UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

October 18, 2000

William A. Eaton, Vice President
Operations - Grand Gulf Nuclear Station
Entergy Operations, Inc.
P.O. Box 756
Port Gibson, Mississippi 39150

SUBJECT: GRAND GULF - NRC INSPECTION REPORT NO. 50-416/00-07

Dear Mr. Eaton:

On September 1, 2000, the NRC completed an inspection at your Grand Gulf Nuclear Station facility. The enclosed report presents the results of this inspection. The preliminary results of the inspection were discussed on September 1, 2000, with you and members of your staff. A telephonic exit meeting was conducted on September 13, 2000, with Mr. Jerry Roberts to inform your staff of the results of the in-office review following the team's departure from the site.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The team concluded that problems were properly identified, evaluated and resolved within the problem identification and resolution programs. However, during the inspection, examples of minor problems were identified. The team noted that your resolution of two Non-Cited Violations for inadequate corrective actions were narrowly focused or incomplete. Your followup for inadequate corrective actions for main steam isolation valve failures did not identify a potentially generic problem incorporating industry operating experience. Also, your followup for inadequate corrective actions for repetitive service water check valve failures did not identify that one of the contributing causes was overly narrow searches for similar issues in response to the individual valve failures.

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 (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

John L. Pellet, Chief
Operations Branch
Division of Reactor Safety

Docket No.: 50-416
License No.: NPF-29

Enclosure:
NRC Inspection Report No.
50-416/00-07

cc w/enclosure:
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SOE:OB	SOE:OB	SOE:OB	PE:PBA	SRI:PBA
MEMurphy/lmb	SLMcCrory	PCGage	DBAllen	NFOKeefe
/**RA**/	/**RA**/	/**RA**/	/**RA**/	/**RA**/
09/26/00	09/24/00	09/27/00	09/26/00	09/27/00

C:OB	C:PBA	C:OB		
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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-416
License No.:	NPF-29
Report No.:	50-416/00-07
Licensee:	Entergy Operations, Inc.
Facility:	Grand Gulf Nuclear Station
Location:	Waterloo Road Port Gibson, Mississippi
Dates:	August 28 through September 1, 2000
Team Leader:	M. E. Murphy, Senior Operations Engineer, Operations Branch
Inspectors:	D. B. Allen, Project Engineer, Project Branch A P. C. Gage, Senior Operations Engineer, Operations Branch S. L. McCrory, Senior Operations Engineer, Operations Branch N. F. O'Keefe, Senior Resident Inspector, Project Branch A
Approved By:	John L. Pellet, Chief Operations Branch Division of Reactor Safety

ATTACHMENTS:

Attachment 1:	Supplemental Information
Attachment 2:	Material Requested
Attachment 3:	NRC's Revised Reactor Oversight Process

Summary of Findings

IR 05000416-00-07; 08/28-09/01/2000; Entergy Operations, Inc.;Grand Gulf Nuclear Station; Annual Baseline Inspection of the Identification and Resolution of Problems.

The inspection was conducted by three regional operations engineers, one resident inspector, and a regional project engineer.

Identification and Resolution of Problems

- The licensee was effective at identifying problems and putting them into the corrective action program. The licensee's program was effective at problem identification. The licensee effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementation of corrective actions. Corrective actions, when specified, were generally implemented in a timely manner. Licensee audits and assessments were found to be effective. Based on the interviews conducted during this inspection, workers at the site felt free to input safety issues into the problem identification and resolution program. However, the licensee's resolution of two Non-Cited Violations for inadequate corrective actions were narrowly focused or incomplete. The licensee's followup for inadequate corrective actions for main steam isolation valve failures did not identify a potentially generic problem incorporating industry operating experience. The licensee's followup for inadequate corrective actions for repetitive service water check valve failures did not identify that one of the contributing causes was overly narrow searches for similar issues in response to the individual valve failures.

Report Details

4 OTHER ACTIVITIES

4OA2 Identification and Resolution of Problems

.1 Effectiveness of Problem Identification

a. Inspection Scope:

The team reviewed items that pertained to the seven cornerstones of the reactor safety, radiation safety, and safeguards strategic performance areas to determine if problems were appropriately being identified, characterized, and entered into the corrective action program. Items reviewed included 121 condition reports initiated in the time period from July 1999 to the present. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings:

Based on a review of the licensee's records, the team concluded that the licensee effectively identified problems. The team identified no findings related to problem identification. The team's review of Condition and Event Reports and comparison to operating events found no instances where previously unidentified problems were not revealed. This was exhibited in the team's review of Licensee Event Report 1999-004-00, the licensee's Condition Reports GGN-1999-1054 and GGN-1999-1083 and Root Cause Analysis Report RCER 99-30 concerning the failure of Division 3 Diesel Generator 'B' bearing. The team concurred in the licensee's conclusion that the cause of the event was a loss of configuration control.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope:

The team reviewed 121 condition reports and supporting documentation and observed condition review group meetings to verify that identified issues were appropriately characterized, an appropriate analysis of the cause of the problem was performed for significant conditions adverse to quality, and the risk associated with combinations of issues was appropriately considered. In addition, the team reviewed the licensee's evaluation of selected industry experience information to assess if issues applicable to Grand Gulf Nuclear Station were appropriately addressed. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings:

Based on a review of the licensee's records, the team concluded that the licensee effectively prioritized and evaluated issues. The team identified no findings related to

prioritization and evaluation of issues. In general, issues were appropriately characterized and appropriate evaluations were conducted for significant conditions adverse to quality. The team did not identify any issues regarding the risk associated with combinations of issues.

However, during the team's review of the manner in which the licensee had reviewed and incorporated industry information it was determined that in one instance the licensee had not incorporated vendor recommendations appropriately. In the case of the General Electric service information letters associated with routine inspection of main steam isolation valves, the licensee had concluded that they applied to Grand Gulf Nuclear Station and created actions into routine work documents to incorporate inspections to detect if Grand Gulf Nuclear Station was experiencing the stated problems. The condition report for each was then closed, so no tracking of completion was in effect. The team determined that the station did not disassemble main steam isolation valves unless absolutely necessary. This, in effect, bypassed the original corrective actions for the subject service information letters to create a run to failure situation, since the problems described in the service information letters could not be detected by nonintrusive methods, and were known to lead to valve operating failures. During the Fall 1999 outage, in response to test failures, the licensee opened, inspected, and repaired all eight main steam isolation valves. The NRC had previously concluded that the history of problems with the main steam isolation valves indicated a pattern of inadequate corrective actions, and issued Non-Cited Violation 50-416/0002-01 for violation of 10 CFR Part 50, Appendix B, Criterion XVI. In response to the team's observation, the licensee agreed to review the generic implications of incorporating industry experience into work instructions without tracking to completion, and wrote Condition Report 00-1329 to track this effort.

.3 Effectiveness of Corrective Actions

a. Inspection Scope:

The team reviewed condition reports, quality assurance audits, and self-assessments to verify that corrective actions commensurate with the issues were identified and implemented in a timely manner, including corrective actions to address common cause or generic concerns. Information that the team reviewed was selected in the time period from July 1999 to the present. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings:

Based on a review of the licensee’s records, the team concluded that the licensee effectively implemented corrective actions. The team identified no findings related to the effectiveness of corrective actions. However, the team noted multiple examples where generic implications, repetitive conditions, and common cause circumstances were not captured in the licensee's initial attempt to resolve failed surveillance tests of standby service water Stop Check Valves P41-F169A/B, as documented within Condition Reports CR-GGN-1999-0802, CR-GGN-1999-0526, CR-GGN-1999-1180, and CR-GGN-1999-1177.

The team's review of these condition reports and supporting materials indicated that the licensee's initial review of the extent of the check valve surveillance failures was not comprehensive and coordinated so that all related conditions were identified. For example, the team noted that the initial reviews failed to capture the same surveillance test failures on similar components. The team noted that there were at least eight similar conditions documented within the paperless condition report system. These initial reviews relied on narrowly focused searches that reduced the effectiveness of the generic impact and common cause reviews for the same failed surveillance conditions. This was not identified by the licensee during its resolution of the problem.

The team noted that a Non-Cited Violation was documented in NRC Inspection Report 50-416/9912-01 for inadequate corrective actions regarding the repetitive valve failures. Subsequent to the Non-Cited Violation, the licensee's staff had implemented a more aggressive approach in identifying the root cause and implementing adequate corrective actions. These actions included increasing testing frequency from quarterly to twice a month, implementing a revision to Surveillance Test Procedure 06-OP-1P41-Q-0005, "Standby Service Water Loop B Valve and Pump Operability Test," Revision 110, the issuing Category C Significant Condition Report CR-GGN-1999-1279, and completing an in-depth root-cause analysis of the failures, which identified 27 potential causes. The potential causes were grouped, eliminated, and combined to produce five root causes and contributors. The final corrective action included the replacement of the stop check valves with an in-line check valve with spring assist closure. The team noted no subsequent failures had occurred since the completion of these actions.

The team also noted that several of the licensee's quality assurance audits identified corrective actions that were deficient. The team reviewed each of these occurrences and determined that none constituted a significant condition adverse to quality and that all were of low safety significance. None of the examples were inadequate with respect to the applicable regulations. Where appropriate, the licensee increased the priority of the re-evaluation and root-cause determination after concluding that the initial corrective actions were less than adequate.

.4 Effectiveness of Licensee Audits and Assessments

a. Inspection Scope:

The team reviewed 12 licensee audits and 6 assessments performed since July 1999. The review was conducted to determine whether the findings from the audits were appropriately captured in action requests. A listing of the audits reviewed during the inspection is attached to the report.

b. Issues and Findings:

Based on a review of the listed licensee's audits and assessments, the team identified no findings related to the effectiveness of licensee audits and assessments. The findings from the audits and assessments reviewed were found to be appropriately captured in action requests and consistent with this inspection team's findings. The

team reviewed QPA 05.02-99 "Effectiveness of Corrective Actions and Quality Assurance Program Manual," which exemplified the basis for the team's conclusion. The audit generated several Condition Reports to followup on identified corrective actions that wereineffective. In each case the licensee increased the priority of the re-evaluation and root cause determination to identify the appropriate level of corrective actions. The team concurred in the results of the licensee's actions.

.5 Assessment of Safety Conscious Work Environment

a. Inspection Scope:

The team interviewed three managers, five supervisors, and eight engineers regarding the licensee's employee concerns program. These interviews assessed whether conditions existed that would challenge the establishment of a safety conscious work environment.

b. Issues and Findings:

Based on interviews, the team identified no findings related to the safety conscious work environment. The team concluded, based on information collected from interviews with 16 licensee personnel, that these employees were willing to identify issues and accepted the responsibility to proactively identify and enter safety issues into the corrective action program.

4OA3 Event Follow-up

(Closed) Violations 50-416/EA-99-305-01013, -01023, -01033, -01043: Division III diesel generator inoperable for 74 days, inadequate annunciator response procedure, failure to comply with procedural requirements in planning a work package to add oil to Division III diesel generator bearing, and failure to enter two identified concerns in the corrective action program. The licensee’s root cause and corrective actions had been adequately addressed in NRC Inspection Report No. 50-416/99-19; Licensee Event Report 1999-004; Entergy Letter GNR0-2000/00002, dated February 4, 2000; and Supplemental NRC Inspection Report No. 50-416/00-09.

4OA6 Meetings

Exit Meeting Summary

The team presented the preliminary inspection results to Mr. Eaton, and other members of licensee management at the conclusion of the onsite inspection on September 1, 2000. The licensee's management acknowledged the findings presented.

A telephonic exit meeting was held on September 13, 2000, with Mr. Roberts, and other licensee staff members, during which the team leader characterized the results of the in-office review following the team's departure from the site.

The team asked the licensee's management whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

A. Barfield, Manager, Design Engineering
C. Bottemiller, Manager, Licensing
C. Brooks, Sr. Licensing Specialist
S. Burris, Supervisor, Engineering
D. Cupstid, Outage Management
W. Deck, Superintendent, Security
N. Deshpande, Supervisor, Design Engineering
W. Eaton, Vice President
J. Edwards, Manager, Maintenance
C. Ellsaesser, Manager, Corrective Action and Assessment
M. Gwynn, Manager, Emergency Preparedness
C. Lambert, Director, Engineering
L. Patterson, Superintendent, Chemistry
B. Raines, Employee Concerns Coordinator
M. Renfroe, Manager, Engineering Programs and Components
J. Roberts, Director, Nuclear Safety Assurance
J. Robertson, Manager, Quality Assurance
W. Shelly, Manager, Training/Emergency Preparedness
G. Sparks, Manager, Operations
C. Stafford, Site Management
T. Thornton, Supervisor, Engineering
J. Venable, General Manager
C. Welling, Manager, Technical Support
D. Wiles, Manager, Engineering Support
R. Wilson, Superintendent, Radiation Protection
M. Wright, Manager, Planning and Scheduling

NRC
P. Alter, Resident Inspector

ITEMS CLOSED

Closed

50-416/ EA-99-305-01013	VIO	Division III diesel generator inoperable from July 9 to Sept 21, 1999 (Section 4OA3).
50-416/ EA-99-305-01023	VIO	Inadequate annunciator response procedure for "Generator RTD TEMP HI" Alarm (Section 4OA3).
50-416/ EA-99-305-01033	VIO	Failure to comply with the procedural requirements to adequately plan a work package to add oil to the Division III diesel generator bearing (Section 4OA3).
50-416/ EA-99-305-01043	VIO	Failure to enter two identified concerns in the corrective action program (Section 4OA3).

PARTIAL LIST OF DOCUMENTS REVIEWED

PROCEDURES

01-S-06-1, Protective Tagging System, Revision 43

02-S-01-12, Station Operating Orders, Revision 102

02-S-01-2, Control and Use of Operations Section Directives, Revision 35

02-S-01-5, Shift Logs and Records, Revision 107

02-S-01-9, Key Control, Revision 21

Entergy, Nuclear Management Manual, Company Procedure NO. LI-102, Corrective Action Process, Revision 0

01-S-11-10, GGNS Employees' Security Responsibilities, Revision 30

06-OP-1P41-Q-0005, Standby Service Water Loop B Valve and Pump Operability Test, Revision 110

01-S-06-5, Incident Reports / Reportable Events, Revision 104

01-S-06-44, Operability Assessment, Revision 103

Radiation Protection Standards and Expectations, Revision 7

Operations Expectations and Standards, May 9, 2000

Operational Experience Reviews

GGNS Operating Experience Group review documents for NRC Information Notices 99-14, 99-21, and 2000-01

Licensee Event Reports

Licensee Event Report 1999-004-00, HPCS System Declared Inoperable Because of a Diesel Generator Shaft Bearing Failure, October 12, 1999

Licensee Event Report 1999-004-01, HPCS System Declared Inoperable Because of a Diesel Generator Shaft Bearing Failure, December 10, 1999

Licensee Event Report 1999-005, Containment isolation valve failed repeatedly, 11/18/99

Licensee Event Reports 99-06, 99-07, 00-01

Engineering Requests

00/0188-00, Evaluate margin between relief vlv stpt and system operating pressure, 5/30/00

00/0231-00, Evaluate margin between relief valve accuracy and test equip accuracy, 7/26/00

00/0232-00, Evaluate relief vlv design to prevent failures due to rust accumulation, 7/26/00

Root Cause Analyses

RCER 99-30, “Failure of Division 3 Diesel Generator ‘B’ Bearing”
99-1279 CA007, "1P41-169A/B check valve failed surveillance"

CONDITION REPORTS

96-0553	99-0686	99-1103	99-1662	00-0173	00-0816
97-0059	99-0723	99-1147	99-1713	00-0177	00-0842
98-0066	99-0742	99-1151	99-1727	00-0192	00-0874
98-0090	99-0751	99-1177	99-1730	00-0204	00-0917
98-0092	99-0802	99-1180	99-1822	00-0257	00-0922
98-0096	99-0905	99-1181	99-1831	00-0275	00-0947
98-0097	99-0946	99-1213	99-1863	00-0281	00-0948
98-0101	99-0951	99-1279	99-1954	00-0370	00-1060
98-0104	99-0962	99-1279	99-1961	00-0386	00-1061
98-0175	99-0989	99-1355	99-1969	00-0393	00-1063
98-0740	99-1004	99-1383	99-2004	00-0419	00-1123
98-0757	99-1040	99-1429	00-0006	00-0479	00-1191
98-0845	99-1044	99-1463	00-0028	00-0536	00-1213
98-1027	99-1054	99-1474	00-0049	00-0578	00-1228
98-1329	99-1083	99-1479	00-0087	00-0596	00-1229
99-0145	99-1084	99-1496	00-0135	00-0601	00-1231
99-0372	99-1085	99-1505	00-0155	00-0705	00-1236
99-0460	99-1090	99-1523	00-0158	00-0730	00-1243
99-0526	99-1098	99-1528	00-0162	00-0759	00-1244
99-0675	99-1099	99-1653	00-0166	00-0809	
99-0681	99-1102				

Assessments and Audits

QPA 25.01.00, Measuring and Test Equipment Program, 03/03/00
QPA 20.01-99, Document Control, Records, and Procedure Reviews, 10/07/99
QPA 05.01.00, Effectiveness of Corrective Actions Resulting from Non-Cited Violations, 06/01/00
QPA 09.01-00, Annual/Biennial Fire Protection Audit, 04/13/00
Quality Assurance Audit of Material, Purchasing, and Contracts, 06/28/00
QPA 04.01-99, Training and Qualification, 08/25/99
QPA 05.02-99, Effectiveness of Corrective Actions and Quality Assurance Program Manual, 11/1/99
QPA 24.01-99, Test Control Program, Attachment A to GIN 99/01604
QPA 07.01-00, Emergency Operating Procedures/ Severe Accident Procedures, 03/01/00
QPA 12.01-00, NPDES, Environmental Protection Plan and Haz Mat Training / Response, 02/18/00

QPA 22.01-00, Special Process Control & Inspection, 06/15/00
QPA 40.01-99, Fitness for Duty Program, 09/02/33
QA Surveillance, GIN 2000-0307, Review of Emergency Response Organization Training, 03/20/00
Physical security, safeguards contingency, and security training and qualification plans, 10/26/99
Audit Report 12.01-99, "ODCM, REMP, Reg. Guide 4.15," 09/16/99
Audit Report 31.01-99, "Special Nuclear Materials Program," 12/06/99
QPA 32.01-99, "Low Level Waste and NRC Approved Packaging Program, 02/02/00
Operations Program Assessment, 01/13/00
Station Engineering Program Assessment, 12/15/99
Maintenance/ Work Management Assessment, 09/09/99
Outage Readiness Assessment, 05/28/99
Chemistry Assessment, 10/13/99
"D" Shift Protective Tag Assessment, 04/06/00

Miscellaneous

Operations Human Performance Monthly Trend Reports for April through July, 2000

Entergy letter dated 2/4/00, GNR0-2000/00002, "Response to Apparent Violation In Inspection Report No. 50-416/99-19 Dated January 7, 2000 (GNR1-2000-00001)"

Quarterly Trend Report, 1st Quarter 1999

Quarterly Trend Report, 2nd Quarter 1999

Quarterly Trend Report, 3rd Quarter 1999

Quarterly Trend Report, 4th Quarter 1999

Quarterly Trend Report, 1st Quarter 2000

Quarterly Trend Report, 2nd Quarter 2000

ATTACHMENT 2

Material Requested for the 71152 Inspection

Information Request
Grand Gulf PIR Inspection

Please provide the following:

1. A listing of all significant condition reports, chronologically, from July 1999 to present.
2. A copy of all self assessments, audits and program metrics.
3. An index of all condition reports, with departmental and chronological grouping from July 1999 to present.
4. A copy of all administrative procedures relating to the Condition Reporting and Corrective Action Program, with all related procedures such as reportability and operability.

5. The complete packages for the following Condition Reports: CR-GGN-

1996-0013	1999-0946	1999-1523	2000-0173
1998-0066-00	1999-0951	1999-1713	2000-0177
1998-0066-01	1999-0962	1999-1714	2000-0185
1998-0090	1999-1044	1999-1727	2000-0186
1998-0092	1999-1054	1999-1773	2000-0192
1998-0096	1999-1083	1999-1822	2000-0198
1998-0097	1999-1084	1999-1831	2000-0204
1998-0098	1999-1085	1999-1863	2000-0229
1998-0101	1999-1090	1999-1954	2000-0275
1998-0104	1999-1098	1999-1976	2000-0307
1998-0175	1999-1099	1999-1997	2000-0536
1998-0845	1999-1103	2000-0006	2000-0544
1998-1027	1999-1147	2000-0028	2000-0545
1999-0372	1999-1213	2000-0056	2000-0583
1999-0460	1999-1270	2000-0087	2000-0584
1999-0675	1999-1355	2000-0122	2000-0617
1999-0681	1999-1383	2000-0155	2000-0759
1999-0755	1999-1458	2000-0158	2000-0805
1999-0832	1999-1471	2000-0162	2000-0842
1999-0866	1999-1479	2000-0166	2000-0947

ATTACHMENT 3

NRC's REVISED REACTOR OVERSIGHT PROCESS

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

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

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

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

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

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

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