

## **Summary of NRC Public Meeting on Safety Culture Initiatives February 14, 2006**

The purpose of this meeting was to provide an opportunity for stakeholders to discuss and ask questions on draft changes to selected inspection procedures (IPs) and manual chapters (MCs) related to the safety culture enhancements to the Reactor Oversight Process (ROP). The staff asked for high level comments for discussion during the meeting and for stakeholders to provide detailed additional comments in writing by February 21, 2006. The exception to this deadline was comments on IP 95003, which the staff will be releasing shortly and will provide an additional period for comments. The staff's presentation for this meeting can be viewed at: <http://www.nrc.gov/what-we-do/regulatory/enforcement/sc-ml060440237.pdf>

### **Manual Chapter 0305**

In response to several comments, the staff provided clarification that a finding must involve a performance deficiency, i.e., cross-cutting aspects do not factor into the determination of the existence of a finding; they are only evaluated after the finding has been developed. Inspector observations that are not related to performance deficiencies do not result in findings. In response to this explanation, there was a comment that this approach is reactive and therefore regulatory actions are taken too late. The staff responded that this approach is consistent with the principles of the ROP and that the program was designed to be reactive. Under the ROP, licensees are provided the opportunity to identify and address smaller problems. If they manifest into larger problems, then NRC would become involved. The cross-cutting areas are designed to have the potential to be more proactive. Several stakeholders expressed confusion on the use of terminology associated with cross-cutting, including areas, aspects, issues, and components. The staff agreed to review these terms in the procedures to ensure they are used accurately and consistently.

Some stakeholders expressed concern that licensees would not know which findings have cross-cutting aspects and if there are cross-cutting aspects, which themes are involved. The staff explained that when a finding has a cross-cutting aspect, that aspect will be documented in the inspection report, along with the reason (theme). This should also be communicated to the licensee at the inspection exit before the inspection team leaves the site. The staff explained that this will be addressed in inspector training to ensure consistent implementation.

On the safety culture components, the staff reiterated that the first nine were determined to be able to be appropriately evaluated under the baseline inspection and the additional four are more appropriately addressed by licensee efforts; all thirteen would be addressed in the supplemental inspection program. In response to several comments, the staff emphasized that inspectors would not be inspecting to the safety culture descriptions; the descriptions would be used to identify contributing causes to findings and in determining cross-cutting aspects. The staff further explained that not all aspects of a component description would be applicable in every situation or to every licensee. Several stakeholders made comments on the component definitions. One stakeholder felt the components appeared to be "watered down" and the threshold for findings to have cross-cutting aspects to be increased. Other stakeholders expressed concern that the use of terminology like "such as" and "for example" can lead to confusion as to what is required to be met and what are examples. Stakeholders indicated that they wanted clearer presentation of the information in the descriptions in order to ensure predictability in implementation. The staff responded that it will consider these comments and revisit the wording of the safety culture component descriptions.

A stakeholder pointed out that the wording in section 06.07.a.2 seemed to indicate that all findings have cross-cutting aspects. The staff answered that this was not the intention and will review the wording. Also regarding this section, the staff clarified that some performance deficiencies can have multiple aspects. Stakeholders commented that this allows for subjectivity, and the staff agreed to evaluate if any wording changes are needed to address this concern and provide clarification.

In response to a stakeholder question, the staff discussed how the Salem/Hope Creek plants would have been treated under this approach. The determination of cross-cutting issues would have been the same, and with the plants' performance under the approach, they would have been requested to conduct a safety culture assessment. Regarding the Davis Besse head incident, the staff explained that there is not enough data to review potential treatment under the enhancements, and in addition there are other changes that have already been implemented that would confound any tests.

Regarding safety conscious work environment (SCWE), there was discussion on what the term "isolated" meant in the criteria statement "the associated impact on safety-conscious work environment was not isolated." The staff provided examples to illustrate its intended meaning. Several stakeholder expressed concern on the one finding threshold for entering the SCWE substantive cross-cutting issue determination process. A stakeholder indicated that licensees should be provided opportunity to give NRC information on actions it is taking to address the SCWE issue prior to NRC making the decision on a SCWE substantive cross-cutting issue. A stakeholder also expressed concern that if there is disagreement among the individuals involved in a finding regarding whether there was discouragement for raising concerns, then the inspector would have to make a determination on how to resolve the disagreement. The staff explained that the burden of proof would be on the NRC who would need to have evidence that the situation is not limited to just one individual and that this is an issue to be addressed in training.

A stakeholder asked about available guidance on when NRC should issue a Chilling Effect Letter (CEL). The staff responded that there is guidance in the NRC Enforcement Manual. If there is a case of discrimination for raising safety concerns that has been substantiated, then a CEL would be sent to ask the licensee for actions they are taking to ensure the case does not have a chilling effect. The staff is also working on additional guidance for other circumstances under which a CEL would be warranted.

There was a comment on the criteria "the NRC has a concern with the licensee's scope of efforts or progress in addressing the cross-cutting area performance deficiency" (section 06.07.b.2) that there could be situations where the licensee took corrective actions but they did not work. The staff responded that they recognize this issue and would address it during implementation and training. A stakeholder stated that it was unclear what the term "minor" refers to in section 06.05.b.3 regarding contribution to performance issues. The staff explained what was intended by the wording and agreed to review and consider revising. There was also a comment regarding why the statement "safety conscious work environment (SCWE) issues shall only be discussed if the agency has previously engaged the licensee via a meeting or docketed correspondence regarding a potential or actual SCWE concern or issue" was deleted in section 06.02.c.3. The staff explained that this statement was not removed but was replaced by more specific guidance elsewhere in the document. The staff will review this change to ensure the intention is still reflected in the document.

NRC staff highlighted the changes to inspection procedures 71152, 95001, and 95002, and inspection manual chapter 0612. The presentation slides are available at: <http://www.nrc.gov/what-we-do/regulatory/enforcement/sc-ml060440237.pdf>, and the draft

revised inspection procedures are available through individual links under the “February 14, 2006” meeting heading on the safety culture webpage:

<http://www.nrc.gov/what-we-do/regulatory/enforcement/safety-culture.html>.

### **Inspection Procedure 71152**

Key points of discussion and NRC staff clarification included the following:

- The enhanced oversight framework would continue the performance-based approach. Inspectors are not going to do programmatic reviews, rather they would look at programmatic contributions to performance deficiencies with a risk-informed performance-based perspective.
- Staff will revisit whether it is appropriate to reference supplemental procedures (e.g., 95001 or 95003) in baseline procedures.
- Regarding a resident inspector’s ability to follow up on SCWE issues, NRC staff clarified that the intention is for resident inspectors to get regional managers involved early in order to improve consistency in response, not to prevent inspectors from following up on a potential issue. Staff will consider rewriting that part of the procedure for clarity.
- There was discussion on whether plant management can (legally) and should communicate disciplinary or other employee actions, in order to avoid a chilled environment created by perceptions of management actions at the plant, and how such communication may occur.
- NRC staff clarified that the intent of the questions listed in IP 71152 is to be guidance, not for the inspectors to use them line by line. In addition, the majority of the procedure is focused around potential problems rather than just a general survey.
- There was a question about the realm of applicability of “current” being two years. NRC staff clarified that there is no time of expiration for performance deficiencies. The two-year cut off in MC 0612 refers to the consideration of cross-cutting areas.

### **Inspection Procedures 95001 and 95002**

- A stakeholder said that in the new inspection objective to determine whether any safety culture components contributed to a performance deficiency, it is unclear whether the NRC is looking at *primary* drivers or *any* contributor, and suggested changing the words to “root cause” rather than contributed in “more than minor way.” NRC staff clarified that it doesn’t want to exclude major factors from consideration, that there is already a lot of guidance on what the “more than minor” threshold is, but that they would clarify the language in the IP.
- There was discussion about the nature of inspectors’ evaluation of root-causes in the proposed framework, and NRC staff clarified that the proposed IP is not substantially different from what is done currently.
- A stakeholder asked where the safety culture assessment would occur in the regulatory framework. NRC staff clarified that: (1) staff would hold the finding open if inadequacies were found in how the licensee addressed the problem; (2) once the problem was addressed, NRC would perform a follow-up inspection to determine whether the issues had been addressed adequately; and (3) follow-up with the Problem Identification and Resolution (IP71152) baseline procedure. There would be a suite of options available depending on the finding.
- NRC staff also reinforced that if a licensee misses something in its Corrective Action Program, the NRC would not automatically request an independent safety culture assessment.
- A stakeholder raised the issue that there may be unintended consequences on how a licensee conducts its root-cause evaluation. Licensees may have an incentive to stop short root-cause evaluations before they call out the cross-cutting common “themes” identified in

regulatory documents. NRC staff responded that if it were to identify that a licensee's root cause evaluation was not uncovering important insights, the staff would investigate that as a separate potential performance deficiency. Staff also responded that this is an issue to track in the initial implementation.

## **Manual Chapter 0612**

Key points of discussion and NRC staff clarification included the following:

- Licensees are having difficulty understanding theming/binning process and understanding what the outcome of the process would be. NRC staff clarified that one should be able to go into the inspection record and identify whether there is a cross-cutting aspect of a finding, and if so, the theme of the cross-cutting aspect(s).
- NRC staff are considering a possible Appendix E that would provide inspectors with additional examples for cross-cutting areas.
- There were questions about at what level of safety culture component description the "common themes" would reside. NRC staff anticipates that the bullets underneath the safety culture component descriptions (in MC 0305) could be the descriptors of common themes.

## **Event Follow-Up Procedures (IP 71153, 93800, 93812)**

- One stakeholder said that event follow-ups are essentially "freezing the facts," and thought it might be premature to try to get safety culture insights out of just freezing the facts. Staff clarified that some event responses have a fact-finding focus, but that that does not encompass all types. Many event follow-ups involve a charter that includes looking at the licensee's root causes. In that context, it is beneficial to get safety culture insights. The revised IP was written broadly to address all the different cases.

## **Next Steps**

- NRC must resolve comments on the draft revised IPs and get the IPs into the formal issuance process by the beginning of March.
- There will not be a second round of comments after February 21<sup>st</sup>. The safety- culture-based revisions and public comment opportunity were already a special addition outside the regular process for IP revisions.
- In March there will be a safety culture briefing for the Commission Technical Assistants.
- In May the NRC staff will send the Commission an information paper with full details of the work.
- The Office of Nuclear Reactor Regulation has the lead on deciding phase-in issues for plants that are already (on July 1<sup>st</sup>) in columns 2-4 of the ROP Action Matrix.
- NRC staff will brief the ACRS on safety culture during the April 4-6 meeting.
- An NEI representative stated that there is a ROP task force meeting next week on February 23. Issues related to cross-cutting areas (that go beyond safety culture) will be discussed.