March 7, 2001

Mr. Ron J. DeGregorio
Vice President Oyster Creek
AmerGen Energy Company, LLC
P.O. Box 388
Forked River, New Jersey 08731

SUBJECT: OYSTER CREEK GENERATING STATION - NRC INSPECTION REPORT 05000219/2000-010

Dear Mr. DeGregorio:

On February 10, 2001, the NRC completed an inspection at your Oyster Creek reactor facility. The enclosed report presents the results of that inspection. The results of this inspection were discussed on March 2, 2001, with you and other members of your staff.

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

Based on the results of this inspection, the inspectors identified three issues of very low safety significance (Green). These issues, regarding the failure to properly review and control a temporary modification, the failure to follow a procedure requiring the removal of a foreign material exclusion plug from a reactor building differential pressure transmitter, and inadequate configuration control associated with a service water pump vent valve, were determined to involve violations of NRC requirements. However, because of the very low safety significance and because they have been entered into your corrective action program, the NRC is treating these issues as a 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 Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region 1; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Oyster Creek facility.

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We appreciate your cooperation. Please contact me at 610 337-5146 if you have any questions regarding this letter.

Sincerely,

/RA/

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

Docket/License Nos.: 05000219/DPR-16

Enclosure: Inspection Report 05000219/2000-010

cc w/encl:
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REGION I

Report No.	05000219/2000-010
Docket No.	05000219
License No.	DPR-16
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Oyster Creek Generating Station
Location:	Forked River, New Jersey
Dates:	December 31, 2000 - February 10, 2001
Inspectors:	Laura A. Dudes, Senior Resident Inspector Thomas R. Hipschman, Resident Inspector
Approved By:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

Oyster Creek Generating Station
NRC Inspection Report 05000219/2000-010

IR 05000219-00-010 on 12/31/00-02/10/01, Amergen, Oyster Creek Generating Station. Equipment alignment, post maintenance testing, temporary modifications.

The inspection was conducted by resident inspectors. The inspection identified three green issues which were also non-cited violations. The significance of issues is indicated by their color (green, white, yellow, red) and was determined by the Significance Determination Process (SDP) in Inspection Manual 0609 (see Attachment 1).

Cornerstone: Initiating Events

- Green. The inspectors identified a Non-cited violation (Technical Specification 6.8.1) for failure to follow Procedure 322, "Service Water System," Attachment 1, requiring a service water vent valve be open. The service water pump failed to develop discharge pressure because the normally open pump casing vent valve was found closed. The inspector identified that the licensee failed to, promptly identify this issue in a corrective action document, verify positive configuration control of that specific valve and ensure that the appropriate configuration control had been maintained on that system. In response, the licensee documented the issue in their corrective action system (CAP 2001-0011) and performed an extent of condition review on all service water pumps in the intake area.

  This service water pump is used to provide cooling water for the turbine building and reactor building closed cooling systems. Loss of service water is modeled as a reactor trip initiating event if the circulating water system is not available. The failure of the service water pump to develop discharge pressure was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for initiating event because the alternate service water pump and the circulating water pumps were available. **(NCV 0500219/2000-010-01)** (Section 1R04)

Cornerstone: Barrier Integrity

- Green. The inspectors identified a Non-cited violation for failure to follow procedures (Technical Specification 6.8.1) to remove a foreign material exclusion plug from the reactor building differential pressure transmitter as required by the job order.

  This differential pressure transmitter is used by operators for entry into abnormal or emergency operating procedures to mitigate the release of fission products from the reactor building to the atmosphere. The failure of the reactor building differential pressure transmitter would be considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for barrier integrity because the licensee was able to take compensatory readings from other instrumentation. **(NCV 0500219/2000-010-02)** (Section 1R19)

- Green. The inspectors identified a Non-cited violation for procedure 108.8, “Temporary Modification Control,” which was inadequate to implement and control a temporary heater that was used during periods of freezing weather to maintain the reactor building differential pressure transmitter operable.

  This differential pressure transmitter is used by operators for entry into abnormal or emergency operating procedures to mitigate the release of fission products from the reactor building to the atmosphere. The failure of the reactor building differential pressure transmitter was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for barrier integrity because the licensee was able to take compensatory readings from other instrumentation. **(NCV 0500219/2000-010-03)** (Section 1R23)

Cross-cutting Issues: Problem Identification and Human Performance

- NO COLOR. Problem identification and human performance errors were identified in the initiating event and barrier integrity cornerstone areas. Operations and maintenance personnel exhibited inadequate procedural adherence with respect to service water system configuration control and reactor building differential pressure transmitter operability. In addition, the licensee identified these issues in the operators shift logs but did not promptly enter them into their corrective action program. (Sections 1R04, 1R19 and 1R23) The safety significance of these individual events was very low.

Report Details

Summary of Plant Status:

Oyster Creek began the inspection period at or near full power. On January 20, 2001, power was reduced to approximately 30 percent to perform main steam isolation valve testing and repair a heater drain tank instrument level column. On January 25, 2001, the licensee again reduced power to approximately 23 percent in order to make repairs to a condenser mechanical vacuum trip device that had the potential to cause an inadvertent plant transient if left uncorrected. Oyster Creek maintained nominal full power for the remainder of the inspection period.

1. REACTOR SAFETY
Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R04 Equipment Alignment

.1 Service Water System

a. Inspection Scope

The inspectors performed a walkdown of the service water system to verify that the licensee properly identified and resolved equipment alignment problems that could impact system availability.

b. Findings

On January 1, 2001, operations personnel started the No. 2 service water (SW) pump in response to a low intake water level. The pump failed to develop discharge pressure because the pump casing continuous vent valve (V-3-300) was closed. This valve is normally open to provide a vent path for non-condensible gases.

The inspector reviewed the system operating procedure and performed a walkdown of portions of the service water system. The inspector identified that the licensee failed to, promptly identify this issue in a corrective action document, verify positive configuration control of that specific valve and ensure that the appropriate configuration control had been maintained on that system. In response, the licensee documented the issue in their corrective action system (CAP 2001-0011) and performed an extent of condition review on all service water pumps in the intake area. The licensee was unable to determine the cause for the valve being closed, however as a result of the extent of condition review they did identify another configuration control problem. The licensee determined the continuous vent valve on the No.1 SW pump was throttled, instead of in the normally full open position as required.

The inspectors concluded that the licensee did not promptly identify this configuration control issue nor adequately address all of the configuration control actions in a timely manner. The failure to maintain the pumps' vent valves in accordance with Procedure 322, "Service Water System," Attachment 1, is a violation of Technical Specification 6.8.1.a "Procedures and Program" and 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings." However, because this condition was

corrected in a timely manner and has been entered into the corrective action program (CAP 2000-0011), this violation is being treated as a Non-cited violation (NCV) consistent with Section VI.A.1 of the Enforcement Policy **(NCV 0500219/2000-010-01).**

This service water pump is used to provide cooling water for the turbine building and reactor building closed cooling systems. Loss of service water is modeled as a reactor trip initiating event if the circulating water system is not available. In addition, the loss of service water causes the loss of reactor building closed cooling water (RBCCW) which results in a loss of cooling to the reactor recirculation pumps. Loss of RBCCW requires operators to initiate a manual reactor trip. The failure of the service water pump to develop discharge pressure was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for initiating events because the alternate service water pump and the circulating water pumps were available.

.2 Emergency Diesel Generator Fuel Oil Transfer System and Electrical Breaker Alignment

a. Inspection Scope

The inspector performed a partial walkdown of the emergency diesel generator (EDG) support systems including the fuel oil transfer system and the electrical switchgear alignment. The inspector reviewed procedure attachment 636.4.013-1, “Diesel Generator Oil Tank Transfer System Check-Off,” and verified that the system was capable of providing adequate fuel supply to the EDG under required conditions. In addition, the inspector verified that all electrical output breakers required to close upon an automatic emergency diesel generator start were charged and available to operate.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

.1 Fire Suppression Equipment Walkdowns

a. Inspection Scope

The inspectors conducted fire protection activities consisting of plant walkdowns, discussions with fire protection personnel, and reviews of procedure 333, “Plant Fire Protection System,” and the Oyster Creek Fire Hazards Analysis Report. Plant walkdowns included observations of combustible material control, fire detection and suppression equipment availability, and compensatory measures. The inspectors conducted fire protection inspections in the following areas due to the potential to impact mitigating systems:

- 480 Volt Switchgear Room, Halon Suppression System
- Control Room Halon Suppression System
- Redundant Fire Water Pumps and Tank
- 4160 Volt Switchgear Room, Cardox Suppression System
- Reactor Building Fuel Floor (119')

b. Findings

No findings of significance were identified.

.2 Fire Drill Observation

a. Inspection Scope

On January 4, 2001, the inspector observed an announced fire drill conducted near the nitrogen compressor on the 51' elevation of the reactor building. The inspector noted that the drill training coordinator appropriately designated that this drill did not meet the procedural expectations criteria and initiated a corrective action document CAP (2001-0019) because only two of four of the designated fire brigade members arrived fully dressed in appropriate gear and prepared to suppress the fire. In addition, management conducted briefings with their work groups to reinforce station expectations for fire brigade response duties.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed licensed operator simulator training on January 11, and January 25, 2001, to verify that the Oyster Creek operator requalification program ensured safe power plant operation. In addition the inspectors observed the post simulator scenario critique to assess the licensee's effectiveness in evaluating and correcting any observed deficiencies.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed the periodic evaluations required by 10 CFR 50.65 (a)(3) for the Oyster Creek Generating Station to verify that structures, systems and components (SSC) within the scope of the maintenance rule were properly evaluated and dispositioned.

The inspectors selected the following safety significant systems in (a)(1) status to verify that: (1) goals and performance criteria were appropriate, (2) industry operating experience was considered, (3) corrective action plans were effective, and (4) performance was being effectively monitored:

- Reactor Vessel: The inspector reviewed action plans associated with the Core Spray Weld Leaks Identified in 17R and 18R.

- Nuclear Fuel: Reviewed status of fuel bundle failures and operating recommendations to preclude future fuel failures.

The inspectors selected the following safety significant systems in (a)(2) status to verify the system performance compared to the licensee's performance criteria was acceptable:

- Drywell Hydrogen and Oxygen Monitoring

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

Turbine Vacuum Trip System

a. Inspection Scope

On January 25, 2001, operators received a condenser low vacuum alarm during steady state full power operations. The licensee determined that condenser vacuum was normal and that one of the two vacuum trip systems was giving a false indication due to mechanical binding. The inspector reviewed the weekly on-line maintenance schedule to verify that the appropriate risk management changes were made due to the emergent activity and during the power reduction for troubleshooting and repair. In addition, the inspector reviewed the scope of the work, operability evaluations and temporary modifications associated with the troubleshooting and repair of the No. 1 vacuum trip system.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability determinations associated with the following plant equipment challenges:

- 000666-010, Deletion of H2/O2 Monitor from engineered safeguards in the Updated Final Safety Analysis Report (UFSAR)
- 000641-120 and 000641-121, Main Turbine Vacuum Trip System

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing

.1 Reactor Building Differential Pressure Transmitter

a. Inspection Scope

On February 8, 2001, the inspector observed the installation of the alternate replacement reactor building differential pressure (d/p) transmitter and reviewed the post maintenance testing documentation. The transmitter is a control room indication used for operator entry into abnormal or emergency operating procedures.

b. Findings

The inspector found a foreign material exclusion (FME) plug installed in the reactor building d/p transmitter after operations personnel declared the transmitter operable. Although the transmitter appeared to be indicating reactor building d/p correctly, this was a degraded condition which could have hampered the operation of the transmitter. The inspector determined that a maintenance technician did not follow the directions in the job order (JO 548700) and failed to remove the FME plug. Additionally, operations and maintenance personnel demonstrated inadequate procedural adherence to procedure 106, "Conduct of Operations," because the job order was not forwarded to operations for completion of post-maintenance testing, although operations had declared the transmitter operable. Operations documented the issue in their corrective action process. These two instances of failure to comply with the job order procedures are a violation of Technical Specification 6.8.1.a "Procedures and Programs" and 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings." However, because these conditions were corrected in a timely manner and have been entered into the corrective action program (CAPs 2001-0196, 2001-0204), this violation is being treated as a Non-cited violation (NCV) consistent with Section V1.A.1 of the Enforcement Policy. **(NCV 0500219/2000-010-02)**

This differential pressure transmitter is used by operators for entry into abnormal or emergency operating procedures to mitigate the release of fission products from the reactor building to the atmosphere. The failure of the reactor building differential pressure transmitter was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for containment barrier because the licensee was able to take compensatory readings from other instrumentation.

.2 Additional Post Maintenance Testing

a. Inspection Scope

The inspector reviewed and observed portions of the following post maintenance testing because of their function as a barrier integrity system:

- 'A' & 'B' H2O2 Analyzer calibration, 604.4.020
- Containment Spray/Emergency Service Water Pump Operability and Inservice Test/Heat Exchanger Cleanliness Evaluation, 607.4.004

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

.1 'A' & 'B' H2O2 Drywell Analyzers

a. Inspection Scope

The inspector reviewed surveillance test procedures 604.4.019 and 604.4.020 "'A' & 'B' H2O2 Analyzer Calibration," to verify that the analyzers were capable of performing their safety function as required by technical specifications and the Updated Final Safety Analysis Report (UFSAR). The inspector reviewed the surveillance test results, interviewed personnel, and sampled the licensee's corrective action program for problems identified during past performance of this surveillance to determine the licensee's threshold for identifying and resolving problems.

b. Findings

No findings of significance were identified.

.2 Emergency Diesel Generator Load Test

a. Inspection Scope

The inspector reviewed the data associated with the bi-weekly emergency diesel generator No. 2 load test, 636.4.013. The inspector verified that all support system were aligned properly and that the technical specification surveillance requirements were met.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

During a routine plant status tour, the inspector observed a halogen light placed on top of a reactor building (d/p) transmitter to keep it from freezing. The inspector reviewed plant operating logs and noted that this transmitter froze four times since December 23, 2000. The inspector reviewed procedure 108.8, "Temporary Modification Control," to determine if this light constituted a temporary modification. In response to the inspectors questions the licensee developed temporary modification document 108.8-3, 2001-004, File No. 20.70.01.07. The inspector also reviewed these engineering documents.

b. Findings

Three instances of the transmitter freezing occurred as a result of inadequate temporary modification controls and procedures. The transmitter initially froze on December 23, 2000. To correct the problem, the shift manager directed placing a halogen lamp on top of the transmitter's weather cover to provide heat to keep it from freezing. On December 29, 2000, the transmitter froze when the halogen light was found unplugged. On January 1, 2001, the light fell off the transmitter cover, and the transmitter froze.

At the time, the licensee did not consider the halogen light to be a temporary modification. However, the inspector observed that without the light, the transmitter was susceptible to freezing during cold weather conditions, and therefore relied on the halogen light to remain operable. The licensee did not have an established procedure to identify the use of additional equipment such as fans or heaters (e.g., halogen lamp) which were used to maintain safety related equipment operable as a temporary modification. The licensee responded by putting the issue into their corrective action system to document inadequate temporary modification controls (CAP 2001-0048). Additionally, the licensee evaluated the temporary modification (engineering evaluation 108.8-1 File No. 20.70.01.07) and added the issue to their temporary modification tracking system. However, the document did not provide adequate operating instructions and checks. Procedure 108.8, "Temporary Modification Control," requires operations personnel to verify each temporary modification quarterly unless otherwise specified. However, since no specific instructions were provided, quarterly checks were inadequate to identify problems that could occur during periods of freezing weather. On February 4, 2001, the halogen light bulb burned out and the transmitter froze again until a replacement halogen bulb could be located (CAP 2001-0174).

The inspectors identified that the licensee's procedure to identify and document temporary modifications was inadequate because fans and heaters used to maintain equipment operable were not addressed. This inadequate procedure to implement and control a temporary modification is a violation of Technical Specification 6.8.1.a "Procedures and Program" and 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings." However, because this condition was corrected in a timely manner and has been entered into the corrective action program (CAPs 2001-0048,

2001-0174), this violation is being treated as a Non-cited violation (NCV) consistent with Section VI.A.1 of the Enforcement Policy **(NCV 0500219/2000-010-03)**

This differential pressure transmitter is used by operators for entry into abnormal or emergency operating procedures to mitigate the release of fission products from the reactor building to the atmosphere. The failure of the reactor building differential pressure transmitter was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for containment barrier because the licensee was able to take compensatory readings from other instrumentation.

Emergency Preparedness

EP6 Drill Evaluation

a. Inspection Scope

The inspector observed a series of emergency preparedness training exercises performed to qualify two new individuals for the Emergency Support Director (ESD) position as defined by the Oyster Creek Emergency Preparedness Implementing Procedure, EPIP-OC-.25. The inspector verified that the scenarios were conducted in accordance with licensee procedures and regulatory requirements. The inspector also verified that the emergency action level classifications and protective action recommendations were appropriate to the drill.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

Reactor Coolant System Activity

a. Inspection Scope

The inspectors reviewed performance indicator (PI) data from the 1st quarter of 2000, through the 4th quarter of 2000, for *Reactor Coolant System (RCS) Activity* to verify its accuracy. The inspectors used Nuclear Energy Institute (NEI) 99-02, Revision 0, "Regulatory Assessment Performance Indicator Guideline," as guidance, interviewed licensee personnel responsible for compiling the information, and observed a chemistry technician obtain and analyze an RCS sample.

b. Findings

No findings of significance were identified.

4OA4 Cross-cutting Issues - Problem Identification and Human Performance

Problem identification and human performance errors were identified in the initiating event and barrier integrity cornerstone areas. Operations and maintenance personnel exhibited inadequate procedural adherence with respect to service water system configuration control and reactor building differential pressure transmitter operability. In addition, the licensee identified these issues in the operators shift logs but did not promptly enter them into their corrective action program. (Sections 1R04, 1R19 and 1R23) The safety significance of these individual events was very low. (NO COLOR)

4OA6 Meetings, including Exit

Exit Meeting Summary

On March 2, 2001, the resident inspectors presented the inspection results to Mr. Ron DeGregorio and other members of licensee management. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee (in alphabetical order)
V. Aggarwal, Director, Engineering
R. Brown, Manager, Experience Assessment
E. Cartwright, Director, Work Management
R. DeGregorio, Vice President
B. DeMerchant, Licensing Engineer
J. Grisewood, EP Manager
E. Harkness, Plant Manager
D. Larson, Emergency Planners
J. Magee, Director, Maintenance
D. McMillan, Senior Manager, Systems
K. Mulligan, Director, Training
D. Slear, Senior Manager, Design
R. Tilton, Manager, Assessment
C. Wilson, Senior Manager, Operations

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

0500219/2000-010-01	NCV	Failure to maintain configuration control of the service water system in accordance with Procedure 322, “Service Water System,” Attachment 1.
0500219/2000-010-02	NCV	Failure to follow procedures (Technical Specification 6.8.1) to remove a foreign material exclusion plug from the reactor building differential pressure transmitter as required by the job order.
0500219/2000-010-03	NCV	Inadequate procedure (Technical Specification 6.8.1) to implement and control a temporary modification that was used during periods of freezing weather to maintain the reactor building differential pressure transmitter operable.

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
AmerGen	AmerGen Energy Company, LLC
CAP	Corrective Action Process
CFR	Code of Federal Regulations
d/p	Differential Pressure
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
EDG	Emergency Diesel Generator
EPIP	Emergency Preparedness Implementing Procedure
ESD	Emergency Support Director
ESW	Emergency Service Water
FME	Foreign Material Exclusion
IST	Inservice Test
JO	Job Order
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
NSIC	Nuclear Safety Information Center
PI	Performance Indicator
RBCCW	Reactor Building Closed Cooling Water
RCS	Reactor Coolant System
SDP	Significance Determination Process
SSC	Structures, Systems and Components
SW	Service Water
TS	Technical Specification
UFSAR	Updated Final Safety Analysis

ATTACHMENT 1

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
- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness

Radiation Safety
- Occupational
- Public

Safeguards
- Physical Protection

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.