UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

October 19, 2000

EA-00-241

William T. Cottle, President and
Chief Executive Officer
STP Nuclear Operating Company
P.O. Box 289
Wadsworth, Texas 77483

SUBJECT: SOUTH TEXAS PROJECT ELECTRIC GENERATING STATION-NRC INTEGRATED INSPECTION REPORT NO. 50-498/00-11; 50-499/00-11

Dear Mr. Cottle:

On September 23, 2000, the NRC completed an inspection at the South Texas Project Electric Generating Station, Units 1 and 2, facility. The enclosed report presents the results of that inspection. The results of the inspection were discussed with you and other members of your staff on September 26, 2000.

The 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 examined 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). This issue was determined to involve a violation of NRC requirements. However, because of its very low safety significance and because it had been entered into your corrective action program, the NRC is treating this issue as a noncited violation in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this noncited violation you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator Region IV; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the South Texas Project Electric Generating Station, Units 1 and 2, 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).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

Joseph I. Tapia, Chief
Project Branch A
Division of Reactor Projects

Docket Nos.: 50-498
50-499
License Nos.: NPF-76
NPF-80

Enclosure:
NRC Inspection Report No.
50-498/00-11; 50-499/00-11

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-498 50-499
License Nos.:	NPF-76 NPF-80
Report No.:	50-498/00-11 50-499/00-11
Licensee:	STP Nuclear Operating Company
Facility:	South Texas Project Electric Generating Station, Units 1 and 2
Location:	FM 521 - 8 miles west of Wadsworth Wadsworth, Texas 77483
Dates:	August 13 through September 23, 2000
Inspectors:	N. F. O'Keefe, Senior Resident Inspector G. L. Guerra, Resident Inspector
Approved By:	J. I. Tapia, Chief, Project Branch A

ATTACHMENTS:

Attachment 1: Supplemental Information

Attachment 2: NRC's Revised Reactor Oversight Program

SUMMARY OF FINDINGS

South Texas Project Nuclear Station, Units 1 & 2
NRC Inspection Report 50-498/00-11; 50-499/00-11

IR 05000498-00-11, 05000499-00-11; on 8/13-9/23/2000; STP Nuclear Operating Company; South Texas Project Electric Generating Station, Units 1& 2; resident integrated report, operability evaluations.

The inspection was conducted by the resident inspectors. The inspection identified one Green finding, which was a noncited violation. The significance of the finding is indicated by its color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "no color" or by the Severity level of the applicable violation.

Cornerstone: Mitigating Systems

- Green. When a 480V safety bus feeder breaker unexpectedly tripped, the licensee determined that the breaker had been installed for 10 months with the overcurrent trip setpoint too low to fulfill the breaker's function of supplying safety related loads on Bus E2C1. This was determined to be a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because the station's procedures did not control the configuration of replacement breakers to ensure that the design basis of the breaker was satisfied. This violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy. The issue was placed into the licensee's problem identification and resolution program as Condition Report 00-13689.

  The safety significance of this finding was very low because the licensee had the ability to restore power to all critical loads in a prompt manner using existing procedures and training (Section 1R15.1).

Report Details

Summary of Plant Status: Units 1 and 2 operated at full power throughout the inspection period.

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

1R02 Evaluation of Changes, Tests or Experiments

.1 (Closed) Unresolved Item 498/99021-01: Fuel handling building emergency ventilation system change without performing a 50.59 evaluation.

The fuel handling emergency exhaust system's function during an accident is to take a suction on the building, filter the air, then run it through up to three parallel booster fans before exhausting it outside. Since the booster fans could not be isolated, the licensee installed a modification to permit installing flanges on both ends of a booster fan inside the ducts to allow removing a fan. This would maintain the ducts intact so the remaining two trains would be capable of functioning. The licensee originally performed the flange installation by briefly declaring all three trains of the system inoperable, since access hatches in the headers common to all three trains were opened for worker access.

The inspectors had identified that the licensee made a change to procedure 0POPO2-HF-0001, "Fuel Handling Building Ventilation," Revision 11, to specifically permit two trains to be considered operable with the access hatches open. The procedure revision specified administrative controls and manual actions to close the hatches in the event of an accident, with the intent of assuring the system function would be fulfilled during an accident, so two trains would not be declared inoperable. However, the 10 CFR 50.59 evaluation referenced in the procedure revision package did not address the periods when the access hatches were open. These hatches were located in portions of the system which were at a pressure lower than the surrounding room. With the hatches open during an accident, the fans could ingest potentially contaminated air that would be released to the environment without being filtered, contrary to the system design function. The impact to the consequences of such a release should have been evaluated as required by 10 CFR 50.59 to ensure any increase was minimal.

In response to this Unresolved Item, the licensee performed Unreviewed Safety Question Evaluation 00-147-1 to evaluate the administrative controls and manual actions used in 0POP02-HF-0001. The inspectors determined that the licensee's evaluation adequately addressed the considerations identified in NRC Information Notice 97-78, "Crediting of Operator Actions in Place of Automatic Actions and Modification of Operator Actions, Including Response Times." The evaluation appropriately concluded that the procedural controls and manual actions were adequate to assure the system would be capable of performing its safety function, and that this change could be performed under the controls of 10 CFR 50.59.

The inspectors concluded that Revision 11 to procedure 0POP02-HF-0001 constituted a change to the fuel handling building system boundaries and operation as described in

the Updated Final Safety Analysis Report (UFSAR) which was not reviewed to ensure that it did not involve an unreviewed safety question until identified by the inspectors. The significance of the issue was determined to be minor based on the conclusion that no unreviewed safety question existed. This failure constitutes a violation of minor significance and is not subject to normal enforcement action (EA-00-241). This item is closed.

1R04 Equipment Alignments (71111.04)

.1 Partial System Walkdown

a. Inspection Scope

The inspectors performed a partial system walkdown of the Unit 1 emergency core cooling systems while portions of Train C were removed from service. The inspectors verified the unaffected trains were in a proper lineup and that components were in good material condition.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

.1 Routine Fire Area Walkdowns

a. Inspection Scope

The inspectors observed the control of transient combustibles and ignition sources, the material condition and operational lineup of reactor plant active and passive fire protection systems, and the material condition and operational status of fire barriers used to prevent fire damage or fire propagation. The following plant areas were inspected:

- Unit 1 mechanical auxiliary building mechanical penetration room (Fire Area 22)
- Common unit fire pump house and fire water storage tanks (Fire Areas 59, 60, and 61)
- Unit 2 Diesel Generator Building Train C (Fire Areas 36, 39, 42, and 45)

b. Findings

No findings of significance were identified.

1R06 Flood Protection (71111.06)

a. Inspection Scope

The inspectors conducted a walkdown inspection of the fuel handling buildings in both units to verify that the equipment was not susceptible to damage resulting from internal or external flooding. The inspectors reviewed the internal flooding analysis design calculation performed to demonstrate that safety related equipment in the fuel handling buildings was not vulnerable to internal flooding and also reviewed the design basis for the plant site to verify that the fuel handling buildings were not vulnerable to external flooding events. Additionally, the inspectors reviewed the UFSAR and the Individual Plant Examination for External Events report to identify risk insights from internal and external flooding. Since the main cooling reservoir is the most significant potential source of flood water, the inspectors walked down the perimeter of the lake embankment and associated monitoring equipment to verify that the embankment integrity was adequately maintained and monitored.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

.1 Maintenance Rule Functional Failure Review

a. Inspection Scope

The inspectors reviewed the licensee's maintenance rule implementation for equipment performance problems, including:

- Unit 2 pilot wire lockout relay failure
- Unit 2 reactor containment personnel airlock inner door seal became dislodged
- Unit 1 balance of plant diesel generator relay calibration error
- Unit 1 reactor coolant hot leg sample containment isolation valve leak

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors reviewed selected activities regarding risk evaluations and overall plant configuration control. The inspectors discussed emergent work issues with work control personnel and reviewed the potential risk impact of these activities to verify that the

work was adequately planned, controlled, and executed. The activities reviewed were associated with:

- Unit 2, Steam Generator B power operated relief valve taken out of service shortly after primary to secondary leak rate increased in Steam Generator B
- Unit 1, Inverter 1203 maintenance
- Unit 1 Essential Chiller 12A failure while Essential Chiller 12C was removed from service for planned maintenance
- Unit 2 component cooling water common header crosstie valve work

b. Findings

No findings of significance were identified.

1R14 Non-routine Plant Evolutions (71111.14)

a. Inspection Scope

The inspectors observed a prejob briefing and performance of work to determine the optimum level setting for feedwater heaters in both units to improve transient response and cycle thermal efficiency. The licensee has had a number transients over the last year that were caused by, or aggravated by, feedwater heater level control problems. The inspectors reviewed the procedure controlling the evolution, 0PEP07-ZE-0009, Revision 0, “Secondary Plant Optimization.”

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

.1 Safety Bus Feeder Breaker Had Overcurrent Trip Set Too Low

a. Inspection Scope (71111.15, 71153)

The inspectors reviewed the circumstances and licensee response to an unexpected breaker trip, resulting in loss of power to a safety related 480V motor control center bus. The maintenance history of the breaker and the programs for replacing and refurbishing breakers were discussed with system engineering and maintenance personnel. Procedures for responding to breaker problems were discussed with operations and maintenance personnel. Emergency response and recovery procedures and accident scenarios were discussed with operations and risk personnel. The inspectors reviewed the licensee’s root cause evaluation and risk assessment.

b. Findings

Following testing of the Unit 2 Train C emergency diesel generator on August 29, 2000, the feeder breaker for one of four 480V safety related motor control centers (E2C1) tripped on overcurrent. The licensee subsequently determined that the breaker had undersized current transformers installed which caused the overcurrent trip setpoint to be 300 amps ±10 percent instead of the design 600 amps. During an Engineered Safety Feature actuation, the breaker was expected to carry about 304 amps, so it was not capable of reliably performing its safety function. The licensee determined that the breaker with the undersized current transformers had been installed for 10 months. This was determined to be a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because the maintenance procedures did not ensure that the design rating of the breaker was maintained by controlling the configuration of the replacement breaker. This violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy (NCV 50-499/200011-01). The issue was placed into the licensee's problem identification and resolution program as Condition Report 00-13689.

The breaker had been installed on October 23, 1999 as a replacement while the existing breaker received a planned overhaul. The breaker had a manufacturer's label plate that stated the correct rating which was apparently used to verify the breaker's configuration prior to installation. However, the current transformers on the breaker were undersized and were not required to be checked by the licensee's configuration control procedures.

The NRC used the significance determination process to evaluate the impact of the low overcurrent trip setpoint during accident scenarios that generate a safety injection actuation signal or standby diesel generator start signal (i.e. situations which would place the breaker under high loading and which could potentially lead to core damage). The staff concluded that the safety significance was very low because the licensee had the ability to restore power to critical loads in a prompt manner using existing procedures and training. The licensee was able to demonstrate that, in conjunction with the two unaffected trains, all critical loads could be restored prior to core damage.

.2 Review of Operability Evaluations

a. Inspection Scope (71111.15)

The inspectors reviewed the following operability evaluations and supporting documents associated with the following problems in accordance with Inspection Procedure 71111, Attachment 15:

- Unit 1 main turbine overspeed test failure. This issue is discussed in Section 4OA4.

- Unit 2 Solid State Protection System Train C Test Circuitry abnormal indications (three Train C relays affected). The circuitry was found to be operable after testing satisfactory.

b. Findings

No findings of significance were identified.

.3 (Closed) Inspection Followup Item 499/98007-01: Review root cause analysis for repeat failures of the power transfer switch for Distribution Panel DP003 when it failed to swap over on loss of normal power.

After replacing the switch, the licensee determined that the root cause was a dent in the midposition that kept the transfer switch from switching power sources. The inspectors determined that the failure of the transfer switch was of no safety significance because no safety related or mitigation equipment was powered from DP003 and the licensee experienced no problems with other similar transfer switches. This item is closed.

.4 (Closed) Licensee Event Report 498/00-006-00: One train of essential chilled water found inoperable due to an oil leak while another train was out of service for maintenance.

The licensee was able to quickly restore the train that had just been removed from service for maintenance, although the plant was in a Technical Specification 3.0.3 required shutdown for 1 hour 9 minutes. This event was determined to be of very low risk signficance due to the brief duration. No violation or performance problems were identified. This item is closed.

1R19 Postmaintenance Testing (71111.19)

a. Inspection Scope

The inspectors observed and/or evaluated postmaintenance testing performed on the following equipment to determine whether the tests adequately confirmed equipment operability:

- Unit 1 pressurizer pressure transmitter replacement and calibration (Ch. 457), WAN 187946
- Unit 1 Technical Support Center diesel generator after maintenance due to fuel found in the lube oil system, WAN 152047
- Unit 1 Nuclear Instrument 41 summing amplifier replacement, WAN 189193

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope
The inspectors evaluated the adequacy of periodic testing of the following important nuclear plant equipment, including aspects such as preconditioning; the impact of

testing during plant operations; the adequacy of acceptance criteria including test frequency and test equipment accuracy, range and calibration; procedure adherence; record keeping; the restoration of standby equipment; and the effectiveness of the licensee's problem identification and correction program. The inspectors observed or reviewed the following tests:

- 0PSP03-CS-0003, "Containment Spray Pump 1C Inservice Test," Revision 6 (Unit 1)
- 0PSP11-CS-0007, "Containment Spray System Train 1B Contaminated System Leak Rate Test," Revision 8 (Unit 1)
- 0PSP03-AF-0007, "Auxiliary Feedwater Pump 24 Inservice Test," Revision 16 (Unit 2)

b. Findings

No findings of significance were identified.

3. OTHER ACTIVITIES

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed the following performance indicators for the first and second quarters of 2000, to assess the accuracy and completeness of the indicator reporting. The inspectors used Nuclear Energy Institute (NEI) guidance NEI 99-02, "Performance Indicator Verification," Revision 0, as guidance for this inspection.

Mitigating Systems - Safety System Performance Indicator Unavailability.

- Emergency Power
- High Head Safety Injection
- Auxiliary Feedwater
- Residual Heat Removal

b. Findings

No findings of significance were identified.

4OA4 Cross-cutting Issues

Licensee Did Not Understand Requirements Related to Main Turbine Mechanical Overspeed Protection

a. Inspection Scope

The inspectors reviewed the licensee's response to a failure of the Unit 1 main turbine mechanical overspeed protection system. The inspectors walked down the turbine front standard with the Unit 1operations manager, and discussed the test history and repair efforts with the Unit 1 operations manager and the system engineer. The inspectors reviewed Technical Requirement Manual (TRM) Section 3.3.4 and bases, UFSAR Sections 3.5 and 10.2, as well as the following test documents and related condition reports for the period 1997 through 2000.

Condition Reports:

00-12869
99-12775
99-12759
98-2092
98-1626

Preventive Maintenance Items:

RO-1-TM-87015603, "Test/Overspeed Trip Oil Pressure Check High Pressure Turbine," WAN Numbers 150578, 147596, 147475, 147421, 147294, 147197, 88341, 82053, 48439

Preventive Maintenance Deferral/Waiver 30382360

Other Documents:

0PGP03-ZE-0004, Revision 19, "Plant Surveillance Program"
0PGP03-ZM-0002, Revision 30, "Preventive Maintenance Program"
0POP07-TM-0001, Revision 4, "Main Turbine Overspeed Test"

b. Findings

The inspectors determined that the licensee did not fully understand the requirements and commitments relating to the mechanical overspeed protection system for the main turbine. As a result, a series of failures and unsuccessful corrective actions over three operating cycles did not result in proper evaluations against commitments, equipment operability or status tracking. No violations were identified.

The inspectors identified that Unit 1 main turbine mechanical overspeed protection system was part of a redundant protection scheme to avoid the turbine overspeeding

and generating missiles which could damage critical plant equipment. UFSAR Sections 3.5 and 10.2 describe the overspeed protection for the main turbine, noting that the protection is single failure proof due to the diversity of the system. The UFSAR commits the licensee to performing quarterly testing of the mechanical overspeed protection system, although the test is not required in the TRM. However, the inspectors concluded that the mechanical overspeed protection system was a system that satisfied the TRM Requirement 3.3.4 that at least one main turbine overspeed protection system shall be operable.

The inspectors determined that the licensee did not know what equipment could be used to satisfy TRM Requirement 3.3.4. The licensee did not credit the mechanical overspeed protection system and relied solely upon the electrical overspeed protection system to satisfy the requirement. As a result, the licensee performed the quarterly mechanical overspeed testing without knowing it was intended to demonstrate operability. The administrative controls applied to the test were those of a preventive maintenance item; when the test failed, no operability evaluation was performed, the equipment failures were not tracked, and subsequent tests were canceled without any evaluation because the commitment was not recognized.

The failures observed related to mechanical binding of an indicating lever which was required to reposition to demonstrate that the mechanical overspeed trip mechanism would function. While the binding was observed with the turbine hot, it was not observed during two outages, and the work was canceled. Tests would pass immediately after turbine startup, then begin to fail during the cycle. Thus corrective actions were not rigorous. When the inspectors raised the issue following the latest failure, the licensee determined that the problem could be corrected on line, and fixed the problem the same week.

Because the electrical overspeed protection system was always available, TRM Requirement 3.3.4 was always satisfied. No violation was identified. This issue was entered into the licensee's corrective action program under Condition Report 00-13277.

4OA5 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. W. Cottle and other members of licensee management at an exit meeting on September 26, 2000. The licensee acknowledged the findings presented. A supplemental exit meeting was performed with Mr. S. Head on October 2, 2000, to discuss the staff's final categorization of the breaker failure discussed in Section 1R15.1 as a green issue.

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

.2 Management Meetings/Site Visits

On August 15, 2000, Mr. A. Howell, Director, Division of Reactor Safety, Region IV, met with Mr. W. Cottle and members of his staff to discuss station performance and to tour the plant.

On September 21, 2000, Commissioner N. Diaz and Mr. E. Merschoff, Regional Administrator, Region IV met with Mr. W. Cottle and members of his staff to discuss the station's use of risk information and to tour the plant.

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

P. Arrington, Licensing Specialist
T. Bowman, Division Manager, Operations
T. Cloninger, Vice President, Generation
K. Coates, Manager, Maintenance
W. Cottle, President and Chief Executive Officer
J. Crenshaw, Manager, Systems Engineering
W. Dowdy, Manager, Generation Support
W. Harrison, Senior Staff Engineering
S. Head, Supervisor, Licensing
T. Jordan, Manager, Engineering
W. Jump, Manager, Projects
A. Kent, Manager, Testing/Programs
F. Mangan, Vice President, Business Services
J. Phelps, Division Manager, Unit 1 Operations
J. Sheppard, Vice President, Engineering and Technical Services

NRC

W. Jones, Senior Reactor Analyst, Region IV

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

499/200011-01	NCV	Criterion III violation for failure to maintain Breaker E2C1 configuration in accordance with its design basis (Section 1R15.1).

Closed

499/200011-01	NCV	Criterion III violation for failure to maintain Breaker E2C1 configuration in accordance with its design basis (Section 1R15.1).
499/98007-01	IFI	Review root cause analysis for repeat failures of the power transfer switch for Distribution Panel DP003 when it failed to swap over on loss of normal power (Section 1R15.3).
498/00-006-00	LER	One train of essential chilled water found inoperable due to an oil leak while another train was out of service for maintenance (Section 1R15.4).
498/99021-01	URI	Change made to fuel handling ventilation without 50.59 evaluation (Section 1R02).

Discussed

None.

LIST OF ACRONYMS AND INITIALISMS USED

ESF	Engineered Safety Features
TRM	Technical Requirement Manual
UFSAR	Updated Final Safety Analysis Report

ATTACHMENT 2

NRC'S REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) 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 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 used 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, or 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. 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.