March 8, 2002

Mr. Jack Skolds
President and CNO
Exelon Nuclear
Exelon Generation Company, LLC
200 Exelon Way, KSA 3-E
Kennett Square, PA 19348

SUBJECT: THREE MILE ISLAND STATION, UNIT 1-NRC INSPECTION REPORT 50-289/01-13

Dear Mr. Skolds:

On February 9, 2002, the NRC completed an inspection at your Three Mile Island Unit 1 facility. The enclosed report documents the inspection findings which were discussed on February 14, 2002, with Mr. Gellrich and other members of your staff.

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

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

Immediately following the terrorist attacks on the World Trade Center and the Pentagon, the NRC issued an advisory recommending that nuclear power plant licensees go to the highest level of security, and all promptly did so. With continued uncertainty about the possibility of additional terrorist activities, the Nation's nuclear power plants remain at the highest level of security and the NRC continues to monitor the situation. This advisory was followed by additional advisories, and although the specific actions are not releasable to the public, they generally include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with law enforcement and military authorities, and more limited access of personnel and vehicles to the sites. The NRC has conducted various audits of your response to these advisories and your ability to respond to terrorist attacks with the capabilities of the current design basis threat (DBT). On February 25, 2002, the NRC issued an Order to all nuclear power plant licensees, requiring them to take certain additional interim compensatory measures to address the generalized high-level threat environment. With the

issuance of the Order, we will evaluate (LICENSEE'S) compliance with these interim requirements.

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

Sincerely,

/RA C. Cowgill for/

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

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

Enclosure: NRC Inspection Report 50-289/01-13
Attachment: Supplemental Information

cc w/encl:
Amergen Energy Company - Correspondence Control Desk
Mr. Bruce Williams, Vice President, TMI Unit 1
J. McElwain, Manager, Regulatory Assurance
G. Gellrich, Plant Manager
M. Gallagher, Director-Licensing
J.A. Benjamin, Licensing - Vice President, Exelon Corporation
TMI-Alert (TMIA)
D. Allard, PADER
M. Schoppman, Framatome

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

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U.S. NUCLEAR REGULATORY COMMISSION

REGION 1

Docket No:	50-289
License No:	DPR-50
Report No:	50-289/01-13
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Three Mile Island Station, Unit 1
Location:	PO Box 480 Middletown, PA 17057
Dates:	December 30, 2001 - February 9, 2002
Inspectors:	J. Daniel Orr, Senior Resident Inspector Craig W. Smith, Resident Inspector Paul H. Bissett, Senior Operations Engineer, DRS John G. Caruso, Senior Operations Engineer, DRS
Approved by:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000289/01-13, on 12/30/2001 - 2/9/2002, AmerGen Energy Company, LLC, Three Mile Island Unit 1, integrated resident inspector report, adverse weather protection, maintenance risk assessments, post-maintenance testing.

The report covered a six-week period of inspection by resident inspectors and two region-based senior operations engineers. The inspection identified three Green findings which were classified as non-cited violations. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- **Green**. AmerGen failed to take adequate corrective actions to address previous ventilation system heater failures and allowed the auxiliary building temperature to fall below the design basis limit. The failure challenged the operability of the containment purge isolation valve and the boric acid heat trace system located in the auxiliary building. This problem also occurred in November 2000.

  The safety significance of AmerGen's failure to maintain auxiliary building temperatures above the design basis limit was very low (Green), because maintenance personnel restored the temperature above the 60°F limit prior to the operability of risk significant structures, systems, or components being adversely affected. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, AmerGen failed to identify auxiliary building temperature below the design limit in December 2001 and also failed to take adequate corrective actions in response to the November 2000 problem to assure auxiliary building temperatures remained above the design basis limit at all times. (Section 1R01)

- **Green.** Operators failed to initiate prompt actions to identify an inoperable intake structure bar rake and to evaluate the affect on plant risk from this emergent equipment issue. The intake structure is a support system for several safety-related river water cooling systems. The error resulted in AmerGen not taking appropriate risk management actions in response to the failed rake.

  The safety significance of AmerGen's failure to promptly initiate actions to investigate the inoperable 'C' bar rake was very low (Green), because the 'C' traveling screen, and the bar rakes and traveling screens in the 'A' and 'B' intake channels remained operable. (Section 1R13.1)

- **Green**. AmerGen failed to establish proper inservice test (IST) reference values and acceptance criteria for the 'B' decay heat removal river water pump (DR-P-1B) following a modification that replaced the pump internals with an improved design. The errors resulted in establishing non-conservative acceptance criteria that would have allowed significant pump degradation to occur before requiring corrective actions to be taken.

The safety significance of this finding was very low (Green) because DR-P-1B remained within the correct acceptable performance range and there was no undetected, negative trend in pump performance. TMI technical specification 4.2.2 requires inservice testing of DR-P-1B to be conducted in accordance with the American Society of Mechanical Engineers (ASME) Code. The IST engineers' failure to establish proper reference values and acceptance criteria for DR-P-1B following modification to improve pump performance was a violation of the technical specification requirement to conduct inservice testing in accordance with the ASME Code. (Section 1R19.1)

B. Licensee Identified Violations

- No violations were identified.

Report Details

Summary of Plant Status

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

1 REACTOR SAFETY

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

R01 Adverse Weather Protection

a. Inspection Scope

The inspectors reviewed AmerGen's implementation of operations surveillance OPS-S85, "Winterization Checks." The inspection focused on cold weather protection measures to protect the river water intake structure, condensate water storage tanks, and ventilation systems in risk significant structures. The inspectors walked down portions of these structures and independently verified the adequacy of the cold weather protection measures. The inspectors reviewed AmerGen's corrective action process (CAP) database to verify problems concerning cold weather protection were being identified and resolved at an appropriate threshold.

b. Findings

The inspectors determined that AmerGen failed to take adequate corrective actions to address previous ventilation system heater failures and allowed the auxiliary building temperature to fall below the design basis limit. The safety significance of this finding was very low (Green) because AmerGen restored auxiliary building temperature above the design basis limit prior to adversely impacting the operability of risk significant systems. AmerGen's failure to take adequate corrective actions to prevent a recurrence of this problem constituted a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action."

On December 27, 2001, the inspectors identified ambient temperatures in the auxiliary building had fallen below the design basis temperature limit of 60°F. The inspectors observed temperatures as low as 58.3°F on the auxiliary building temperature recorder. The inspectors found the ventilation supply heaters tagged out-of-service for corrective maintenance. The work management organization failed to ensure that the heaters were returned to service prior to the onset of cold weather conditions. Additionally, control room operators were not aware of the 60°F temperature limit and did not initiate actions to restore auxiliary building temperatures above the design basis limit until the deficient condition was identified by the inspectors.

In November 2000, AmerGen identified similar low temperature conditions in the auxiliary building and entered the issue into its CAP for resolution (T2000-0967). The cause was determined to be unreliable heater control. Immediate corrective actions were taken and two heaters were returned to service. Maintenance on the other heater control was deferred due to parts obsolescence. The heater controls were still out-of-service when the inspectors identified the repeat problem in December 2001.

Following the November 2000 problem, a corrective action was assigned to the system engineering department to review the auxiliary building design temperature limit. In September 2001, system engineers completed an evaluation reaffirming the 60°F limit. However, this information was not incorporated into plant operating procedures. The 60°F ambient temperature limit was required to maintain a 30°F design margin above the material property limit for the containment purge isolation valve and was the ambient temperature assumed in the design of the boric acid heat trace system. In December 2001, control room operators were not aware of the requirement for maintaining auxiliary building temperature above the 60°F limit.

This finding was more than minor because, if left uncorrected, failure to maintain plant equipment within the operating parameters assumed in the design basis could adversely impact the operability of risk significant systems. The safety significance of AmerGen's failure to maintain auxiliary building temperatures above the design basis limit was very low (Green), because maintenance personnel restored the temperature above 60°F prior to challenging the operability of risk significant structures, systems, or components. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, AmerGen failed identify the low temperature in December 2001 and also failed to take adequate corrective actions following November 2000, to assure auxiliary building temperatures were maintained above the design basis limit at all times. However, because of the very low safety significance of this finding, and because AmerGen entered the issue into its corrective action process (CR 00088243), this violation is being treated as a non-cited violation (**NCV 50-289/01-13-01**).

R04 Equipment Alignment

.1 Nuclear Service Closed Cooling Water System Walkdown

a. Inspection Scope

The inspectors conducted a complete system walkdown of the nuclear service closed cooling water (NSCCW) system. The NSCCW system was chosen because of its risk importance for supplying cooling water to the reactor coolant pump thermal barrier heat exchangers. References and aspects of the NSCCW reviewed to verify the system was properly aligned and fully operable included the NSCCW design basis document, operating procedure 1104-1, "Nuclear Service Closed Cooling Water System," abnormal procedure 1203-20, "Nuclear Services Closed Cooling System Failure," NSCCW maintenance backlog, updated final safety analysis report, system engineer interviews, physical walkdown of all NSCCW accessible areas, and insights from AmerGen's probabilistic risk analysis for TMI. The inspectors reviewed the CAP database to verify that AmerGen identified and resolved equipment alignment problems at an appropriate threshold.

b. Findings

No findings of significance were identified.

.2 Partial Equipment Alignments

a. Inspection Scope

The inspectors conducted one partial system walkdown on the 'A' decay heat river water system train while the 'B' train was out-of-service for planned maintenance. The decay heat river water system serves a risk significant function as the primary means of reactor decay heat removal for normal plant shutdowns and for design accident conditions. The inspectors verified the system alignment was in accordance with operating procedure 1104-32, "Decay Heat River Water System," and that operating parameters were consistent with the plant operating condition.

b. Findings

No findings of significance were identified.

R05 Fire Protection

a. Inspection Scope

The inspectors conducted fire protection inspections in the control building inverter and battery rooms, the fuel handling building refuel floor, and the new fuel storage vault. The rooms and areas were selected based on enclosing equipment important to safety. The inspectors conducted plant walkdowns and verified the areas were as described in the fire hazard analysis report. The plant walkdowns included observations of combustible material control, fire detection and suppression equipment operability, and compensatory measures established for degraded fire protection equipment.

b. Findings

No findings of significance were identified.

R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed a simulator training session on January 14, 2002, for an operating crew consisting of licensed reactor and senior reactor operators. The inspectors observed procedure implementation and operator responses for a loss of off-site power with a failed emergency diesel generator and an uncomplicated reactor plant trip. Afterwards, the inspectors observed the training instructors' and shift manager's drill critique.

b. Findings

No findings of significance were identified.

R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors verified AmerGen's implementation of the maintenance rule for a high pressure injection system status change from a(1) to a(2) and an equipment problem that resulted from an improperly installed bearing support on the 'A' decay heat removal pump. Aspects of maintenance rule implementation inspected included safety significance classification, a(2) performance monitoring or a(1) goal setting and corrective actions, and maintenance preventable function failure determinations. The inspectors referenced: 10 CFR 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants;" NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Plants;" and AmerGen administrative procedure 1082, "NRC Maintenance Rule."

b. Findings

No findings of significance were identified.

R13 Maintenance Risk Assessments and Emergent Work Evaluation

.1 Intake Structure Emergent Work Risk Evaluation

a. Inspection Scope

On January 2, 2002, the inspectors toured the intake structure and found the 'C' bar rake not operating. The inspectors interviewed plant operators and system engineers, reviewed the intake structure design basis, and referenced AmerGen administrative procedure 1082.1, "TMI Risk Management Program," to assess the risk significance of this emergent equipment issue.

b. Findings

The inspectors determined that operators did not promptly initiate actions to repair an inoperable intake structure bar rake and to evaluate the increased risk resulting from this emergent equipment issue. The safety significance of this finding was very low (Green) because the associated traveling screen for the 'C' intake channel, and the bar rakes and traveling screens in the 'A' and 'B' intake channels, remained operable.

The TMI intake structure and river water pump house supports all safety-related and nonsafety-related river water cooling systems. The intake structure has three separate intake channels that flow into a common river water pump suction bay. Each intake channel includes a bar rake and a traveling screen which function to limit river water debris from entering the pump suctions. The rakes and screens operate in automatic on a pre-set timer or in response to a high differential pressure caused by debris collecting on the rake or screen surface. The timers are set to operate the rakes and screens at

staggering 8 hour intervals. Washing the traveling screens and removing debris from the bar rakes during all modes of plant operation is a risk significant function in TMI's maintenance rule program.

On January 2, 2002, the inspectors found the 'C' bar rake not operating when it should have been based on a valid start signal from the automatic timer. The inspectors observed the other two bar rakes and all three traveling screens operating as expected. On January 3, 2002, the inspectors identified no work request was entered in TMI's work management system identifying the inoperable 'C' bar rake, although the auxiliary operator log required verifying operation of all three bar rakes and screens each shift. The auxiliary operator entered a note in the turnover log concerning the 'C' bar rake not operating, but a work request was not initiated to investigate the cause and make the necessary repairs. The inspectors discussed the condition of the 'C' bar rake with the operations shift manager, who was aware of the situation based on the turnover log entry, but had not initiated actions to determine the cause or evaluate the impact on plant risk.

The inspectors discussed the risk significance of the inoperable bar rake with the system engineer. The system engineer was not aware of the inoperable bar rake, because no work request was initiated. On January 4, 2002, two days after the initial failure of the 'C' bar rake, and after discussing the situation with the system engineer, operations completed a risk evaluation. The evaluation resulted in a yellow risk condition, slightly higher risk of core damage or large early release. Yellow is one increment above the lowest risk category of green. As a result of the higher risk condition, operators put into place required compensatory actions to increase the monitoring of intake structure equipment and river conditions. A work request was submitted and the 'C' bar rake was repaired and returned to service later that day.

This finding was more than minor because if left uncorrected, failure to promptly initiate corrective actions for emergent equipment issues, could result in an unidentified, increased level of plant risk without appropriate risk management actions being put into place. The safety significance of AmerGen's failure to promptly initiate corrective actions to investigate the inoperable 'C' bar rake was very low (Green), because the 'C' traveling screen, and the bar rakes and traveling screens in the 'A' and 'B' intake channels remained operable. AmerGen entered the issue into its CAP (CR 00088989).

.2 Other Maintenance Risk Evaluations

a. Inspection Scope

The inspectors reviewed AmerGen's planning and risk assessments for two risk significant maintenance activities: the 'B' decay heat river water pump replacement and emergent repairs to the reactor coolant system flow instrument for the 'C' reactor protection system channel. The inspectors reviewed the risk assessment of these maintenance activities with respect to 10 CFR 50.65(a)(4). The inspectors referenced AmerGen administrative procedure 1082.1, "TMI Risk Management Program," and NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants."

b. Findings

No findings of significance were identified.

R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability evaluations for a 'C' high pressure injection valve control panel switch failure and an anomaly with the 'B' reactor coolant pump status monitor. The 'C' high pressure injection valve control panel switch failed to remotely operate the associated motor-operated valve. Wiring discrepancies were identified by maintenance technicians working in the vicinity of the panel switch and prompted control room operators to investigate the switch operation. The 'B' reactor coolant pump status monitor had a sluggish instrument response that was identified during associated surveillance testing. The reactor coolant pump status monitors input trip signals to the reactor protection system.

The inspectors verified that the degraded conditions were properly characterized, that operability of the affected systems was properly justified or inoperability considered and the appropriate action statements completed, and that no unrecognized increase in plant risk resulted from the equipment issues.

b. Findings

No findings of significance were identified.

R19 Post-Maintenance Testing

.1 'B' Decay River Water Pump Replacement

a. Inspection Scope

The inspectors observed post-maintenance testing of the 'B' decay river water pump (DR-P-1B) following a modification to replace the pump internals with an improved design. AmerGen conducted the post-maintenance testing on January 3, 2002, using TMI surveillance procedure 1300-3D, "IST [Inservice Testing] of DR [Decay River] Pumps and Valves." The inspectors observed portions of the test and compared the test results against the acceptance criteria established by the test procedure. The inspectors reviewed system design documents and maintenance records to determine if the acceptance criteria were appropriately established and in accordance with American Society of Mechanical Engineers (ASME) code requirements.

b. Findings

The inspectors found that AmerGen failed to establish the correct reference values and acceptance criteria for DR-P-1B hydraulic performance following a modification that replaced the pump internals with an improved design. The safety significance of this finding was very low (Green) because DR-P-1B remained in the correct acceptable performance range and there was no undetected, negative trend in pump performance. AmerGen's failure to establish the correct reference values and acceptance criteria was contrary to ASME code requirements and constituted a violation of TMI technical specification (TS) 4.2.2.

On January 2, 2002, AmerGen installed a modification on DR-P-1B to improve the hydraulic performance and the pump shaft coupling design. Hydraulic performance was improved through installation of a larger pump impeller. Maintenance personnel completed the modification and operations conducted post-maintenance testing on January 3, 2002, using surveillance procedure 1300-3D. Surveillance procedure 1300-3D provided acceptance criteria for monitoring pump performance against established reference values in accordance with Section XI of the ASME code. The ASME code required that new reference values and acceptance criteria be determined following modification that affected pump hydraulic performance. The IST engineers documented the new DR-P-1B reference values and acceptance criteria in engineering change request (ECR) 02-00005 dated January 3, 2002.

In reviewing ECR 02-00005, the inspectors identified that IST engineers established reference values and acceptance criteria contrary to ASME code requirements. The ASME code established acceptance criteria for pump hydraulic performance depending on the pump design (centrifugal, vertical line shaft, or positive displacement). DR-P-1B is a vertical line shaft pump. The inspectors found that the IST engineers inappropriately applied the acceptance criteria for a centrifugal pump. For a vertical line shaft pump, the ASME code established an acceptance criteria for the pump head alert range at five percent to seven percent degradation from the measured reference value, and for the pump head required action range at greater than seven percent degradation from the measured reference value. For centrifugal pumps, the ASME code establishes a less restrictive pump head required action range at greater than ten percent degradation from the measured reference value. The IST engineers inappropriately applied the less restrictive centrifugal pump acceptance criteria to the vertical line shaft DR-P-1B. The inspectors also identified that the IST engineers adjusted the DR-P-1B pump head reference value in a non-conservative direction from the 40.2 pounds per square inch differential (psid) measured during the post-maintenance test to 39.0 psid with no justification provided in ECR 02-00005. The cumulative affect of the two errors was that DR-P-1B hydraulic performance could have degraded 4.8 psid, or 11.9 percent degradation from the measured reference value, before the IST program would have required action to be taken. The correct acceptance criteria would have required an evaluation of pump performance after 2.0 psid of degradation, or five percent degradation from the measured reference value.

This finding was more than minor because, if left uncorrected, failure to follow regulatory requirements for monitoring equipment performance could result in AmerGen not identifying and taking corrective actions to resolve equipment performance issues prior to the operability of systems important to safety being challenged. The safety

significance of this finding was very low (Green) because DR-P-1B remained within the correct acceptable performance range and there was no undetected, negative trend in pump performance. The IST engineers' failure to establish correct reference values and acceptance criteria for DR-P-1B following modification that affected pump performance was a violation of TMI TS 4.2.2. TMI TS 4.2.2 requires that IST of ASME Code Class 3 pumps, such as DR-P-1B, shall be performed in accordance with Section XI of the ASME Boiler and Pressure Vessel Code and applicable Addenda, as required by 10 CFR 50, Section 50.55a(f). However, because of the very low safety significance of this finding, and because AmerGen entered the issue into its CAP (CR 00093427), this violation is being treated as a non-cited violation (**NCV 50-289/01-13-02**).

.2 Other Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance tests performed by AmerGen in conjunction with work activities on the'C' high pressure injection valve indicting lights, the main steam atmospheric dump valves (ADVs) and the 'B' reactor coolant pump status monitor. The ADVs provide a risk significant function and means for decay heat removal when the main condenser is not available. The reactor coolant pump status monitors input trip signals to the reactor protection system. The inspectors verified that the post-maintenance test procedures and test activities were adequate to verify operability and functional capability prior to the affected systems being returned to service.

b. Findings

No findings of significance were identified.

R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the following surveillance tests:

- 1302-5.4, "Reactor Protection System Flux Flow Comparator"
- 1300-3B, "Inservice Test of 'A' and 'B' Decay Heat Pumps and Valves"
- 1300-3G, "Inservice Test of Turbine Driven Emergency Feedwater Pump and Valves"

The surveillances all involved risk significant systems. The inspectors observed portions of the selected surveillance tests and verified, based on the test results, that the systems met TS and procedural requirements. The inspectors reviewed AmerGen's CAP for problems identified during previous performances of the tests to determine if problems involving surveillance testing were being identified and resolved at an appropriate threshold.

b. Findings

No findings of significance were identified.

4 OTHER ACTIVITIES

OA6 Management Meetings

Exit Meeting Summary

On February 14, 2002, the resident inspectors presented the inspection results to members of AmerGen management led by Mr. Gellrich. AmerGen acknowledged the findings presented. AmerGen did not indicate that any of the information presented at the exit meeting was proprietary.

ATTACHMENT A

SUPPLEMENTAL INFORMATION

a. Key Points of Contact

D. Atherholt, Shift Operations Superintendent
G. Gellrich, Plant Manager
J. Stanley, Acting Director, Site Engineering
D. McDermott, Director, Maintenance
J. McElwain, Manager, Regulatory Assurance
S. Queen, Senior Manager, Plant Engineering
J. Robertson, Plant Operations Director
B. Williams, Vice President, TMI Unit I

b. Items Opened, Closed, and Discussed

Opened and Closed

50-289/01-13-01	NCV	Failure to Take Adequate Corrective Actions for Monitoring Equipment Performance
50-289/01-13-02	NCV	Failure to Follow Regulatory Requirements for Monitoring Equipment Performance

c. Acronyms

ADAMS	Agencywide Documents and Management System
ADV	Atmospheric Dump Valves
AmerGen	AmerGen Energy Company, LLC
ASME	American Society of Mechanical Engineers
CAP	Corrective Action Process
CFR	Code of Federal Regulations
DR	Decay River Water System
DRS	Division of Reactor Safety
ECR	Engineering Change Request
IR	Inspection Report
IST	Inservice Test
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
NSCCW	Nuclear Service Closed Cooling Water
psid	Pounds per Square Inch Differential
TMI	Three Mile Island, Unit 1
TS	Technical Specification