October 13, 2000

Mr. Ted C. Feigenbaum
Executive Vice President and Chief Nuclear Officer
Seabrook Station
North Atlantic Energy Service Corporation
c/o Mr. James M. Peschel
P. O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK GENERATING STATION - NRC INSPECTION REPORT NO. 05000443/2000-010

Dear Mr. Feigenbaum:

This refers to the problem identification and resolution inspection completed on September 15, 2000 at Seabrook. The enclosed report presents the results of this inspection. The results were discussed on September 15, 2000, with you and other members of your staff.

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.

Based on the results of the inspection, there were no findings identified during this inspection. The team concluded that problems were properly identified, evaluated and resolved within the problem identification and resolution programs.

In accordance with 10 CFR 2.790 of the NRC "Rules of Practice," a copy of this letter and its enclosures 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).

Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 05000443
License No. NPF-56

Enclosure: NRC Inspection Report No. 05000443/2000-010

cc w/encl:
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D. Brown-Couture, Director, Nuclear Safety, Massachusetts Emergency Management Agency
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M. Metcalf, Seacoast Anti-Pollution League
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S. Allen, Polestar Applied Technology, Incorporated

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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	05000443
License No:	NPF-56
Report No:	05000443/2000-010
Licensee:	North Atlantic Energy Service Corporation
Facility:	Seabrook Generating Station, Unit 1
Location:	Post Office Box 300 Seabrook, New Hampshire 03874
Dates:	August 28 - September 1, 2000 September 11 - 15, 2000
Inspectors:	James Noggle, Team Leader Javier Brand, Resident Inspector Alfred Lohmeier, Reactor Inspector Carl Sisco, Operations Engineer
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

Summary of Findings

Seabrook Generating Station, Unit 1
NRC Inspection Report 05000443/2000-010

IR 05000443-00-10; on 08/28-09/15/00; North Atlantic Energy Service Corporation; Seabrook Station, Unit 1; Annual baseline inspection of the Identification and Resolution of Problems.

The inspection was conducted by three regional inspectors and a resident inspector. This inspection was an examination of licensed activities as they relate to the identification and resolution of problems. No significant findings resulted from this inspection.

Identification and Resolution of Problems:

The team concluded that significant conditions adverse to safety were properly identified and captured in the condition report program. A recently implemented electronic condition reporting system along with additional computer workstations provided for use by the non-office staff, promoted easy access for the reporting of safety issues. Appropriate significance and priority of problems was assigned by a team representing all major departments. The formal root cause analyses reviewed were found to be appropriate. Lower significance issue cause evaluations were generally effective. A management review team, representing all departments, reviewed and approved all root cause evaluations and effectively screened the closure of condition reports that were significant conditions adverse to quality. Corrective actions for identified issues were commensurate with the safety significance of the issues. The corrections were sensitive to the necessity for reliable equipment performance. The extent of condition, generic applicability for significant conditions adverse to safety were properly considered and implemented. Corrective actions were generally effective in preventing recurrence. However, Seabrook has identified several repetitive and lingering minor problems for which corrective actions have not been fully effective. For example, human performance issues included tagging errors and unannounced emergency drill attendance. Seabrook maintained a separate engineering staff overseen by Nuclear Oversight that provided a broad review of both internal and external industry events. Appropriate awareness of significant industry operating experience was evident. Operating experience information was distributed and utilized by appropriate departments. An effective nuclear oversight audit and plant performance assessment program was complimented by a large number of departmental self-assessments of good quality. Assignment of departmental self-assessments was generally well focused. The team did not identify any indications of staff reluctance to bring forward safety issues.

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Report Details

4. OTHER ACTIVITIES (OA)

4OA1 Problem Identification and Resolution (IP 71152)

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team reviewed discrepancy items selected from various processes and activities to determine if the licensee was properly characterizing and entering problems into the corrective action program (CAP) for evaluation and resolution.

The team examined: control room logs; control room deficiencies; operability and reportability determinations; engineering supporting analyses; temporary modifications; system health reports; and problem identification (work orders) to identify safety issues and review the licensee's performance in accurately and completely identifying problems in a timely manner.

The team reviewed issues reported in approximately 150 condition reports representing all cornerstones classified as significant conditions adverse to quality and those that represented sufficient safety risk conditions to determine whether the licensee was properly characterizing and prioritizing problems into the corrective action program for evaluation and resolution. The team also interviewed plant personnel to identify and review other processes that may exist where problems or issues could be identified.

The team evaluated the licensee's use of external operating experience by the licensee in applying industry issues with respect to generic application to Seabrook Station. The team reviewed issues of similar or identical degraded plant equipment reported at other plants, and how the licensee utilized this information to preclude such degradation at the Seabrook site. Operating experience reviewed by the team included steam generator tube degradation as well as other areas.

b. Issues and Findings

There were no findings in this area identified during this inspection.

Significant conditions adverse to quality were properly identified and captured in the condition report program. The new electronic condition reporting system along with additional computer workstations provided for use by the non-office staff, promoted easy access for the reporting of safety issues. Systematic and accurate operability and reportability determinations were observed. Appropriate significance and priority of issues was assigned by a team representing all major departments. This team also effectively reviewed work requests to ensure that any applicable condition reports were written.

Seabrook maintained a separate engineering staff overseen by Nuclear Oversight that provided a broad review of both internal and external industry events. The team found

licensee awareness of significant industry operating experience evident in preventive maintenance activity directed at issues that have occurred at other plants on similar equipment.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

Since the last NRC inspection of the corrective action program implementation in July 1999, the team reviewed approximately 150 condition reports to evaluate the appropriateness of the resolution, including prioritization of issue, the depth and scope of the root cause analysis or common cause evaluation, and the recommended approach for problem resolution.

The team's sample selection included items from all seven cornerstones. The selection of condition reports was based on a review of the Seabrook Station Performance Summary Report for the first quarter of year 2000, plant risk insights derived from Seabrook individual plant evaluation, and system maintenance rule significance. The sample population included:

- 12 Category A condition reports for significant events that warrant prompt attention and require root cause analysis

- 131 Category B condition reports that require routine processing, including common cause evaluations

- Condition reports associated with 7 Non-Cited Violations (NCVs)
  The team examined the appropriateness of issue prioritizations, root cause evaluations (where warranted), the assigned corrective and preventive actions, and the associated engineering supporting analyses and operability determinations. The team also reviewed selected corrective action effectiveness reviews (CAERs) which were performed periodically in accordance with the Self-Assessment process.

b. Issues and Findings

There were no findings in this area identified during this inspection.

The significance category prioritization of condition report issues and formal root cause analyses that were reviewed were found to be appropriate (e.g., steam generator salt water intrusion, residual heat removal, service water pump vibration, and tritium discovery in the containment annulus). Lower significance issue cause evaluations were also generally effective. A management review team, representing all departments, reviewed and approved all root cause evaluations and effectively screened the closure of condition reports that were significant conditions adverse to quality.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed corrective actions associated with approximately 150 condition reports initiated since July 1999 to determine if appropriate corrective actions were prescribed and, where appropriate, implemented by the licensee. The sample of CRs selected was based on factors such as plant risk and maintenance rule significance. The team also reviewed the backlog of corrective actions to determine if there were any items that individually or collectively could present an adverse effect on plant risk significance or an adverse trend in the implementation of the corrective action program.

b. Issues and Findings

There were no findings in this area identified during this inspection.

Corrective actions to identified safety issues were commensurate with the safety significance of the issues. The corrections were sensitive to the necessity for reliable equipment performance. The extent of condition, generic applicability for significant conditions adverse to safety were properly considered and implemented. Risk worth of planned work activities were appropriately reviewed by Operations during shift turnover briefings and at daily plant morning meetings. The size of the corrective action backlog and timeliness of corrective action completion, with respect to safety significance, was formally tracked and managed. Corrective actions were generally effective in preventing recurrence. However, Seabrook has experienced several repetitive and lingering minor problems issues for which corrective actions have not been fully effective. For example, human performance issues included tagging errors and unannounced emergency drill attendance. Examples of equipment issues included: containment personnel hatch and rod motion nuisance alarms.

.4 Effectiveness of Licensee Audits and Self-Assessments

a. Inspection Scope

The team selectively sampled and reviewed approximately 13 out of 87 Nuclear Oversight (QA) audits and assessments and self-assessments completed by various departments since July 1999, to determine the following: (1) if problems and issues identified in CRs resulted in assessments to focus areas for improvement; (2) if the licensee's assessment of performance problems were understood; and (3) if the licensee's assessment of performance in the corrective action program area was comparable to the NRC's assessment results.

In particular, the team review of audit reports included: corrective action, chemistry control program, reactor engineering, and steam generator program.

Licensee self-assessments reviewed by the team included: comparison of human error DCNs to design engineering condition reports, assessment of the issues that accompanied the IP2 tube rupture, corrective action effectiveness, replacement valve strategy, and timely resolution of failure reports.

b. Issues and Findings

There were no findings identified in this area during the inspection.

An effective nuclear oversight audit and plant performance assessment program was found to be complimented by a large number of departmental self-assessments of good quality. Assignment of departmental self-assessments was generally focused on significant issues. The audits reviewed were found to be comprehensive and cover the focused areas. As a result, the audits provided recommendations for improvement in corrective action, chemistry control, reactor engineering, and steam generator operation. Likewise, the self-assessments covered a wide range of performance issues and provided recommendations for improved performance. Areas the team identified as repetitive minor problem areas (e.g., tagging errors and engineering design of minor modifications) were also identified by the licensee's oversight groups and were under appropriate evaluation.

.5 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During inspection interviews, the team probed the licensee's staff for reluctance of reporting safety problems. The team reviewed the licensee's safety conscious work environment program to determine if conditions existed that would challenge the establishment of a safety culture at Seabrook Station. The team reviewed Seabrook Station Culture Survey - Summer 2000, interviewed the employee concerns program manager, interviewed several plant personnel, and reviewed the records of employment termination interviews and concerns raised by plant personnel.

b. Issues and Findings

There were no findings identified in this area during the inspection.

The team found a professional and open demeanor of the staff and did not observe any instances of staff reluctance to bring forward safety issues and there were no indications of staff dissatisfaction with the resolution of plant problems. A recent culture survey indicated a positive safety culture environment.

4OA5 Management Meetings

.1 Exit Meeting Summary

The team presented the inspection results to Mr. Ted Feigenbaum and other members of the North Atlantic staff during an exit meeting on September 15, 2000. The licensee acknowledged the results presented. No information examined or reviewed during the inspection was considered to be proprietary.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

R. Bergeron, Electrical Engineering Manager
M. Carmichael, Nuclear Oversight Manager
W. Cash, Health Physics Manager
A. Chesno, Technical Maintenance Manager
W. Diprofio, Station Director
S. Dodge, Corrective Action Specialist
T. Feigenbaum, Executive Vice President and Chief Nuclear Officer
P. Freeman, Assistant Operations Manager
R. Godbout, Instrument and Controls Supervisor
G. Gram, Support Services Director
T. Grew, Technical Training Manager
J. Grillo, Assistant Station Director
P. Harvey, Chemistry Department Manager
W. Hinton, Instrument and Controls Technical Support
R. Jones, Corrective Action Specialist
W. Leland, Chemistry/HP Manager
M. Makowicz, Corrective Action Manager
J. Marchi, Audit Manager
T. Nichols, Technical Support Manager
M. Ossing, NRC Coordinator
J. Pandolfo, Security Manager
D. Perkins, Chem/HP Corrective Actions Coordinator
J. Peschel, Regulatory Programs Manager
P. Richardson, NSARC Chairman
B. Roach, Self-Assessment Program Manager
D. Sherwin, Maintenance Manager
E. Sovetsky, Technical Projects Supervisor
G. StPierre, Operations Manager
P. Stroup, Performance Improvement Manager
M. Strum, NSARC
D. Tailleart, Emergency Preparedness Manager
J. Vargas, Director of Engineering
S. Westing, Instrument and Controls Technical Support
R. White, Mechanical Engineering Manager
E. Woss, Consultant Engineer/Analyst

INSPECTION PROCEDURE USED

IP 71152 Identification and Resolution of Problems

ITEMS OPENED, CLOSED, AND DISCUSSED

Open/Closed: None

LIST OF ACRONYMS USED

ACR	Adverse Condition Report
CAP	Corrective Action Program
CAER	Corrective Action Effectiveness Review
CBA	Control Building Air Handling
CR	Condition Report
CS	Chemical and Volume Control System
DCN	Design Change Notice
DG	Diesel Generator
DOT	U.S. Department of Transportation
EDG	Emergency Diesel Generator
FW	Emergency Feedwater
HCV	Hydraulic Control Valve
HX	Heat Exchanger
I&C	Instrumentation and Controls
IN	USNRC Information Notice
ISI	Inservice Inspection
MA	Maintenance
NRC	Nuclear Regulatory Commission
NSARC	Nuclear Safety Audit and Review Committee
OE	Operating Experience
OR	Operations Report
PAH	Primary Auxiliary Building Air Handling
PCCW	Primary Closed Cooling Water
PRT	Pressurizer Relief Tank
RCA	Radiologically Controlled Area
RH	Residual Heat Removal
RHR	Residual Heat Removal
SA	Self-Assessment
SER	Significant Event Reports
S/G	Steam Generator
SI	Safety Injection
SSOE	Seabrook Station Operating Experience
SW	Service Water
WM	Work Management
WR	Work request

LIST OF LICENSEE PROGRAM DOCUMENTS REVIEWED

Procedures

PEG-48, Plant Engineering Guideline for Monitoring Printed Circuit Board Failures
Initiating a Condition Report, OE 3.1, Rev. 13
Initiating a Condition Report Using the Condition Reporting System, OR 5.1
Assignment and Approval of Actions and Tasks Using the Condition Reporting System, OR 5.5
Root Cause Analysis, OR 2.1, Rev. 2
Operating Experience Manual, SSOE, Rev. 31
Self-Assessment Manual, Rev. 0
Configuration Control during Maintenance and Troubleshooting, MA 4.5, Rev. 9
Temporary Modifications, MA 4.3, Rev. 15
On-Line Maintenance, WM 10.1, Rev. 2
Temporary Modifications, MA 4.3, Rev. 15
Repetitive Task Process, WM 8.2, Rev. 2
Work Request Process, WM 8.1, Rev. 2

Seabrook (Adverse) Condition Reports

Electrical

ACR 99-3661 Also CR 98-1709. Rod Motion Alarms Spurious Actuations
CR 00-08403 Failure of Westinghouse 7300 Card (also reviewed the total list of similar failed cards).
CR 99-5042 Rod H-12 in Shutdown Bank “E” Mis-aligned
CR 00-2021 Rod Control failure (also ACR’s 95-0032 and 97-2073)
CR 00-06708 Shutdown Bank “E”, Rods H-4 and H-12 Position Slippage

Low Pressure Turbine

ACR 99-2860 Low Pressure turbine dovetail cracking

Vibration

ACR 99-4557 RHR pump elevated vibration
ACR 99-4607 RHR pump vibration
ACR 99-4982 Both RHR pumps vibrating

Plant Operations

ACR 99-3105 Service Water system operations
ACR 99-3248 Area hi temperature condition
ACR 99-3327 Plant process computer
ACR 99-3821 Condenser air in leakage
ACR 99-3824 EDG switch positions
ACR 99-4484 CBA failure to auto start
ACR 00-0688 Refueling bridge surveillance

Human Performance
ACR 99-2626 Incorrect weld rod used in DG HX dissimilar metal weld
ACR 99-3506 Diaphragm plate found damaged
ACR 99-2724 Plant configuration control
ACR 99-2730 Switching and Tagging
ACR 99-3029 Switching and Tagging
ACR 99-3158 Shift Turnover Meetings
ACR 99-3159 Co-worker coaching
ACR 99-3160 Adverse trend human performance
ACR 99-3234 Plant configuration control
ACR 99-3256 Adverse trend human performance
ACR 99-3873 Missed tech spec surveillance
ACR 99-4333 Switching and tagging error
ACR 99-4384 Plant configuration control
ACR 00-07309 Adverse trend switching and tagging errors
ACR 00-08439 Adverse trend human performance

Steam Generator
ACR 00-0125 Steam generator salt water intrusion
ACR 00-0125 Steam generator salt water intrusion - Root Cause Analysis

Valves
ACR 99-3043 Ball bearing found in SI valve discussed seal leakage
ACR 99-3614 Water hammer following main turbine valve test
ACR 99-3193 Service water valve gear teeth broken off
ACR 99-2626 FW shell side relief valve leaking
ACR 99-3235 PRT level and pressure slowly increasing
ACR 99-3277 PCCW flow loop had loose control air fitting
ACR 99-3506 Valve diaphragm plate found damaged
ACR 99-3861 RH-HCV-607 failed stroke time during test

Public Radiation Safety

CR 99-13853 Identification of tritium in containment annulus
CR 99-2764 A steam generator blowdown monitor spiked to Alert level (8 other CRs included)
CR 00-1924 Contaminated equipment control within RCA
CR 99-3035 Gaseous release package deficiencies
CR 99-3826 DOT shipping self-assessment program deficiencies

Occupational Radiation Safety

CR 99-2837 Various electronic dosimeter problems from Jan-June 1999 resolved
CR 99-4337 Radiation workers not knowledgeable
CR 99-15638 New radiation workers less than adequate training
CR 99-4222 I&C planning did not identify dose estimate for scaffold for testing smoke detector
CR 99-3732 Radiation worker unable to hear electronic dosimeter alarm
CR 99-2946 INPO SER 4-98 reviewed unplanned personnel radiation dose

Emergency Preparedness

CR 00-8986 Off-hours unannounced drill failed to meet timely attendance criterion
CR 00-7554 Emergency siren repeater was inoperable

Plant Physical Protection

CR 00-5547 QA audit discovered a vital area key unaccounted for
CR 00-1857 Security failed to identify a safeguards issue
ACR 99-3894 Circuit fault occurred caused security alarms to be inoperable
ACR 99-2892 Vital door inactivated during maintenance and not detected
CR 00-4324 Security failed to identify a target component critical to defense strategy

Root Cause Evaluations

CR 99-08207 Alterrex bearing #12 exhibiting high vibration
CR 99-09948 SW-P-41C experienced high amps which required it's shutdown
CR 99-13853 Determine source of identified Tritium in containment annulus water.
CR 00-00359 Sodium Intrusion in the Steam Generators, while at 15% power.
CR 00-05593 Non-Safety Wire Installed in Safety Related Component (CBS-V-53)
CR 00-07927 Entered TS 3.03 for approx 4minutes due to CBA -H-372 having deenergized on high temperature
CR 00-08835 Bump Guard on CBA did not perform as intended
NAH-98-049 Evaluation of Motorola High Threshold Logic (MHTL) Integrated Circuit MC668L

Nuclear Oversight

99-A10-01 Audit Report - Corrective Action
00-A05-01 Audit Report - Corrective Action
99-A07-01 Audit Report - Chemistry Control Program
00-A07-02 Audit Report - Reactor Engineering
00-A05-03 Audit Report - Steam Generator Program 6/9/00
00-A03-01 Audit Report - Configuration Control (Temporary Modifications)
Nuclear Oversight 6 Month Self Evaluation (July - December 1999)
Nuclear Safety Audit and Review Committee (NSARC) meeting minutes (Aug - Dec 1999)

Nuclear Oversight monthly reports: assessment of plant performance (June 1999 - May 2000)
NSE Monthly Reports August 1999 - June 2000 Significant Operating Experience Report Status and Results of OE and Technical Review Programs
00-08116-01 Review of NRC Info. Notice IN 2000-09, SG Tube Rupture at Indian Point
AR98007192 Nuclear Safety Engineering Report - Evaluation of IN 98-11: Cracking of Reactor Vessel Internals Baffle Former Bolts in Foreign Plants 2/19/99

NCVs Reviewed

NCV 99-01-01 Failure to test safety related fans/ACR 99-474
NCV 99-01-02 Inadequate corrective actions for PAH test failures/ACR 99-1176
NCV 99-03-01 Failure to periodically calibrate PCCW pump hi temps/ACR 99-857 (1020)
NCV 99-05-01 Failure to include multiple components within the ISI program/ACR 98-0087
NCV 99-07-01 Closing CS-V475 during plant operations/CR 99-4144
NCV 99-08-01 UT testing failed to meet applicable standards/CR 99-4553
NCV 99-10-01 Failure to recognize adverse trend of training deficiencies/ACR 98-1530 and air operated valve failure ACR 99-3429

Assessment Reports

SA 00-0065 Assessment of the Issues that Accompanied the IP2 S/G Tube Rupture
SA 00-0073 Corrective Action Effectiveness
SA 00-0094 Comparison of Human Error DCNs to Design Engineering CRs
SA 00-0130 Mechanical Engineering Self-Assessment - A, B, C Corrective Actions
SA 00-0163 Timely Resolution of Failure Reports - Measure and Test Equipment
SA 00-0164 Replacement Valve Strategy
SA 00-0223 Design Engineering Use of Operating Experience- Self-Assessment Report
Common Cause Assessment of the Seabrook Station Tagging Program (Dated July 14, 2000)
Common Cause assessment of Reactivity Management
Common Cause assessment of industrial safety practices
Common Cause assessment of operator training issues
ESAR 99-027 Engineering self-assessment on Design Change Implementation
ESAR 99-029 Engineering Self-Assessment Report on I&C Design Changes Package Quality
1999 North Atlantic Engineering Progress Report
GT6016C, Human Performance Time Out, Dated September 19, 2000
Seabrook Station Culture Survey - Summer 2000

Maintenance Rule Documents Reviewed

Periodic Assessment of Maintenance Rule Program Report, July 1998 through March 2000
Rod Control System maintenance rule performance criteria
Solid State Protection System maintenance rule performance criteria

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	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.