good routine radioactive liquid and gaseous effluent control programs. The radiation monitoring system (RMS) calibration program was good, as were the ventilation system surveillance program and quality assurance (QA) and quality control (QC) programs.
1/24/98	Positive	IR 97-10	N	PS	2A 3B	The licensee's provisions for land vehicle control measures satisfy regulatory requirements and licensee commitments.
1/24/98	Positive	IR 97-10	N	PS	1C 2A 3A	The licensee maintained an effective security program. Management support was evident based on the implementation of the security program. Audits were thorough and in-depth, alarm station operators were knowledgeable of their duties and responsibilities, communications requirements were being performed in accordance with the NRC-approved physical security plan (the Plan) and assessment aids had good picture quality and excellent zone overlap. Effective controls were in place for identifying, resolving and preventing programmatic problems and security training was being performed in accordance with the NRC-approved training and qualification (T&Q) plan.
11/1/97	Positive	IR 97-09	N	PS	3A 1C	All openings in the protected area boundary were controlled properly by the security department for the entire 12R refueling outage. Based on this improved performance, the inspectors concluded that GPUN had taken effective corrective actions for prior problems.
11/1/97	Positive	IR 97-09	N	PS	3A	NSA conducted a good quality audit of the RC area with proper scope and depth. The surveillances by RC personnel resulted in the correction of numerous minor deficiencies.
11/1/97	Positive	IR 97-09	N	PS	3A 3B	The selection, training, and qualification of contracted radiological control technicians for the outage were in accordance with requirements. The new radiation worker coaching process set up by radiological controls (RC) Field Operations was a good initiative.

THREE MILE ISLAND 1 PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/1/97	NCV Negative	IR 97-09 EEI 97-09-06 NCV 97-09-06	L	PS	3A	A contract worker failed to follow the high radiation control procedure; the action led to an unlocked high radiation area, the 'B' OTSG shield door, with the potential for an inadvertent radiation exposure greater than personnel limits. This failure was similar to a prior problem that occurred in the 1993 and 1995 refuel outages. This issue appeared to be a violation of TS 6.8.1, in that procedures for locking high radiation areas were not followed. NCV closed EEI 97-09-06. (Enforcement Discretion per VII B.1 of the Enforcement Policy)
11/1/97	Positive	IR 97-09	N	PS	3A 1C	Activities to maintain personnel exposures as low as reasonably achievable (ALARA) were generally considered strong, especially the prejob reviews.
11/1/97	VIO	IR 97-09 EA 97-533-03014 EEI 97-09-05 VIO 97-09-05	S	PS	3A 3B	GPUN failed to survey adequately during the removal of the reactor vessel seal plates. As such, adequate hot particle controls were not in place and did not prevent a personnel skin contamination. This appears to be a failure to follow TS 6.11. VIO EA 97-533-03014 issued 1/27/98 closed EEI 97-09-05. (Violation of TS 6.11)
11/1/97	Positive	IR 97-09	N	PS	3A	Adequate contamination controls and radiation survey and monitoring programs were being carried out. However, weak attributes were noted in the establishment and maintenance of contaminated areas and in the survey program. Local postings did not agree with the area conditions and material was allowed to cross contaminated area boundaries. In these cases the radiation protection staff corrected the conditions.
11/1/97	Positive	IR 97-09	N	PS	2A	Material conditions continued to be good. Equipment needed to meet TS requirements for shutdown conditions was maintained and operated well.
11/1/97	Negative	IR 97-09	N	PS	3A	Generally, housekeeping degraded over the outage. This degradation was particularly evident in the reactor building (RB), where outage related activities resulted in large amounts of debris to be left on floors and surfaces. The debris observed included nails and pieces of wood and sawdust from scaffolding activities, plastic tie-wraps from the installation of temporary hoses and cables, a large roll of sheet plastic, pop-rivet stems from sheet metal installations, and tape materials left following work.

ABBREVIATIONS USED IN PIM TABLE

AMSE	American Society of Mechanical Engineers
CAP	Corrective Action Process
CAS	Central Alarm Station
CF	Core Flood
DDD	Design Basis Document
DH	Decay Heat
DR	Decay River
EA	Enforcement Action
ECCS	Emergency Core Cooling System
EQ	Equipment Qualification
ES	Emergency Safeguards
GORB	General Office Review Board
GPUN	GPU Nuclear, Inc.
HPRB	Human Performance Review Board
I&C	Instrument and Control
IST	Inservice Test
LER	Licensee Event Report
MR	Maintenance Rule
MU	Makeup
NI	Nuclear Instrument
NRC	Nuclear Regulatory Commission
NSA	Nuclear Safety Assessment
NSCC	Nuclear Safety and Compliance Committee

OE	Operational Experience
OTSG	Once Through Steam Generator
PMT	Post Maintenance Test
PORV	Power Operated Relief Valve
PRG	Plant Review Group
RB	Reactor Building
RBEC	Reactor Building Emergency Cooler
RC	Radiological Controls
RCP	Reactor Coolant Pump
RCS	Reactor Coolant System
RHR	Residual Heat Removal
RPS	Reactor Protection System
RR	Reactor River
SAS	Secondary Alarm Station
SE	Safety Evaluation
SFP	Spent Fuel Pool
SS	Shift Supervisor
SSCs	Systems, Structures and Components
TMI	Three Mile Island
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report

GENERAL DESCRIPTION OF PIM TABLE COLUMNS

Date	The actual date of an event or significant issue for those items that have a clear date of occurrence (mainly LERs), the date the source of the information was issued (such as for EALs), or the last date of the inspection period (for IRs).
Type	The categorization of the item or finding - see the Type / Findings Type Code table, below.
Source	The document that describes the findings: LER for Licensee Event Reports, EAL for Enforcement Action Letters, or IR for NRC Inspection Reports.
ID	Identification of who discovered issue: N for NRC; L for Licensee; or S for Self Identifying (events).
SFA	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
Code	Template Code - see table below.
Item Description	Details of NRC findings on LERs that have safety significance (as stated in IRs), findings described in IR Executive Summaries, and amplifying information contained in EALs.

TYPE / FINDINGS CODES

ED	Enforcement Discretion - No Civil Penalty
Strength	Overall Strong Licensee Performance
Weakness	Overall Weak Licensee Performance
EEL *	Escalated Enforcement Item - Waiting Final NRC Action
VIO	Violation Level I, II, III, or IV
NCV	Non-Cited Violation
DEV	Deviation from Licensee Commitment to NRC
Positive	Individual Good Inspection Finding
Negative	Individual Poor Inspection Finding
LER	Licensee Event Report to the NRC
URI **	Unresolved Item from Inspection Report
Licensing	Licensing Issue from NRR
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc. The type of all MISC findings are to be put in the Item Description column.

TEMPLATE CODES

1	Operational Performance: A - Normal Operations; B - Operations During Transients; and C - Programs and Processes
2	Material Condition: A - Equipment Condition or B - Programs and Processes
3	Human Performance: A - Work Performance; B - Knowledge, Skills, and Abilities / Training; C - Work Environment
4	Engineering/Design: A - Design; B - Engineering Support; C - Programs and Processes
5	Problem Identification and Resolution: A - Identification; B - Analysis; and C - Resolution

NOTES:

- * EELs 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 EELs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** 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. 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.

ENCLOSURE 2

THREE MILE ISLAND 6 MONTH INSPECTION PLAN

INSPECTION	TITLE/PROGRAM AREA	PLANNED DATES	TYPE INSPECTION COMMENTS
IP 83726	Control of Radiation Materials and Contamination, Surveys and Monitoring	6/1/98	Regional Initiative
IP 86750	Solid Radioactive Waste Management and Transportation of Radioactive Materials	7/20/98	Core Inspection
IP 92903	Engineering Follow-up	8/10/98	Regional Initiative
IP 81700	Physical Security Program	8/31/98	Core Inspection
IP 82301	Emergency Preparedness Exercise	9/30/98	Regional Initiative
IP 83750	Occupational Radiation Exposure	10/26/98	Core Inspection

Legend:

- IP - Inspection Procedure
- TI - Temporary Instruction
- Core Inspection - Minimum NRC Inspection Program (mandatory at all plants)
- Regional Initiative - Additional Inspection Effort Planned by Region I