UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
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March 21, 2001

Carolina Power & Light Company
ATTN: Mr. John W. Moyer
Vice President
H.B. Robinson Steam Electric Plant
Unit 2
3851 West Entrance Road
Hartsville, SC 29550

SUBJECT: H.B. ROBINSON STEAM ELECTRIC PLANT- NRC INSPECTION REPORT 50-261/01-02

Dear Mr. Moyer:

On March 1, 2001, the Nuclear Regulatory Commission (NRC) completed an inspection at the H.B. Robinson Steam Electric Plant. The enclosed report documents the inspection findings which were discussed on March 1, 2001, with Mr. T. Cleary 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 operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the samples selected for review, there were no findings of significance identified during this inspection. The team concluded that problems were properly identified, evaluated, and resolved within the problem identification and resolution programs. However, during the inspection, several examples of minor problems were identified that included conditions adverse to quality that were not being entered into the corrective action program, corrective actions that did not match the apparent cause of the problem, and an action request that was assigned an incorrect priority.

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 Publically 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.: 50-261
License No.: NPF-23

Enclosure: (See page 3)

Enclosure: Inspection Report

cc w/encl:
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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No:	50-261
License No:	DPR-23
Report No:	50-261/01-02
Licensee:	Carolina Power & Light (CP&L)
Facility:	H. B. Robinson Steam Electric Plant, Unit 2
Location:	3581 West Entrance Road Hartsville, SC 29550
Dates:	February 5 - 9, 2001 (Week 1) February 26 - March 1, 2001 (Week 2)
Inspectors:	T. Easlick, Senior Resident Inspector A. Hutto, Resident Inspector W. Bearden, Reactor Inspector
Approved by:	B. Bonser, Chief Reactor Projects Branch 4 Division of Reactor Projects

SUMMARY OF FINDINGS

Adams Template:

IR 05000261-01-02, on 02/5-03/01/2001, Carolina Power & Light Company. H. B. Robinson Steam Electric Plant Unit 2, annual baseline inspection of the identification and resolution of problems. Corrective action program was acceptable with negative observations noted.

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 (CAP) was acceptable with concerns noted. Management oversight was evident in all aspects of the program, and trending was extensive and informative with an appropriate focus on human performance. The licensee was generally effective at identifying problems and placing them into the CAP as evidenced by the inspectors' review of problem identification programs/processes, audits and self-assessments, external operating experience, and through plant tours. However, several instances where the licensee had not initiated action requests (ARs) were noted. Licensee audits and assessments were found to be effective. In addition, observations identified by the audits and assessments were consistent with the team's observations. The licensee appropriately evaluated individual problems and established acceptable schedules for implementing corrective actions. Corrective actions were generally implemented in a timely manner. Apparent cause determinations appeared to accurately identify why the equipment problems occurred. The inspectors determined that the licensee properly classified discrepant conditions, but did not have a formal process for use of risk significance when classifying/assigning prioritization of these items. The inspectors concluded that the scope and depth of corrective actions assigned by the licensee were appropriate for the severity and risk significance of the problems identified. However, one AR was assigned an incorrect priority and two ARs were identified with corrective actions that did not match the apparent cause of the problem. Interviews of plant personnel indicated that they felt free to input safety issues and conditions adverse to quality into the CAP. A safety conscious work environment was evident at Robinson.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspectors reviewed items selected across the seven cornerstones of safety to verify that problems were being properly identified, appropriately characterized, and entered into the CAP for evaluation and resolution. Specifically, the inspectors reviewed operator work-arounds, engineering service requests, maintenance requests, temporary modifications, procedure change requests, training needs request/evaluations, the Technical Specification Limiting Condition for Operation log entry list, and control room and safety system deficiencies to determine if all identified deficiencies were being entered into the CAP. Additionally, the inspectors reviewed a sample of Maintenance Rule equipment failure evaluations to assure that the associated equipment failures had been properly captured within the CAP.

The inspectors conducted plant walkdowns with operators and interviewed personnel to identify other processes that may exist where problems and issues could be identified. The inspectors attended the licensee's daily plan-of-the-day and management review committee meetings to help understand plant management's involvement in the CAP.

The inspectors reviewed NRC inspection reports and a Licensee Event Report (LER) for the past year 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 reviewed the following licensee audits and self-assessments associated with problem identification and resolution to determine whether they were consistent with NRC findings, and to determine whether the assessments were performed in accordance with the licensee's commitments to the NRC. The inspectors compared the findings and problems identified by the audits and self-assessments with the findings and observations of the inspectors. Corrective actions resulting from the audits and self-assessments were evaluated for appropriateness to the circumstances.

Self-Assessment/Audits Reviewed:

- Self-Assessment Report, Assessment Number 9999, "Action Tracking Implementation"
- Self-Assessment 10194, "SOER & OE Effectiveness"
- Nuclear Assessment Section, Report File No. RR-CA-00-01, "RNP, BNP, HNP Round Robin Correction Action Program Assessment"
- "Quarterly State-Wide Common Cause Analysis of July-September 2000"

The inspectors reviewed a sample of operating experience (OE) items to determine if they had been appropriately evaluated for plant applicability, and to evaluate the capability of the licensee's CAP to address NRC and industry identified issues.

OE Items Reviewed:

- Information Notice (IN) 00-04, "Enforcement Sanctions for Deliberate Violations of NRC Employee Protection Requirements"
- IN 00-08, "Inadequate Assessment of the Effect of Operability"
- IN 00-09, "Steam Generator Tube Failure at Indian Point 2"
- IN 00-14, "Non-vital Bus Fault Leads to Fire and Loss of Offsite Power"
- IN 00-20, "Potential Loss of Redundant Safety-Related Equipment Because of the Lack of High Energy Line Break Barriers"
- NRC Part 21 00-18-0, ABB Siemens, "Epoxy Seal on Output Interface Relay"
- NRC Part 21 00-19-0, Eaton/Cutler Hammer, "Inadvertent Trip of Westinghouse Breakers at TVA Sequoyah"
- NRC Part 21 00-23-0, Siemens Power, "Pump Model Computer Code CONTRANSA2 Error"
- NRC Part 21 00-27-0, Girard, "Wrong Tube Clamps"
- Significant Event Notification (SEN) 217, "EDG Failure During Surveillance Testing"
- SEN 214, "Stuck Open Relief Valve Causes Reduction in Reactor Coolant Inventory"
- Significant Event Report (SER) 2-00, "Recurring Operational Events During Outages"
- SER 4-00, "Continued Operation When Conditions Called for Manually Scramming the Reactor"
- Nuclear Safety Advisory Letter (NSAL) 00-02, "Regenerative Heat Exchanger Tubesheet"
- NSAL 00-07, "Steam Generator Primary to Secondary Differential"
- NSAL 00-09, "LOCA-Related Vessel Motion Input to Reactor Coolant Loop Analysis"

(2) Issues and Findings

No findings of significance were identified.

The licensee was generally effective at identifying problems and placing them into the CAP as evidenced by the inspectors' review of problem identification programs/processes, audits and self-assessments, external operating experience, and through the inspectors' plant tours. The threshold for documenting conditions adverse to quality was at an appropriate level. However, the inspectors identified the following concern related to the effectiveness of problem identification.

- During review of work request (WR) 99AESK1, perform as built drawing verification of the Post Accident Sampling System (PASS); WR 99AFJF1, troubleshoot improper operation of spare breaker in MCC 17; work order (WO) 52930, troubleshoot undesired automatic control rod insertion; and WR AHLF 005, inspection and testing of 52/34C, the inspectors identified four examples

where the licensee had not initiated ARs. The four examples included PASS drawing discrepancies, missing electrical breaker components, an undesired automatic rod control insertion problem when one of the motor driven auxiliary feedwater pumps was started, and a charging lever cam failure on breaker 52/34C. None of these conditions would have caused the affected systems to be inoperable. Upon identification by the inspectors, the licensee immediately initiated ARs to document the problems.

The licensee's self-assessments and audits were generally thorough and effective in identifying deficiencies in the CAP. Corrective actions were appropriate to the circumstances. The inspectors noted during the February 27 meeting of the Robinson Self-Evaluation Board that a total of 68 self-assessments were completed in 2000. This number had declined compared to the previous two years totals of 87 in 1999 and 88 in 1998. As a result, the licensee initiated AR 28866, "Reduction in 2000 Self-Assessments Conducted," to determine the cause for the decrease in self-assessments.

The inspectors determined that external operating experience had been appropriately evaluated for plant applicability, and both internal and external operating experience issues had been incorporated into the CAP. The inspectors concluded that implementation of the licensee's CAP provided for identifying and dispositioning issues characterized in NRC generic communications and industry operating experience.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed a sample of corrective action documents to determine if the licensee appropriately characterized problems and entered them into the CAP for evaluation and resolution. The corrective action documents were selected across the seven cornerstones of safety primarily associated with plant systems which have the highest risk significance, as determined by the plant-specific probabilistic risk assessment. These systems included rod control, chemical and volume control, safety injection, containment isolation, condensate, post accident sampling, instrument air, service water, main steam, emergency diesel generators, and alternating current (AC)/direct current (DC) electrical distribution.

Additionally, the inspectors reviewed ARs associated with the radiation protection, plant chemistry, fire protection, and emergency preparedness areas to assess if any potential CAP issues existed. The inspectors determined if problems were being properly classified in accordance with the licensee's procedure CAP-NGGC-0200, Corrective Action Program, Rev. 2, and if the licensee considered risk significance for assigning prioritization of correction actions.

Rod Control System:

- AR 28780, (ESR 00-00103), Automatic Rod Control insertion when starting AFW Pump
- AR 14924, Rod Worth Prediction Anomaly During RNP Cycle 20 Startup

Safety Injection System:

- AR 27323, Revisit SI Pump A Thrust Bearing Oil Discoloration

Chemical and Volume Control System:

- AR 24244, Charging Pump A thrust bearing failure
- AR 22270, Charging Pump C failed to meet flow rate acceptance criteria
- AR 19225, PW Addition During Performance of LP-203
- AR 16132, Potential for Gas Intrusion During Shifting of Charging Pumps

Condensate System:

- AR 21319, Condensate system exceeded plant level performance criteria

Containment Isolation System:

- AR 20513, Containment isolation valve exceeded maintenance rule performance criteria

Post Accident Sampling System:

- AR 28788, Discrepancies noted between PASS System and as-built drawing

Instrument Air System:

- AR 24107, Instrument Air Compressor D Functional Failure

Emergency Diesel Generators:

- CR 9802536 (ESR 9900039), EDG Prelube, Coolant, Standby Lube Oil Recirc Pumps
- CR 9900549 (ESR 9900088), Bolt material inconsistencies at EDG 3B and inspection cover
- AR 22546, Loss of EDG room ventilation for a fire
- AR 22494, Replacement of the B EDG Fuel Oil Transfer Pump and Motor
- AR 20541, EDG A Solenoid DA-19A Manual Operator Lever
- AR 26046, EDG A Inoperability
- AR 22093, B EDG Run Time Extended Due to Vibration Machine Failure
- AR 19566, EDG B Automatic Voltage Control Potentiometer
- AR 22585, EDG A Fuel Oil Transfer Pump Motor
- AR 20244, DSD Fuel Oil Storage Tank Sediment
- AR 24407, EDG Fuel Oil Day Tank Minimum Level

- AR 18605, EDG B SBJW Pump Rework

AC Power:

- AR 28760, Spare MCC - 17 bucket has missing components
- AR 20346, Inability to verify SW Pump D alternate supply breaker racked in
- AR 17434, Electrical equipment failure negative trend
- AR 20549, 52/34C Functional Failure and Unplanned Unavailability

Service Water:

- AR 27744, SW Booster Pump A failed to meet flow rate acceptance criteria

Main Steam System:

- AR 18192, Pipe wall thickness in main steam system

Electro-Hydraulic Control System:

- AR 20790, Manual Reactor Trip Due to EH Oil Leak
- AR 20895, Plant Startup Delayed Due to EH Oil Leak

Deepwell Pumps:

- AR 16711, Deepwell Pump C Functional Failure
- AR 24363, Functional Failure of Deepwell Pump B

Plant Instrumentation:

- AR 20732, Steam Flow/Feed Flow Trip Allowable Value
- AR 25913, SG A PORV Lift Due to Freezing Sensing Line

Radiation Protection:

- AR 16245, Dose Received Draining Oil From A RCP
- AR 24388, RAD Material Labeling

Emergency Preparedness:

- AR 13050, EAL Classification
- AR 15895, Public Warning Siren Failures

Plant Chemistry:

- AR 21003, Steam Generator Sulfate Secondary Action Level
- AR 24338, RCS Boron Discrepancy
- AR 25380, Chemistry Primary Action Level
- AR 27098, Increase in SG Sulfates
- AR 27922, Unexpected Increase in SG Chlorides

Fire protection:

- AR 12968, (CR 9902351), Fire Brigade Manning
- AR 22236, Zone 19/20 Halon System main bank OOS greater than 14 days
- AR 16040, Fire drill observations

Nuclear Assessment Section:

- AR 25161, NAS Special Processes Assessment Weakness
- AR 22626, Inadequate Evaluation of Corrective Actions to Address NAS
- AR 25073, NAS Assessment RR-SPP-00-01, Missing Weld Data Report (WDR)
- AR 21336, RR-CA-00-01 NAS Issue 1., Deficiencies Exist in Determining Apparent Causes for Adverse Conditions

Other AR's Reviewed:

- AR 25458, Action items from NSRC meetings
- AR 15958, Security lighting deficiencies
- AR 23634, ISI program discrepancy
- AR 19494, Implementation of 10 CFR 50 App. J Option B for type A tests
- AR 21953, SSFI Concern With Plant Calculations
- AR 09627, Personnel Eye Injury
- AR 12336, Non-Q Parts in Safety Related Applications
- AR 12990, Safety Significant Functional Failure (Control Room Door)
- AR 18939, Apparent Failure to Meet Requirements of 10 CFR 72.80(b)
- AR 27394, Additional Exclusion Basis for MOVs in ESR 99-00123
- AR 26491, Potential Weakness 1 00-18-OP-R
- AR 16802, INPO Evaluation (February 7-18, 2000)
- AR 19721, USQD 99-1405 Evaluation is Inadequate

Procedures Reviewed:

- CAP-NGGC-0200, "Corrective Action Program," Rev. 2
- AP-022, "Procedure Review and Approval Process," Rev. 33
- TAP-100, "Training Administrative Procedure, Analysis Phase," Rev. 10
- OMM-004, "Operations Work Procedure," Rev. 17
- EGR-NGGC-0005, "Engineering Service Requests," Rev. 13
- ADM-NGGC-0104, "Work Management Process," Rev. 10

(2) Issues and Findings

No findings of significance were identified.

The licensee appropriately evaluated individual problems and established acceptable schedules for implementing corrective actions. Corrective actions were generally implemented in a timely manner. The inspectors determined that the licensee properly classified discrepant conditions, but did not have a formal process for using risk significance when classifying/assigning prioritization of these items. This issue was

discussed with the self-evaluation supervisor. The licensee had recently conducted a benchmarking trip to the Crystal River Plant and noted that they were using risk significance in their CAP. Subsequently, the Self-Evaluation Section initiated an improvement AR (28195) to evaluate the method used at Crystal River for assigning risk significance of potentially inoperable equipment, and to consider the method for inclusion in CAP-NGGC-0200, "Corrective Action Program and Action Tracking." This improvement item was also listed in the "Robinson 2001-2003 Business Plan Initiative" for the Self-Evaluation Section.

The inspectors identified the following concerns related to issue prioritization and evaluation.

- One instance was identified where an AR (27960) was not correctly prioritized. This involved a condition that was determined to be a repeat functional failure of the A-1 battery charger. The initiator of the AR classified the condition as a priority 2 AR; however, CAP-NGGC-0200 requires that repeat functional failures be characterized as priority 1. This requirement was identified during the supervisory review, but the unit evaluator did not make the appropriate change and the AR remained as a priority 2. The licensee immediately assigned the appropriate AR classification when informed by the inspectors of this situation.

- An adverse trend AR (25299) was initiated regarding the initiation and review of ARs by engineering that potentially affect operability of equipment. The inspectors' review of the AR indicated that the issues and apparent causes listed in the investigation results section of the evaluation did not match the corrective actions stated in the AR. The licensee reviewed the evaluation, revised the event investigation results, and verified that the corrective actions were appropriate. The AR was in an open status at the time of the inspectors review.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed the ARs listed in Section b.(1) to verify that the licensee had identified and implemented corrective actions commensurate with the safety-significance of the issue, and where possible, evaluated the effectiveness of the actions taken. The inspectors also verified that common causes and generic concerns were addressed where appropriate. Corrective actions developed and implemented for plant equipment problems were reviewed to ensure that design engineering requirements and the plant's current licensing bases were satisfied.

(2) Issues and Findings

No findings of significance were identified.

Corrective actions developed and implemented for plant equipment problems were effective in correcting the equipment deficiencies. The apparent cause determinations appeared to accurately identify why the equipment problems occurred. The inspectors concluded that the scope and depth of corrective actions assigned by the licensee were appropriate for the severity and risk significance of the problem identified. One exception was identified by the inspectors in AR 11860, "AFW SSFI Calc. Review." The evaluation determined that the apparent cause for the problems identified with the safety system functional inspection calculations, such as proper revisions, updates, and voiding outdated calculations, was personnel error. However, there were no corrective actions identified to address the personnel error issue, only to correct the calculations. Following discussions with the inspectors the licensee initiated AR 28919, "Apparent Cause Not Addressed In Corrective Actions," to resolve this discrepancy.

Management oversight was evident in all aspects of the program, and trending was extensive and informative with an appropriate focus on human performance. Particularly noteworthy was the licensee's implementation of the Robinson Self-Evaluations Board which meets every other month to review the site self-evaluation programs (CAP, self-assessment, OE, and benchmarking). The inspectors concluded that the licensee has taken aggressive actions to address the quality and effectiveness of ARs and corrective actions. The implementation of apparent cause training, unit evaluator continuing training, monthly CAP roll-up meetings, and the review and numerical grading of completed ARs has improved the overall quality and effectiveness of the program. The inspectors determined that the licensee was thorough and was timely in completing corrective actions within the program standards. The licensee also identified appropriate ARs for consideration as a generic concern and evaluation of common causes.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The inspectors interviewed licensee personnel to develop a general view of the safety culture at Robinson and to determine whether any conditions existed that would cause workers to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program (ECP), which provides an alternate method to the CAP for employees to raise safety concerns with the option of remaining anonymous. The inspectors reviewed ECP resolution reports to determine if concerns were being properly reviewed and resolved.

Employee Concern Program Reports Reviewed:

35799	35344	41556
04621	37260	

(2) Issues and Findings

No findings of significance were identified.

The inspectors concluded that licensee management fostered a safety-conscious work environment by emphasizing safe operations and encouraging problem reporting. Methods available included deficiency log entries, WRs, ARs, and the ECP. These methods were readily accessible to all employees. A review of the ECP reports indicated that concerns were being properly investigated and resolved, and identified deficiencies were being addressed. These reports also demonstrated that management's early intervention into problem areas have kept issues from escalating, particularly concerning personnel interactions.

Based on discussions with plant employees from various departments, the inspectors determined that employees felt free to identify safety concerns to either supervision or the employee concerns program. The inspectors noted that there was a small number of employee concerns on file for this year.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. T. Cleary, Plant General Manager Robinson Steam Electric Plant and other members of licensee management at the conclusion of the inspection on March 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

T. Bardauskas, Maintenance Rule Engineer
T. Cleary, Plant General Manager
M. Clouse, IST Engineer
S. Collins, Radiation Protection Superintendent
J. Fletcher, Regulatory Affairs Manager
K. Jensen, Mechanical Maintenance Superintendent
C. Jernigan, Mechanical Maintenance Supervisor
E. Kapopoulos, Operations Manager
K. Kirks, Empolyee Concerns
C. Martin, Site Support Services Manager
J. Moyer, Vice President, Robinson Nuclear Plant
E. Rothe, Maintenance Manager
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T. Walt, Director of Site Operations
A. Williams, Training Manager

NRC

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

ITEMS OPENED, CLOSED AND DISCUSSED

None

LIST OF ACRONYMS USED

AC	Alternating Current
AR	Action Request
CAP	Corrective Action Program
CR	Condition Report
ECP	Employee Concerns Program
LER	Licensee Event Report
NRC	Nuclear Regulatory Commission
OE	Operating Experience
PASS	Post Accident Sampling System
WO	Work Order
WR	Work Request

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.