Resolution of External Stakeholder Comments on Inspection Manual Chapters (IMC) 0305, 0612, 0612-Appendix D, Inspection Procedures 71152, 95001, 95002, 71153, 93800, 93812

IMC 0305		
Comment	**Added (Yes [Y], No [N], not applicable [N/A])**	**Remarks**
Clarify that the individual bullets of the safety culture components are considered to be the aspects that would be used by the inspectors as listed in section 06.07.c.	Y	See sections 04 and 06.07
Define cross-cutting area, component, aspect, and theme in the procedure. Change and clarify terminology associated with cross-cutting issues to be more consistent.	Y	See sections 04 and 06.07
Better define “in more than a minor way” as discussed in section 06.05.b.3.	Y	See section 06.05.b.3
Clarify discussion in section 06.07.a to reflect that not all inspection findings are associated with cross-cutting aspects and those that associated with cross-cutting aspects are documented IAW IMC 0612.	Y	See section 06.07.a
Delete first part of first sentence since it is a redundant statement in section 06.07.a.3.	Y	See section 06.07.a.3
Add a statement that it is not typical for a single finding to be binned against multiple cross-cutting components.	Y	See section 06.07.a.2
There is no guidance for the cross-cutting components that are NOT part of the cross-cutting areas that discusses how these will be used by the inspectors. There is considerable subjectivity introduced by several of the terms in those components. The descriptors for these components are broad and it is unclear how an inspector should employ them.	N	Those components that are NOT part of the cross-cutting areas are covered in supplemental procedures. This comment will be addressed with other comments received on IP 95003.

Failure to follow procedures should not be routinely used as it is not typically considered the cause of the finding.	Y	See section 06.07.a
Provide clarification on what the term “not isolated” means as used in section 06.07.b.	Y	See note in section 06.07. b
Licensee should be given the opportunity of a meeting to discuss their perspective prior to the NRC determining that licensees have a substantive cross-cutting issue.	N	The comment proposes a change to the existing program that is not specific to the safety culture initiative. The ROP already provides various communication mechanisms for the licensee and the NRC to engage on issues of mutual concern.
In section 6.01 there are some non-SDP issues that are not associated with SCWE, such as 50.59 evaluations.	N	Statement in section 6.01 is a high level discussion that addresses the relationship between various elements of the ROP.
Clarify definition of the “independence” part of independent assessment.	Y	See sections 06.05.b.3 and 06.05.b.4.
Clarify how long the NRC will credit or use licensee recent assessments of safety culture.	N	The relevance of a safety culture evaluation will be determined on a case-by-case basis.
Can safety culture information from old design issues be factored into the Agency’s assessment?	N/A	This process is described in section 06.06.a and remains unchanged. Cross-cutting aspects associated with findings from supplemental inspections would be dispositioned as they are today.

Clarify the timeframe for counting inspection findings as it relates to common theme analysis.	N/A	Section 06.06. c describes when findings start counting in the assessment process. The comment proposes a change to the existing program that is not specific to the safety culture initiative.
Remove the discussion that has the inspectors evaluate whether "individuals assigned to perform assessments have the necessary skills and authority."	Y	See section 06.07.c
Add substantiated allegations to description of assessment inputs in sections such as 04.02.	N	The definition of assessment inputs is used to describe those inputs that move a plant in the Action Matrix. Substantiated allegations do not move a plant in the Action Matrix.
Change the definition of SCWE in section 04.11.	N	Existing definition is consistent with the NRC's Policy Statement on SCWE.
Change the description of a substantive cross-cutting issue in section 04.14.	Y	See section 04.14
Reference where allegation input is used in sections 05.07.	Y	See section 05.07
Reference in section 06.01 where SCWE substantive cross-cutting guidance is located	Y	See section 06.01.
Include the daily review of CAP products from the IP 71152 inspection in section 06.01.a.	N	This is a high level discussion of the continuous regional review of inspection findings and performance indicators. There is no discussion of any of the individual inspection procedures or performance indicators in this section.

Several comments asked to incorporate a detailed discussion of allegations into several sections of IMC 0305.	N	These sections of the procedure are high level discussions. The treatment of allegations in the assessment program is discussed in the appropriate sections that details the conduct of the mid-cycle and end-of-cycle review meetings and regional operating instructions.
Add deleted text that discusses when SCWE substantive cross-cutting issues may be discussed in the assessment letters.	N	This discussion has been superceded by the development of the criteria for determining when a SCWE substantive cross-cutting issue exists (section 06.07.c).
Change “should” to “shall” and “expected” to “required” when discussing licensee actions on performing a safety culture evaluation.	N	The terms “shall” and “ required” are used to discuss regulatory requirements. The current terminology is consistent with existing guidance in IMC 0305. For example, the Action Matrix lists “expected” licensee actions. There are follow-up NRC actions for instances in which expected licensee actions are not completed.
Add a requirement to the discussion of IMC 0350 to require an independent assessment of safety culture at the 12 month and 30 month point after restart.	N/A	This section is a high-level discussion of IMC 0350 that does not detail individual inspection requirements. However, the staff will initiate a feedback form to consider this comment for the next revision of IMC 0350.
Comments on cross-cutting components terminology.	Partially	See section 06.07.c

Move “Safety Policies” to the section that is associated with cross-cutting components that are evaluated under the baseline inspection program.	N	Safety Policies will be evaluated during supplemental inspection activities only. Safety policies are not closely aligned with the cross-cutting areas and are not evaluated under the baseline inspection program.
IMC 0612		
Comment	**Added**	**Remarks**
Add an appendix with examples to clarify how binning findings against aspects will occur.	Y	IMC 0612, Appendix F, “EXAMPLES OF CROSS-CUTTING ASPECTS” was developed.
IMC 0612 Appendix D		
p. D-3, Item d: Inspection Scope – last sentence appears to erroneously broaden scope of SCWE; revise to read “reluctance to raise nuclear safety concerns.”	Y	Revised as suggested.
IP 71152		
Comment	**Added**	**Remarks**
Operating experience and self-assessments read like programmatic vs. effectiveness assessments when using the word “ability” – are we assessing programs or performance?	Y	Reworded to target performance.
Page 7, paragraph 5, as written, it appears that this change will apply the safety culture components comparison to all root cause analyses. It is unclear what in IP 95001 are you pointing to when the staff says to use 95001 as an “aid.” A safety culture review of all root causes would be outside of the process that was conceptually agreed upon and is outside the guidance of the SRM.	Y	The reference to 95001 was deleted in that location. Other sections which look more in depth at root causes still refer to 95001 for guidance on how to review a root cause. IP 95001 guidance is written so that safety culture components will only be referred to where the root cause results indicate a potential issue.

Please explain what Item 5 on p. 11 means.	Y	Deleted
Is there a specific reason “periodic” is used?	Y	Deleted
Audits – this is used narrowly by some licensees as typically Appendix B. Is that what is meant? Is this for all work done by your assessment groups?	N	Audits are typically done by an independent licensee organization. That is the intent.
Is this being linked to IP 95003? Unclear from the changes in this procedure.	N	It is not intended as a link, but additional questions are available for use by inspectors at regional management’s discretion.
Page 14, section d. third paragraph: Portion regarding inspectors pursing issues was deleted. It was not clear why this was removed. However, we believe that it is a good practice typically to engage regional management in issues of this nature. We also believe this practice would be consistent with MC 2515, 12.04, Findings Outside of Inspector’s Qualifications, “Inspectors sometimes identify issues or violations outside of the inspector’s qualifications or expertise. In these cases the inspector is responsible for (1) determining if an immediate threat to public or worker health or safety exists, and if one does exist to notify licensee management immediately, (2) determining if the issue is better addressed by an inspector with different qualifications (i.e., a specialist inspector). Inspectors may follow issues outside of their qualifications or expertise with the concurrence of a regional manager responsible for the area associated with the issue and the inspector’s supervisor.” With respect to SCWE issues, in order to determine if some findings would be placed in the SCWE bin, the RI’s would need to conduct at least basic investigations (distinct from inspections) and sometimes make credibility determinations. We are concerned about the RIs training and expertise in conducting investigations and making credibility determinations in matters such where credibility issues exist (e.g., a "he said," "she said" situation.); therefore, we believe that discussions with supervision would be prudent.	Y	In the paragraph prior, it allows inspector to pursue issues within the bounds of IP 71152 using Appendix 1. If further followup is needed, the inspector must contact regional management to decide the course of action. In addition, findings and observation have management review before issuance in an inspection report.

Page 15, para. f. Findings were NOT to be defined in terms of safety culture, but in terms of the cross-cutting components. This statement specifically discusses talking in terms of safety culture. The description of “any” issues related to safety culture is documenting “observations”. In addition, findings are to be reviewed against the cross-cutting aspects, not against all safety culture components.	Y	Reworded. Documenting findings is not the intention of this paragraph. This is to document observations that relate to cross-cutting components. Findings and cross-cutting aspects are the same for all inspection results and follow the documentation requirements of MC 0612.
Appendix 1. The last sentence of the opening paragraph in this appendix contains a reference to IP 95003 “for more detailed questions for the workforce and management.” Industry has two concerns with this reference: first, 95-003 is unavailable to the public at this time; therefore, we are unable to ascertain the intent of this statement; secondly, during the PI&R inspection, there should be no need for more detailed questions of the workforce than those provided in the procedure itself.	N	If further followup is needed, the inspector must contact regional management to decide the course of action.

Appendix 1. The industry believes that several of the questions in this appendix are misleading or will result in unintended consequences. For example, for some of these questions, there needs to be a historical perspective added. With respect to proposed Question 8, we expressed at the February 14 meeting a concern that this question implies that communication of disciplinary actions is expected or even required. In the 2-14-06 public meeting, an explanation was given that this is a good practice for the good of the many versus the potential litigation resulting from a breach of privacy for the individual. The industry completely disagrees with this characterization and feels it is unwise in many circumstances to globally communicate specific actions. With respect to NRC Question #7 - Non-management personnel will likely not be aware of all the things that are occurring to prevent and detect retaliation and/or chilling effect. With respect to proposed Question 9b, this part of the question should be eliminated. The question presumes a conclusion that may not be supported by facts and then encourages the interviewee to give an opinion that they may not be qualified to give. Identifying a contributing cause requires some review of the facts and analysis. Otherwise, the response is just a shot from the hip.	Y	Reworded the questions.
Editorial - Number 1 disappeared Starts with 2. Item #10 has no question.	Y	Revised.
Table on page 20. If kept, recommend adding a column titled: “Other” to be consistent with item 7 on page 6.	Y	Added the additional column.
Page 20, #8 - This question needs to be rewritten so that it is not implied that it is acceptable to violate privacy laws to address a safety culture issue.	Y	Reworded the question.
Several of the questions are asking for individual opinions. Words need to be added to require that individuals supply evidence to support their opinion. Opinions with no supporting evidence are just opinions and of little value.	Y	Reworded the questions.

Regarding documentation at this stage (IP 71152), you are gong to document in terms of safety culture. But 0612 talks about documenting cross-cutting aspects, not safety culture. There seems to be a disconnect between the two.	Y	Reworded the documentation guidance. Appendix F to MC 0612 has been created to provide consistency on cross-cutting aspects. The documentation requirements for a finding remain the same, but the IP 71152 documentation will provide the latitude for observations relating to cross-cutting area components to inform subsequent performance assessments.
In IP 71152, last paragraph under "d" says "if inspectors become aware of personnel being unwilling to raise issues…" -- you've X-ed out the one issue we stated months ago, to make sure the resident inspector can get to the bottom of "why"… now it looks like you have to call home and ask Mom (or Dad) to do that. Why did that happen? The resident has the best handle on what is going on , why do they have to get permission first to pursue?	N	The PI&R biennial inspection has a task of assessing PI&R. A SCWE concern should receive the inspection/investigation resources and expertise determined by regional management. The resident inspectors will have input to the decisions.
Provided a marked up copy of the procedure.	Partially	Many suggestions were incorporated where they improved language, did not conflict with the purpose of the procedure to gauge PI&R and observe the SCWE, and met the ROP performance-based approach.

IP 95001		
In IP 95001 there seems to be confusion on violations… the implication is that there might be a violation that is not tied to regulatory requirement, which is not possible.	Y	The guidance in 03.02.e was revised to provide clearer direction for inspectors to look for cases in which a weakness in a safety culture component actually caused or made a contribution to the performance deficiency and the licensee did not recognize that cause or contribution. Language in that guidance parallels similar language elsewhere in the procedure, and language in the associated regulatory requirement. See below.
The NOTE below items e. on p. 11 contains language that does not appear to be consistent with regulations – consider modifying note to ensure that it is clear that violations are associated with regulatory requirements.	Y	See above.
The words associated with NRC staff's review of a root cause against the components may unintentionally influence root cause evaluations conducted by licensees – the results of the root causes should be compared to the list, not a look at the list to see if the root cause looked at all aspects – it is a fine point, but the outcome of the root cause should be compared against the list so that you don't direct / influence the investigation. The procedure correctly indicates that inspectors should ensure a systematic root cause analysis technique is used. The technique does NOT need to specifically call out all the safety culture components.	Y	The guidance in 03.02.e was revised to provide clearer direction for inspectors to look for cases in which a weakness in a safety culture component actually caused or made a contribution to the performance deficiency and the licensee did not recognize that cause or contribution. Language in that guidance parallels similar language elsewhere in the procedure, and language in the associated regulatory requirement.

Page 11, Section 3.02(e) Revise to read “for each performance deficiency that prompted this inspection, determine whether the root cause evaluation appropriately considered safety culture components.” Delete the next sentence as it implies that the licensee must systematically consider each SC component.	Y	See above.
p. 11: Confusion about the direction of root-cause – one stakeholder felt the terminology implied starting with a list of causes and going up the tree, rather than the other way around – the right way is to dig down to the roots. He also commented that standard methods like the tap-root method may not contain all the safety culture components as possible “roots.”	Y	See above.
pg. 13, Section 03.05 Numbers 2 and 3. insert the word "appropriately" between methodology and considered" in number 2 to emphasize that we do not expect licensee's to systematically evaluate whether each SC component contributed to the finding. On No. 3, Delete the first sentence up to the first comma so it should read "If the inspectors determined that a weakness in a component could reasonably have caused or contributed to the deficiency, and the licensee did not identify this as a root or contributing cause... Again, this will make it clearer that we do not expect the licensee to "check" each SC component off a list when doing their root cause.	Y	See above.
IP 95002		
In IP 95002, the phrase contributed in “more than a minor way” is not clear.	Y	See below
1.03, 02.05“in more than a minor way” – what does this mean? This should mean that this factor is one of the root causes for the event. You are really trying to get to the primary drivers of the event, not all potential “contributors.”	Y	The phrase “contributed in more than a minor way” was revised to “was a Root Cause or Contributing Cause”. (Root Cause and Contributing Cause are both defined in the procedure.)

IP 71153		
Comment	**Added**	**Remarks**
“Appropriate ROP inspection,” and “governing ROP inspections” - not sure what is meant by these terms.	Y	Reworded to add word ”baseline.”
IP 93800		
Comment	**Added**	**Remarks**
03.01b; Should "contributing" be "primary"? When we talk safety culture, we had said we don’t need to bin all causes but just the primary causes.	Y	The collection of information on event causes is not only for identifying a cross-cutting aspect for an issue, but for understanding all causes to an event. Wording was changed to be consistent with the rest of the guidance.
IP 93812		
Comment	**Added**	**Remarks**
03.01b; Should "contributing" be "primary"? When we talk safety culture, we had said we don’t need to bin all causes but just the primary causes.	Y	The collection of information on event causes is not only for identifying a cross-cutting aspect for an issue, but for understanding all causes to an event. Wording was changed to be consistent with the rest of the guidance.