



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
SAM NUNN ATLANTA FEDERAL CENTER  
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September 28, 2000

Carolina Power & Light Company  
ATTN: Mr. J. S. Keenan  
Vice President  
Brunswick Steam Electric Plant  
P. O. Box 10429  
Southport, NC 28461

**SUBJECT: BRUNSWICK - NRC INSPECTION REPORT 50-325/00-07 AND 50-324/00-07**

Dear Mr. Keenan:

On September 1, 2000, the Nuclear Regulatory Commission (NRC) completed an inspection at your Brunswick Units 1 and 2 reactor facilities. The enclosed report presents the results of that inspection which were discussed on September 1, 2000, with you and other members of your staff.

The 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 license. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of the inspection, no findings were 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'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).

Sincerely,

*/RA/*

Brian Bonser, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

Docket No.: 50-325 and 50-324  
License No.: DPR-71 and DPR 62

Enclosure: Inspection Report

cc w/encl: (See page 3)

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-325, 50-324  
License Nos: DPR-71, DPR-62

Report No: 50-325/00-07, 50-324/00-07

Licensee: Carolina Power & Light (CP&L)

Facility: Brunswick Steam Electric Plant, Units 1 & 2

Location: 8470 River Road SE  
Southport, NC 28461

Dates: August 7- 11, 2000 (week 1)  
August 28- September 1, 2000 (week 2)

Inspectors: B. Desai, Senior Resident Inspector, Robinson Nuclear Plant  
(lead)  
R. Gibbs, Senior Reactor Inspector, Division of Reactor Safety,  
Region II  
E. Guthrie, Resident Inspector, Brunswick Nuclear Plant

Approved by: B. Bonser, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

## SUMMARY OF FINDINGS

Brunswick Nuclear Power Plant, Units 1 and 2  
NRC Inspection Report 50-325/00-07 and 50-324/00-07

### Adams Template

IR 050/00325-00-07 and 324-00-07 on 08/07-09/01/2000; Brunswick Nuclear Power Plant; Annual baseline inspection of the Identification and Resolution of Problems. Corrective action program was acceptable with negative observations noted. One unresolved item was identified.

The inspection was conducted by resident inspectors and a regional reactor inspector. There were no findings identified. The significance of issues is indicated by their color (green, white, yellow, red) as determined by the Significance Determination Process (See Attachment).

### **Identification and Resolution of Problems:**

- Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program was acceptable with concerns noted. The licensee was generally effective at identifying problems and placing them into the corrective action program as evidenced by the inspectors review of external operating experience, Corrective Action Program Trend Reports, and items from system health reports and through plant tours. However, several instances where the licensee had not initiated condition reports were noted. When conditions adverse to quality were identified, the licensee generally identified the appropriate causes and developed and implemented effective corrective actions. The inspectors determined that the licensee properly classified discrepant conditions, but did not use risk when classifying/assigning prioritization of these items. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions with plant employees from various departments, the inspectors determined that employees felt free to report safety concerns.

## Report Details

### 4. OTHER ACTIVITIES

#### 4OA2 Identification and Resolution of Problems

##### .1 Effectiveness of Problem Identification

###### a. Inspection Scope

The inspectors reviewed NRC inspection reports and Licensee Event Reports (LERs) for the past two years and discussed the licensee's performance of problem identification with the resident inspectors who independently observed problem identification and resolution on a routine basis.

The inspectors also reviewed an operator workaround list, inservice test results, licensee trend reports, and the Technical Specification Limiting Condition for Operation log entry list, to determine if deficiencies were being entered into the corrective action program. The inspectors also toured the plant to determine if deficiencies existed that had not been entered into the corrective action program. Further, the inspectors reviewed a sample of Maintenance Rule equipment failure evaluations to assure that the associated equipment failures had been properly captured within the corrective action program. This review included verification that equipment failures had been properly classified as functional failures, corrective actions had been properly developed and implemented, performance had been assessed against performance criteria, and that adequate MR a(1) goals and monitoring had been established where required.

Additionally, the inspectors reviewed a sample of operating experience (OE) items to determine if they had been appropriately evaluated for plant applicability, and whether problems identified through these reviews were entered into the corrective action program:

#### **OE ITEMS REVIEWED**

- Information Notice (IN) 99-21, "Recent Plant Events Caused By Human Performance Errors"
- IN 99-19, "Rupture Of The Shell Side Of A Feedwater Heater At The Point Beach Nuclear Plant"
- IN 99-17, "Problems Associated With Post-Fire Safe-Shutdown Circuit Analyses"
- IN 99-13, "Insights From NRC Inspections Of Low And Medium Voltage Circuit Breaker Maintenance Programs"

- IN 99-07, "Failed Fire Protection Deluge Valves And Potential Testing Deficiencies In Preaction Sprinkler Systems"
- IN 98-41, "Spurious Shutdown Of Emergency Diesel Generators From Design Oversight"
- Significant Event Notice (SEN) 199, "Feedwater Heater Shell Rupture"
- Preliminary Notification (PN) 35672, "HPCI/RCIC TS Outside Design Basis"
- PN 35243, "Part 21 Rosemount Model Series B, Rev 1"
- OE 9981, "Quad Cities Unit 1 Reactor Scram On Scram Discharge Volume High Level"
- OE 9878, "Cracks on Emergency Diesel Generator Exhaust Valve Spring Seats"
- OE 9797, "GE Voltage Sensitive Relay 3S7511VS580 - Low Wattage Rating For Resistor 18R"
- OE 9774, "Out Of Adjustment Tripping Lever Causes Breaker To Close While Racked Out - Near Miss"
- OE 9768, "Switchyard Air Leaks Caused By Defective O-rings"
- Significant Operating Experience Report (SOER) 87-02, "Inadvertent Reactor Vessel Level Decrease During Shutdown Cooling Loop Transfer for Applicability"

b. Issues and Findings

The inspectors determined that external operating experience had been appropriately evaluated for plant applicability, and both external and internal operating experience had been effectively distributed to the plant staff. Problems identified through the review of external operating experience, and trend reports had been entered into the corrective action program.

On August 30, the inspectors found that the licensee had not generated specific corrective actions for deficiencies identified by the licensee during inspections of the site safety-related manhole system, and cable raceways and ductbanks within the manholes. The inspectors had been reviewing these safety-related systems and components as part of inspection Attachment 71111.06, Flood Protection Measures. The inspectors determined that the first manhole inspection which occurred on January 21, 1999, was on manhole SY2. The adverse conditions identified in manhole SY2 and the expectation that similar conditions would be found in other manholes caused the licensee to place the entire manhole system in MR a(1) status. The MR a(1) classification status was based on the inspected adverse conditions in the SY2 manhole not meeting the system performance criteria for functional failure. The MR a(1) status required goals and corrective actions to be established to return the system to a MR a(2) status. A MR a(2) status would return the system to a normal maintaining and



monitoring condition. A significant root cause investigation, conducted as part of the MR a(1) classification, was completed on March 1, 1999. The inspectors found that the licensee inspected the other fifty-seven MR scoped manholes from January 21, 1999 to July 28, 2000. The inspectors determined that no deficiency, work order, CR, or corrective action was taken as a result of these licensee inspections. The conditions of the site manhole system were reviewed by inspector observation and review of digital pictures taken by the licensee during their inspections. The inspectors noted numerous deficiencies during the review. Deficiencies noted were cable jacket tears, cable supports corroded and broken, submerged cabling and cable splices, and leaking duct banks. Further inspection was required to determine the extent and significance of this issue and the apparent failure to enter the deficiencies identified into the corrective action program. This issue is considered an Unresolved Item (URI) 50-325/324 00-07-01, Site Manhole Corrective Actions, and will be inspected further using inspection attachment 71111.06, Flood Protection.

The inspectors identified the following concern related to the effectiveness of problem identification.

- The inspectors identified two examples where the licensee had not initiated CRs. The two examples included a failure of a Reactor Coolant Isolation Cooling (RCIC) system check valve during an inservice test (IST) and a recurring RCIC pressurization problem when the Residual Heat Removal (RHR) system was in the suppression pool cooling mode. Neither of these conditions would have caused the RCIC system to be inoperable. Upon identification by the inspectors, the licensee immediately initiated CRs to document the problem.

## .2 Prioritization and Effectiveness of Corrective Actions

### a. Inspection Scope

The inspectors reviewed the following sample of corrective action documents, including previously identified NRC concerns, to determine if the licensee determined the causes, and identified corrective action to prevent recurrence (including common cause and generic concerns). The corrective action documents selected were primarily associated with plant systems which have the highest risk significance, as determined by the plant-specific probabilistic risk assessment. These systems included RCIC, emergency diesel generators, AC electrical distribution, high pressure coolant injection (HPCI), and reactor vessels and internals. Further, the inspectors reviewed CRs associated with the radiation protection and emergency preparedness areas to assess if any potential corrective action program issues existed. The inspectors also reviewed the corrective action documents to determine if they were being properly classified based on the licensee's definition of significance levels in procedure CAP-NGGC-0200, Rev 1, "Corrective Action Program." In addition, the inspectors reviewed these corrective action documents to determine whether the licensee considered risk significance for assigning prioritization of correction actions.

### **RCIC system:**

- Action Request (AR) 0005959 (CR 99-0580), “NAS assessment determined that 50.59 of ESR 98-00198, Rev. 0 was inadequate”
- AR 0005815 (CR 99-432), “ Clarification to Technical Specifications needed on what instruments provide the steam flow-high signal”
- AR 0006879 (CR 99-1523), “Setpoints not changed in all procedures”
- AR 0007651 (CR 99-2257), “RCIC pump tripped during PMT for replacing oil strainer”
- AR 0009677, “RCIC pump trip”

**Emergency Diesel Generators:**

- AR 0005663 (CR 99-307), “EDG jacket water pump maintenance”
- AR 0005814 (CR 99-430), “SOER on EDG exhaust valve seats”
- AR 0006737 (CR 99-1363), “EDG governor component failure”
- AR 0006883 (CR 99-1496), “EDG failed to start due to defective hand switch”
- AR 0007213 (CR 99-1805), “ERFIS and I&C procedure not updated to provide latest engineering setpoint changes”
- AR 00014706, “Wrong gage read during EDG surveillance”
- AR 00017292, “EDG #2 tripped while supplying power to bus E-2 following an actual LOOP event”
- AR 00017528, “During EDG surveillance, the new transformer output was greater than normal”
- AR 00017567, “EDG ventilation fan switches were found in the wrong positions”
- AR 00020680, “During EDG surveillance, operations was unable to raise load to the required value”

**AC Power:**

- AR 0006010 (CR 99-631), "Needed instructions for attaching test equipment to ERFIS"
- AR 0006592 (CR 99-1200), "Breaker failed instantaneous trip function test during PM"
- AR 0006720 (CR 99-1323), : "Breaker 2XL tripped twice"
- AR 0006923 (CR 99-1517), "The unavailability performance criteria for the cross-tie breaker was exceeded"
- AR 0008892, "Guidance on independent verification of MOV valve lineups is inadequate"
- AR 00016653, "Operations is not cycling breakers in accordance with a previous safety evaluation recommendation"
- AR 00017202, "The "C" phase of a breaker failed to trip"

**High Pressure Coolant Injection:**

- AR 0005551 (CR 99-0157), "NRC SSFI questioned analysis which increased HPCI initiation time from 30 to 60 seconds"
- AR 0005669 (CR 99-289), "Site failed to identify a HPCI Maintenance Rule functional failure"
- AR 0005795 (CR 99-404), "HPCI flow instruments are out of calibration"
- AR 0006552 (CR 99-1180), "Stroke time of HPCI turbine valve out of tolerance"
- AR 0000666 (CR 99-1289), "Stroke time of 2-E41-F001 out of tolerance"

**Vessel and Internals:**

- AR 0005598 (CR 99-246), "RPV bottom head cooldown rate exceeded"
- AR 0007206 (CR 99-1824), "Request to establish a Scram Reduction Team"
- AR 0007477 (CR 99-1970), "Incorrect control rod movement during startup"
- AR 000789 (CR 99-2389), "Startup scram"
- AR 0007808 (CR 99-2301), "Scram discharge volume level transmitter cards defective"
- AR 00017758, "SRV setpoint drifted low"

- AR 00018724, "Site failed to identify a Maintenance Rule functional failure"

#### **Previously Identified NRC Concerns**

- NCV (1999-05-01)/B, "Nuclear Service Water Strainer Instrument Corrective Action"  
(A/R NCR 00007323)
- NCV (1999-04-03), "Reactor Recirculation Discharge Bypass Valve Inoperability"  
(A/R 00006135)
- NCV (1999-003-01), "Degraded Drywall Pressure Instrumentation"  
(A/R 00006157)
- NCV (1999-08-01), "Lack of Programmatic Controls for Instructional Aids"  
(A/R 00008891)
- NCV (1999-02-01), "Failure to Perform CREVS Surveillance Testing"  
(A/R 00006222)
- NCV (1999-01-02), "Failure to Implement Procedures"  
(A/R 00005596)
- NRC Report (199-005), "Adverse Condition Identification by Operations Personnel"  
(A/R 00007232)
- NCV (1999-0005-02), "Failure to Enter TS 3.0.3"  
(A/R 00007161)
- NCV (1999-04-02), "Failure to Properly Identify Conditions Adverse to Quality"  
(A/R 0007039)

#### **Radiation Protection AR's:**

- AR 00005198- "Storm H2O Input To Radwaste"
- AR 00007351- "Second Qtr 99 Adverse Trend"
- AR 00006638- "Purple Tool Control Adv. Trend"
- AR 00005891- "Incorrectly Labeled Container"
- AR 00015808- "High Radiation Area Swing Gate Found Tied Open"
- AR 00005633- "Resin In Clean Area"

- AR 00008238- "Contamination Of The Radwaste -3FT North Walkway"
- AR 00021423- "Radwaste Contamination Event"
- AR 00017674- "Incorrect RWP Use Adverse Trend"
- AR 00006570- "Purple Tool in Control Room"
- AR 00014929- "Purple Tools Outside RCA"
- AR 00021911- "Purple Tool Found Outside RCA"
- AR 00019666- "Purple Tool Found Outside RCA"

#### **Emergency Preparedness ARs**

- AR 00022140- "Offsite Notification Process Challenged the CREVS"
- AR 00020191- "Untimely Emergency Notification During ERO Drill"
- AR 000022141- "Turnover Responsibilities and Sharing of Information"
- AR 00017309- "Emergency Notification Forms"

#### **Other Materials Reviewed**

- CAP Backlog- Open NCR's Priority 1 and Priority 2 with open Corrective Actions > 1 year
- EP Self-Assessment Report EP 00-02- EP Team Training Drills - June 2000
- Health Physics Job Standard Exhibit HPJS-3.1:- CR Thresholds
- AR 00005202- "DC MOV Contactors"
- AR 00005640- "DC MOV Overloads"
- CR 98-00155- "Water Leakage in DG Basement"
- AR 00006610- "1B Battery Bus Gnd"

b. Issues and Findings

No findings of significance were identified.

When conditions adverse to quality were identified, the licensee entered those conditions into the corrective action program and generally identified the causes, and developed and implemented effective corrective actions. The inspectors determined that the licensee properly classified discrepant conditions, but did not use risk when classifying/assigning prioritization of these items.

The inspectors had the following concerns related to prioritization and effectiveness of corrective actions:

- Two CRs were identified by the inspectors in the emergency preparedness area that were not given the appropriate priority classification. Upon identification, the licensee immediately corrected the problem.
- The inspectors noted the age of high priority CRs to be longer than that of the lower priority CRs. Further, extensions to completion dates for corrective action items resulting from CRs were routinely granted.

.3 Effectiveness of Licensee Audits and Self Assessments

a. Inspection Scope

The inspectors reviewed the following licensee audits and self assessments (focusing on problem identification and resolution) to determine whether they were consistent with NRC findings, to determine whether the assessments were performed in accordance with the licensee's commitments to NRC, to determine if assessment findings were entered into the licensee's corrective action program, and to determine if corrective actions were completed to resolve identified program deficiencies.

**LIST OF SELF ASSESSMENTS REVIEWED:**

- SA-B-9761, "NAS Issue/Weakness Statusing And Closure"
- ESS-99-11, "Inactive Engineering Service Requests"
- 9794, "Document Services Requirements Validation"
- 14926, "Emergency Operating Procedure Compliance"

b. Issues and Findings

No findings of significance were identified.

The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors queried licensee employees to determine whether any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program which provides an alternate method to the corrective action program for employees to raise safety concerns and remain anonymous. The inspectors reviewed Employee Concern Resolution Reports to determine if concerns were being properly reviewed and identified deficiencies were being resolved in accordance with the licensee's corrective action program.

**Employee Concern Program Reports Reviewed:**

34848	34513	34840
34935	34514	34948
34979	36516	36534
34553	34529	

b. Issues and Findings

No findings of significance were identified.

Licensee management emphasized the need for all employees to identify and report nonconforming conditions using the appropriate methods established within their administrative programs. Methods available include deficiency log entries, work requests, CRs, and the employee concerns program. These methods were readily accessible to all employees. Based on discussions with plant employees from various departments, the inspectors determined that employees felt free to report safety concerns.

#### 4OA6 Management Meetings

##### .1 Exit Meeting Summary

The inspectors presented the inspection results to J. Keenan, Vice President Brunswick Steam Electric Plant and other members of licensee management at the conclusion of the inspection on September 1. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

### **PARTIAL LIST OF PERSONS CONTACTED**

#### Licensee

N. Gannon, Plant General Manager  
G. Johnson, Manager Nuclear Assessment (Acting)  
J. Gawron, Training Manager  
W. Dorman, Manager Regulatory Affairs  
J. Keenan, Site Vice President  
J. Lyash, Director of Site Operations  
J. Franke, Manager Engineering Support Section  
W. Noll, Manager Operations  
E. Quidley, Manager Maintenance  
H. Wall, Manager Outage and Scheduling

#### NRC

B. Desai, Senior Resident Inspector, Robinson  
B. Bonser, Chief, Reactor Projects Branch 4  
L. Plisco, Director, Division of Reactor Projects



**ITEMS OPENED, CLOSED AND DISCUSSED**

**OPENED**

(URI) 50-325/324, 00-07-01; Site Manhole Corrective Actions (section 4OA2.1.b)

**LIST OF ACRONYMS USED**

AC	Alternating Current
AR	Action Request
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CR	Condition Report
CREVS	Control Room Emergency Ventilation System
EDG	Emergency Diesel Generator
EOP	Emergency Operating Procedure
EP	Emergency Preparedness
ESR	Engineering Service Request
HPCI	High Pressure Coolant Injection
IN	Information Notice
MOV	Motor Operated Valve
MR	Maintenance Rule
NAS	Nuclear Assessment Section
NRC	Nuclear Regulatory Commission
OE	Operating Experience
OMP	Outage Management Procedure
OWP	Operations Work Procedure
OST	Operations Surveillance Test
PMT	Post Maintenance Testing
PN	Preliminary Notification
RCIC	Reactor Coolant Isolation Cooling
RHR	Residual Heat Removal
RPV	Reactor Pressure Vessel
RWP	Radiation Work Permit
SEN	Significant Event Notification
SDP	Significance Determination Process
TS	Technical Specifications

## 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:

<b>Reactor Safety</b>	<b>Radiation Safety</b>	<b>Safeguards</b>
<ul style="list-style-type: none"> <li>● Initiating Events</li> <li>● Mitigating Systems</li> <li>● Barrier Integrity</li> <li>● Emergency Preparedness</li> </ul>	<ul style="list-style-type: none"> <li>● Occupational</li> <li>● Public</li> </ul>	<ul style="list-style-type: none"> <li>● Physical Protection</li> </ul>

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>.