January 25, 2001

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

SUBJECT: NRC's OYSTER CREEK GENERATING STATION INTEGRATED INSPECTION REPORT 05000219/2000-009

Dear Mr. DeGregorio:

On December 30, 2000, the NRC completed an integrated inspection at your Oyster Creek reactor facility. The enclosed report presents the results of that inspection. The results of this inspection were discussed on January 19, 2001, with Mr. Ernie Harkness 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 one issue of very low safety significance (Green) regarding inadequate cold weather preparations. This issue was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because it has been entered into your corrective action program, the NRC is treating this issue as a Non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, 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.

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).

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: NRC Inspection Report No. 05000219/2000-009

cc w/encl:
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ADAMS ACCESSION NUMBER: ML010250342

ADAMS DOCUMENT TITLE: IR 05000219-00-009; 11/19-12/30/00; Amergen, Oyster Creek. Adverse Weather.

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OFFICE	RI/DRP	E	RI/DRP	E				
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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Report No.	05000219/2000-009
Docket No.	05000219
License No.	DPR-16
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Oyster Creek Generating Station
Location:	Forked River, New Jersey
Dates:	November 19, 2000 - December 30, 2000
Inspectors:	Laura A. Dudes, Senior Resident Inspector Thomas R. Hipschman, Resident Inspector Nancy T. McNamara, Emergency Preparedness Inspector December 4-8, 2000 Joseph T. Furia, Senior Health Physicist, December 4-8, 2000
Approved By:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

Oyster Creek Generating Station
NRC Inspection Report 05000219/2000-009

IR 05000219-00-009; 11/19-12/30/00; Amergen, Oyster Creek. Adverse Weather.

The inspection was conducted by resident and region based inspectors. The inspection identified one green issue. 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: Mitigating Systems

- Green. The inspectors identified a Non-cited violation for failure to assure that maintenance procedures adequately control equipment and take cold weather conditions into consideration. This resulted in the condensate storage tank (CST) local level instrument becoming frozen because the power supply for the heat trace equipment was inadvertently de-energized for maintenance on an unrelated system (Technical Specification 6.8.1). Separately, the reactor building low differential pressure alarm was locked in due to freezing conditions because the licensee did not include this piece of equipment in their winterization preventive maintenance program.

  The inspectors evaluated the licensee's failure to properly implement adequate procedures and controls during cold weather conditions. The frozen CST level instrument was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for mitigating systems because the normal source of water for the core spray system from the suppression pool was available. Additionally, an alternate source of water was available from the fire protection system. 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 mitigating systems because the licensee was able to take compensatory readings from other instrumentation. **(NCV 50-219/2000-009-01)** (Section 1R01)

Report Details

Summary of Plant Status:

Oyster Creek began the inspection period at approximately thirty-four percent power, in progress of ascending to full power after completion of refueling outage 18. The plant achieved full power on November 24, 2000, and remained there for the duration of the inspection period.

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

1R01 Adverse Weather Protection

Cold Weather Preparations

a. Inspection Scope

The inspector reviewed selected systems and components, including plant features such as freeze protection and procedures, to verify that they would remain functional when challenged by cold weather. In addition, the inspector reviewed the licensee's Emergency Operating Procedures and Appendix R program commitments in order to determine the impact on plant safety due to components adversely affected by cold weather issues.

b. Findings

The inspectors identified a non-cited violation for failure to assure that maintenance procedures adequately implemented equipment controls and take cold weather conditions into consideration. This finding was of very low safety significance because mitigating systems were lined up to normal supplies and operators were able to take compensatory actions.

On November 24, 2000, the licensee entered a Technical Specification Limiting Condition for Operation when the condensate storage tank (CST) local level indication failed high because the sensing line was frozen. The heat trace for this instrument was rendered inoperable when the power supply was inadvertently de-energized for maintenance on another piece of equipment powered from the same source. Additionally, the licensee identified a failed bearing pressure gage on service water pump No.1, and a leak from a circulating water pump seal water pressure switch due to a similar problem with the heat trace power supply being tagged out of service for work on an unrelated piece of equipment. These last two examples of equipment freezing were considered to be minor issues. These three items are examples of the licensee's work management program failing to properly implement adequate procedures and controls during cold weather conditions. The inspector concluded that the freezing of the CST level instrument had the potential to impact safety of the plant because the instrumentation may be required during a loss of remote indications such as during a remote reactor shutdown scenario during a control room evacuation. The frozen CST level instrument was considered to have very low safety significance (Green) using the Significance Determination Process (SDP) phase 1 evaluation for mitigating systems because the normal source of water for the core spray system from the suppression

pool was available. Additionally, an alternate source of water was available from the fire protection system.

Separately, on December 23, 2000, the reactor building low differential pressure alarm (L-6-C) was locked in due to freezing conditions requiring operators to take compensatory actions to monitor reactor building differential pressure. Although the reactor building differential pressure transmitter was located outside of the reactor building and was susceptible to cold weather conditions, the licensee did not include this piece of equipment in their winterization preventive maintenance program. This differential pressure transmitter may be used by operators in abnormal and 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 mitigating systems because the licensee was able to take compensatory readings from other instrumentation.

The licensee's failure to properly control maintenance activities to control equipment and to take into account external factors such as cold weather is a violation of Technical Specification 6.8.1.a, which requires that written procedures shall be established, implemented, and maintained. The licensee documented the need for adequate procedures and controls to prepare for cold weather in CAP 2000-2028. **(NCV 50-219/2000-009-01)**

1R04 Equipment Alignment

.1 "B" Control Rod Drive System

a. Inspection Scope

The inspector performed a partial walkdown of the "B" control rod drive system to verify that the system was in service and operating properly after the "A" control rod drive pump became inoperable due to a circuit breaker failure. The inspection consisted of a partial valve verification per licensee procedure 302, "Control Rod Drive Hydraulic System," and its associated valve and instrument line up attachments. In addition, the inspector reviewed a sample of recent corrective action documents associated with this system to verify that there were no outstanding equipment problems with the system.

b. Findings

No findings of significance were identified.

.2 Instrument Air Compressors and Dryers

a. Inspection Scope

The inspector performed a partial walkdown of the instrument air system, particularly the air compressor, dryers and receivers. The inspector reviewed this system because the loss of instrument air may result in a reactor transient. The inspection consisted of a partial valve verification per licensee procedure 334, "Instrument and Service Air System," and its associated valve and instrument line up attachments. In addition, the inspector reviewed corrective action documents dating back to 1999 to verify that there were no outstanding equipment problems with the system.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors conducted fire protection inspection 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:

- Diesel driven fire pumps
- Control room halon system
- "C" Battery Room
- Reactor Building, 51 foot Elevation.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

Inspection Scope

The inspectors reviewed the periodic evaluations required by 10 CFR 50.65 (a)(3) for 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:

- Instrument Air Compressors and Dryers
- Emergency Service Water

In addition, the inspectors reviewed the following safety significant systems in (a)(2) status to verify that system performance compared to the licensee's performance criteria was acceptable.

- Drywell and Torus Vacuum Breakers
- Standby Liquid Control System

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

.1 "A" Control Rod Drive (CRD) Pump Breaker Failure

a. Inspection Scope

On December 17, 2000, while attempting to start the "A" CRD pump, the circuit breaker failed to latch and start the pump. The inspector reviewed the weekly on-line maintenance schedule to verify that the appropriate risk management changes would be made due to the emergent activity. In addition, the inspector reviewed recent circuit breaker failures to verify that the licensee was appropriately addressing potential common cause failure issues.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

Calibration of Torus to Drywell Vacuum Breaker Limit Switches

a. Inspection Scope

On December 22, 2000, during the performance of procedure 604.4.016, "Torus to Drywell Vacuum Breaker Operability and In-Service Test," the licensee identified that vacuum breaker V-26-011 failed its surveillance test due to the limit switches sticking and failing to indicate the open position within the Technical Specification required time limit. The licensee developed an alternate method to replace and calibrate the limit switches with the reactor at power without breaching the valve. The inspector reviewed engineering evaluation 125-1-0428-00, which documented the alternate calibration

method.

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspector reviewed and observed portions of the following post maintenance testing because of their function as mitigating systems:

- 'A' Control Room HVAC Operability Test (JO 548035, ST 654.4.003)
- 'B' Standby Liquid Control Pump and Valve Operability and Inservice Test (JO544995, ST 612.4.001)

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

.1 Fire Pump In-service Test

a. Inspection Scope

The inspector reviewed surveillance test procedure 645.4.001 (JO 545218), "Fire Pump In-service Test," to verify that the diesel driven fire pumps were capable of performing their safety function as required by procedure 333, "Plant Fire Protection System," and the Oyster Creek Fire Hazards Analysis Report. The inspector reviewed the No. 1 fire pump test, the final acceptance of the test results, 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 Core Spray System I Isolation Valve Actuation Test and Calibration

a. Inspection Scope

The inspector reviewed surveillance procedure 610.3.006, "Core Spray Isolation Valve Actuation Test and Calibration," and the resulting "as left" test data including verification of calibration requirements for the testing equipment. The inspector verified that the licensee implemented the appropriate Technical Specification Limiting Condition for Operation for the duration of the test and concurrently verified the availability of redundant safety systems.

b. Findings

No findings of significance were identified.

Emergency Preparedness

1EP2 Alert and Notification System Testing (ANS)

a. Inspection Scope

The inspector reviewed Emergency Plan Administrative Procedure No. OEP-ADM-1319.04, "Prompt Notification System," which described the licensee's offsite siren program and the commitments for performing surveillance tests and routine maintenance. Surveillance test records and the ANS performance indicator (PI) data was reviewed for compliance with the PI criteria and Emergency Plan commitments. The inspector interviewed the technicians responsible for the sirens and observed routine maintenance of an offsite siren to evaluate the design of the offsite siren system and the adequacy of their testing protocol, maintenance program and corrective actions for inoperable sirens. In addition, a visit was made to the Ocean County Sheriffs Department Communications Center to determine the adequacy of training for sounding the sirens during a real event.

b. Findings

No findings of significance were identified.

1EP3 Emergency Response Organization (ERO) Augmentation Testing

a. Inspection Scope

The inspector reviewed drill/exercise reports, ERO qualifications and automated pager notification test records to determine the licensee's ability to achieve facility activation goals and identify any problems related to the effectiveness of ERO augmentation. Also, Surveillance Test Procedure No. OEP-SUR-1310.09, Emergency Communications Surveillance and Emergency Implementing Procedure No. EPIP-OC-1300.41, Emergency Duty Roster Activation, was reviewed for the licensee's commitments for ERO augmentation, system activation and a description of the overall maintenance of the program.

b. Findings

No findings of significance were identified.

1EP4 Emergency Action Level (EAL) and Emergency Plan Changes

a. Inspection Scope

A regional in-office review of revisions to the Oyster Creek Emergency Plan, Implementing Procedures and EAL changes was performed to determine that the changes did not decrease the effectiveness of the Emergency Plan.

b. Findings

No findings of significance were identified.

1EP5 Correction of Emergency Preparedness Weaknesses and Deficiencies

a. Inspection Scope

To determine the licensee's ability to effectively identify program weaknesses and correct deficiencies, the following documentation was reviewed:

- Corporate Procedure No. 1000-ADM-1291.03, "Self Assessment Program Guide"
- Corporate Procedure No. 1000-7216.01, "Corrective Action Process"
- Quality Assurance Audit Report Nos. S-OC-00-01 and S-OC-99-01
- Self Assessment Reports entitled, "Area of Weaknesses Follow up" and "EP Corrective Actions"
- EP Program Post-Indian Point 2 SGTF Event Assessment for Oyster Creek
- Drill and exercise critique reports and licensed operator requalification training records
- Action items (opened and closed) listed in the corrective action process tracking system

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY
Cornerstone: Public Radiation Safety

2PS2 Radioactive Material Processing and Shipping

a. Inspection Scope

The inspector reviewed the licensee's facilities, processes and programs for the collection, processing, treatment, shipping, storage and disposal of radioactive materials and radwaste. The inspector conducted reviews of the following: in-plant liquid and solid waste systems; waste processing and sampling program; shipment activities and records; assurance of quality, including corrective action reports; and training.

Systems reviews, which included system descriptions, control panel review, facilities tours, and a review of system changes in accordance with 10 CFR 50.59, was conducted for the high purity waste (low conductivity) and chemical/floor drain waste systems. The inspector also toured abandoned in-place radwaste equipment and

facilities, and interim storage locations used for processed radwaste. Highly contaminated and/or high dose rate areas toured included the cubicles containing the following radwaste components: high purity waste collector tank (NV-01); floor drain collector tank (NV-49); waste neutralizer tanks (NV-05A & 05B); concentrated waste tank (NV-28); batch tank (SL-T-008); evaporators (WC-E-1A & 1B); chemical waste filter (WC-F-1b); and, high purity waste filter (HP-F-1B). The cubicles containing the following components were inaccessible (access via shield plugs only): filter sludge storage tank (NV-09);old radwaste spent resin tank (NV-29); high purity waste collector tank (HP-T-1A); chemical waste/floor drain collector tanks (WC-T-1A, 1B & 1C); and, spent resin tanks (SL-T-2A & 2B). The inspector also toured the low-level waste storage facility, and reviewed licensee records of materials in storage against the actual inventory.

The inspector reviewed the licensee's Process Control Program (PCP), including: PCP procedures; process documentation; scaling factor derivation, sampling type, sampling frequency, and effect of changing plant conditions; and, determination of waste characteristics and waste classification.

The inspector selected five solid radwaste shipping records for detailed review against the requirements contained in 10 CFR Parts 20, 61 and 71, and 49 CFR Parts 100-177. The shipments selected included were Nos. 3003-99, 5001-00, 5002-00, 5003-00, and 5004-00.

The inspector reviewed the licensee's program for assurance of quality in the radwaste processing and radioactive materials transportation program by reviewing the most recent quality assurance audit (S-OC-00-12) and four issues documented in the corrective action process (CAP) system involving the radwaste and transportation program in 2000 [2000-0835, 2000-0999, 2000-1134, 2000-1453].

The inspector reviewed the licensee's training program for personnel involved in the radwaste and radioactive materials transportation program with regard to the requirements contained in NRC IE Bulletin 79-19 and DOT 49 CFR, Subpart H. Records reviewed included training requirements, course outlines/training modules, test questions, examinations and examination scores. Reviewed records were for licensee personnel in materials handling, radiation protection and radwaste.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

.1 Drill/Exercise Participation, ERO Drill Participation and ANS Reliability

a. Inspection Scope

The inspector reviewed the licensee's programs for gathering and submitting data as described in the "Oyster Creek NRC Performance Indicator Process and Preparation Guideline" for the Drill/Exercise Performance (DEP) Indicator. The review included the licensee's exercise/drill critique reports, licensed operators' requalification records and drill participation records with respect to making emergency classifications, notifications, protective action recommendations and drill participation of key ERO positions within the past 24 months. The review of the ANS PI was conducted as a part of 1EP2. The PI data reviewed was through the 3rd quarter of 2000.

b. Findings

No findings of significance were identified.

.2 Scrams with Loss of Normal Heat Removal

a. Inspection Scope

The inspectors reviewed performance indicator (PI) data from the 4th quarter of 1997, through the 3rd quarter of 2000, for *Scrams with Loss of Normal Heat Removal* to verify its accuracy. The inspectors used Nuclear Energy Institute (NEI) 99-02, Revision 0, "Regulatory Assessment Performance Indicator Guideline," as guidance and interviewed licensee personnel responsible for compiling the information.

b. Findings

No findings of significance were identified.

.3 Reactor Coolant System Leakage

a. Inspection Scope

The inspectors reviewed performance indicator (PI) data for the year 2000, for *Reactor Coolant System Leakage* to verify its accuracy. The inspectors used Nuclear Energy Institute (NEI) 99-02, Revision 0, "Regulatory Assessment Performance Indicator Guideline," as guidance and interviewed licensee personnel responsible for compiling the information.

b. Findings

No findings of significance were identified.

4OA6 Meetings, including Exit

Exit Meeting Summary

On January 19, 2001, the resident inspectors presented the inspection results to Mr. Ernie Harkness 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.

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
G. Campesi, Technical Training
W. Collier, Radwaste Shipping
R. DeGregorio, Vice President
B. DeMerchant, Licensing Engineer
R. Fenti, Quality Assurance Auditor
J. Grisewood, EP Manager
R. Hillman, Manager, Chemistry & Radwaste
D. Larson, Emergency Planners
J. Magee, Director, Maintenance
D. McMillan, Senior Manager, Systems
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D. Slear, Senior Manager, Design
A. Smith, Emergency Planners
R. Tilton, Manager, Assessment
W. Truax, Director, Work Management
J. Vouglitous, Supervisor, Radwaste & Environmental
C. Wilson, Senior Manager, Operations
K. Wolf, Manager, Radiological Protection

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000219/2000-009-01	NCV	Failure to properly control maintenance activities and to take into account external factors is a violation of Technical Specification 6.8.1.a, which requires that written procedures shall be established, implemented, and maintained. (Section 1R01)

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
AmerGen	AmerGen Energy Company, LLC
ANS	Alert and Notification System
CAP	Corrective Action Process
CFR	Code of Federal Regulations
CST	Condensate Storage Tank
CRD	Control Rod Drive
DEP	Drill/Exercise Performance
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
EAL	Emergency Action Level
ERO	Emergency Response Organization
HVAC	Heating, Ventilation and Air Conditioning
JO	Job Order
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NOED	Notice of Enforcement Discretion
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
NSIC	Nuclear Safety Information Center
PARS	Publicly Available Records
PCP	Process Control Program
PI	Performance Indicator
SDP	Significance Determination Process
SSC	Structures, Systems and Components

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.