NRCREP - STARS Comments on the ROP Process

10/11/07
72FR 57975
(6)

From: "Moser, Tod A." <TMoser@ameren.com>
To: <nrcrep@nrc.gov>
Date: 12/08/2007 1:56 AM
Subject: STARS Comments on the ROP Process
CC: <Duane.Kanitz@aps.com>, "Moser, Tod A." <TMoser@ameren.com>

Michael T. Lesar, Chief
Rulemaking, Directives and Editing Branch
Office of Administration (Mail Stop T–6D59)
U.S. Nuclear Regulatory Commission
Washington, DC 20555–0001

RECEIVED
2007 DEC 11 PM 3:47
RULES AND DIRECTIVES BRANCH USNRC

Dear Mr. Lesar,

Please find attached comments on the ROP process prepared by the STARS alliance.

Best regards,

Tod A. Moser
Manager, STARS Regulatory Affairs
573-676-4775 (office)
573-823-9253 (cell)
TMoser@ameren.com

********** The information contained in this message may be privileged and/or confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. Note that any views or opinions presented in this message are solely those of the author and do not necessarily represent those of Ameren. All emails are subject to monitoring and archival. Finally, the recipient should check this message and any attachments for the presence of viruses. Ameren accepts no liability for any damage caused by any virus transmitted by this email. If you have received this in error, please notify the sender immediately by replying to the message and deleting the material from any computer. Ameren Corporation
****

SUNSI Review Complete
Template = ADM-013

E-RIDS = ADM-03
Add = B. Fu (zbf)
R. Frahm (RKF)

Mail Envelope Properties (475A3FFD.26B : 20 : 62059)

Subject: STARS Comments on the ROP Process
Creation Date Fri, Dec 7, 2007 5:09 PM
From: "Moser, Tod A." <TMoser@ameren.com>

Created By: TMoser@ameren.com

Recipients
nrc.gov
TWGWPO01.HQGWDO01
NRCREP

aps.com
Duane.Kanitz CC

Post Office	**Route**
TWGWPO01.HQGWDO01	nrc.gov
	aps.com

Files	**Size**	**Date & Time**
MESSAGE	1406	Friday, December 7, 2007 5:09 PM
TEXT.htm	5491	
STARS07018 - ROP Survey.pdf		71643
Mime.822	108467	

Options

Expiration Date:	None
Priority:	Standard
ReplyRequested:	No
Return Notification:	None
Concealed Subject:	No
Security:	Standard

Junk Mail Handling Evaluation Results
Message is eligible for Junk Mail handling
This message was not classified as Junk Mail

Junk Mail settings when this message was delivered
Junk Mail handling disabled by User
Junk Mail handling disabled by Administrator
Junk List is not enabled
Junk Mail using personal address books is not enabled

Block List is not enabled

Strategic Teaming and Resource Sharing

T. Moser, Chairman
STARS Integrated Regulatory Affairs Group
P.O. Box 620, Fulton, Missouri 65251

Ref: 72 FR 57975

STARS-07018

December 07, 2007

Michael T. Lesar, Chief
Rules and Directives Branch, Office of Administration
Mail Stop T-6D59
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

Strategic Teaming and Resource Sharing (STARS)
Comments on the Implementation of the Reactor Oversight Process
72 FR 57975 (October 11, 2007)

The Strategic Teaming and Resource Sharing (STARS)[1] alliance would like to take advantage of this opportunity to comment on implementation of the Reactor Oversight Process (ROP). The STARS alliance has been working with NEI and RUG IV in the development of industry comments. The STARS alliance supports the comments submitted by NEI and RUG IV.

Since implementation in April 2000, the ROP has exhibited marked improvement over the former inspection and enforcement process. The continued improvement by way of the routine ROP public meetings and the periodic solicitation of public feedback has assisted the ROP in effectively meeting the intended objectives, i.e., to provide tools for inspecting and assessing Licensee performance in a manner that is more risk-informed, objective, predictable, and understandable than the previous oversight process and provides for regulatory actions that are open, effective, efficient, realistic, and timely.

Reassessment of the performance indicators and adopting more effective indicators (e.g., Mitigating Systems Performance Index and Unplanned Scrams with Complications) is noteworthy. Also noteworthy is the structured Frequently Asked Question (FAQ) and FAQ appeal process which improves consistency in application of performance indicator guidance and captures the rationale for the decisions made in a more durable way. The STARS alliance supports and looks forward to assisting in the

[1] STARS is an alliance of six plants (eleven nuclear units) operated by Luminant Power, AmerenUE, Wolf Creek Nuclear Operating Corporation, Pacific Gas and Electric Company, STP Nuclear Operating Company and Arizona Public Service Company.

continuing efforts to further develop and improve the ROP. Attached please find the STARS alliance response to the "Solicitation of Public Comments on the Implementation of the Reactor Oversight Process" as published in the Federal Register on October 11, 2007.

The STARS alliance appreciates the opportunity to comment on the implementation of the Reactor Oversight Process. If there are any questions regarding these comments, please contact me at 573-676-4775, or tmoser@ameren.com, or Duane Kanitz at 623-393-5427, or duane.kanitz@aps.com.

Sincerely,

T. Moser, Chairman
STARS Integrated Regulatory Affairs Group

Attachment:

Attachment to STARS-07018

STARS Comments on the Implementation of the Reactor Oversight Process

I

Questions related to specific Reactor Oversight Process (ROP) program areas
(As appropriate, please provide specific examples and suggestions for improvement.)

(1) Does the Performance Indicator Program provide useful insights to help ensure plant safety?

Comments:

The Performance Indicators (PIs) have developed into performance standards that the industry strives to exceed. Since the PIs are based on NRC defined acceptable limits, they reinforce industry and Licensee safety performance. The program enhancements made to the PIs in the Initiating Events and Mitigating Systems cornerstones (i.e. Scrams with Complications and Mitigating Systems Performance Index PIs) help maintain risk informed focus on equipment and plant operations most important to plant safety. While more time is needed to fully assess the effectiveness of these program enhancements, initial indications are that the changes have improved the program. In addition, the technical basis documents that have been developed to support the changes help provide a better understanding of the safety basis for the program.

(2) Does appropriate overlap exist between the Performance Indicator Program and the Inspection Program to provide for a comprehensive indication of Licensee performance?

Comments:

Performance Indicators look at the areas where clear performance thresholds have been developed. This allows the inspection program to spend more time looking at those areas that require more evaluation and investigation. The process is well integrated and, while overlap exists, the overlap seems appropriate in most cornerstones.

(3) Does NEI 99-02, "Regulatory Assessment Performance Indicator Guideline" provide clear guidance regarding Performance Indicators?

Comments:

While questions on the guidance do arise, a formal Frequently Asked Question (FAQ) process is available to the industry and NRC inspectors to resolve questions with the guidance. An industry task force (the Reactor Oversight Process Task Force or ROPTF) meets monthly with the inspection and assessment branch of the NRC to discuss and resolve the questions that arise with the guidance. When resolution is not achieved at the monthly Reactor Oversight Process (ROP) meetings, an FAQ appeal process is available and has been used to drive issues to resolution. The FAQ process and appeal process have proven to be effective and should be maintained.

(4) Can the Performance Indicator Program effectively identify declining performance based on risk-informed, objective, and predictable indicators?

Comments:

Some PIs produce more visible trends than others. Visible trends are more clearly seen in the Initiating Events, Emergency Preparedness and Occupational Radiation Safety cornerstones and tend to be objective and predictable. However, not all PI results produce visible trends and not all are risk informed. The MSPI is the first risk-based indicator and identifies conditions based on risk implications but does not typically produce a visible trend. Most other PIs have limited risk insights and may inaccurately identify risk significant conditions. A current example is the Yellow Alert and Notification System (ANS) PI at Cook Units 1 and 2. The ANS design and implementation is approved by FEMA with recognized limitations that are mitigated through the use of diverse media and actions specified under the emergency plan. A Yellow band for this PI is overly conservative.

The industry and NRC staff should continue efforts to better risk inform all of the PIs.

(5) Does the Inspection Program adequately cover areas important to safety, and is it effective in identifying and ensuring the prompt correction of any performance deficiencies?

Comments:

The resident inspectors are effective in ensuring areas important to safety are appropriately addressed. However, enhancements could be made to the inspection program to make better use of the NRC's generic communications program – especially for inspection issues that have generic implications such as technical questions identified during inspections that involve development of new regulatory positions. Two examples of inspection issues with generic implications are manual actions for response to fires and assessment of post-fire safe shut down equipment. A process is needed to ensure early stakeholder involvement in the identification and resolution of inspection issues that potentially have generic implications. The current FAQ process used for PIs could serve as a model for such a process. Enhanced use of generic communications would also promote consistency between the NRC regions.

(6) Is the information contained in inspection reports relevant, useful, and written in plain English?

Comments:

Generally the reports are relevant, useful and well written. The recent revision to the ROP guidance which provides a numbering scheme for the cross-cutting aspects identified in inspection reports is a welcomed improvement.

(7) Does the Significance Determination Process result in an objective and understandable regulatory response to performance issues?

Comments:

There are too many SDPs not based on risk or actual effect thresholds. Specifically, the Radiation Protection, Security, and Emergency Preparedness SDPs are subjective and deterministic. Many of these produce inconsistent results because of the dependence on the subjective views of the individuals applying the SDP guidance, especially in the case of the Security SDP. The industry and NRC staff should strive to improve these SDPs by including more risk-based elements, thus limiting the subjectivity and promoting more consistent significance determinations between cornerstone areas. Also, the SPAR models used by the NRC in determining risk are of limited value. The STARS alliance encourages the use of Licensee's Regulatory Guide 1.200 compliant PRA models to support the SDP process as they become available. The NRC could maintain a degree of independence by using a verification process modeled after the PI verification process.

(8) Does the NRC take appropriate actions to address performance issues for those plants with identified performance deficiencies?

Comments:

NRC action in accordance with the Action Matrix is clear and consistent for single white findings and single white performance indicators; but is less clear for more complex issues. Also less clear is the assessment and disposition of substantive cross-cutting issues. For Licensees with identified substantive cross-cutting issues in Region IV, the rate of findings identified with cross-cutting aspects was essentially 100 percent, where as for the other three Regions, the rate was closer to 75 percent. There appears to be a degree of inconsistency between regions with the assignment of cross-cutting aspects.

(9) Is the information contained in assessment reports relevant, useful, and written in plain English?

Comments:

The information contained in assessment reports is, for the most part, relevant, useful, and well written. Inspection schedules in particular are good to have in advance even if they are not fully refined. One area that could be improved deals with cross-cutting aspects that change from the time they are initially identified in an inspection report. The current assessment guidance permits cross-cutting aspects to be changed if additional insights are available following publication of the associated inspection report. Given the regulatory principles that guided the development of the ROP (that overall assessments of Licensee performance remain transparent, understandable, objective, predictable, risk-informed, and performance-based), any change in the assigned aspect should be readily available to the Licensee as well as other stakeholders. When an assigned cross-cutting aspect is changed, the issue should be re-exited and the inspection report updated before the assessment report is issued.

Questions related to the efficacy of the overall ROP. (As appropriate, please provide specific examples and suggestions for improvement.)

(10) Are the ROP oversight activities predictable (i.e., controlled by the process) and reasonably objective (i.e., based on supported facts, rather than relying on subjective judgment)?

Comments:

The STARS alliance has some concerns that applicable ROP guidance is not being followed as written or intended particularly in the areas of double counting and determination that a finding is greater than minor.

Relative to double counting, the STARS alliance has the following concern:

On page 8 of the NRC consolidated response to the 2006 Reactor Oversight Process (ROP) external survey (ADAMS Accession Number ML072070140) the response states:

> "Additionally, with the development and implementation of the relatively new MSPI, given that this is the first set of PIs that are risk-informed, there will be instances where MSPI inputs and inspection findings on the same system will both be counted in the Action Matrix, because the two processes are fundamentally different in concept, thus have different meanings and each should stand on their own merit."

The STARS alliance views this last sentence to be inconsistent with the stated basic tenet of the ROP to not "double-count" events/findings in the Action Matrix. Contrary to the NRC staff statement made above, MSPI results are risk-informed and share more in common with risk-informed Significant Determination Process (SDP) results than any other performance indicator.

Relative to the determination that a finding is greater than minor, the STARS alliance has the following concern:

Manual Chapter 0612, Appendix E contains examples of findings that should be characterized as minor. Some potential findings bypass the examples in Appendix E and default to the rationale of "affecting a cornerstone objective" as the reason for the issue being greater than minor. The decision point in the examples in Appendix E appears to be focused on consequences – if there were no consequences, the potential finding is generally characterized as minor. When the screening defaults to the question of affecting the cornerstone objective, the focus on consequences is eliminated. As such, some minor issues are being classified as greater than minor.

As an example, Licensees routinely establish <u>dose rate</u> limits in addition to <u>integrated</u> dose limits for a given work activity. Both types of limits are typically incorporated into radiation work permit requirements and associated with electronic dosimeter alarm setpoints. However, except in extreme cases, dose rates are not clearly tied (if at all) to quantifiable risk to the worker's health and safety – provided that the integrated dose

limits established for the worker are not exceeded. Dose rate limitations are generally used to increase the sensitivity of the worker and RP staff to worker practices as well as potential changes in area dose rate conditions. As such, dose rate limits established by the Licensee are essentially administrative limits more conservative than any regulatory or industry standards. Accordingly, the intent of the administrative limit examples in Appendix E should apply to deficiencies associated with dose rate limitations. However, the NRC has established the interpretation that an administrative limit is a self-imposed limit that has a corresponding regulatory limit and since there is no regulatory requirement for limiting dose rates during work activities, there cannot be an associated "administrative limit." Based on this position, the NRC has not applied Appendix E examples in the screening process for performance deficiencies associated with dose rate alarms. Clearly, there is a level of performance deficiency related to dose rate limits that can be considered minor - where the intended integrated dose is not exceeded or there is no substantial potential to challenge the worker's health and safety.

Manual Chapter 0612 Appendix E should be a living document. More examples are needed to provide better guidance on characterizing minor issues.

(11) Is the ROP risk-informed, in that the NRC's actions are appropriately graduated on the basis of increased significance?

Comments:

The NRC's Action Matrix, if properly implemented, provides appropriate graduation on the basis of increased risk as the basis for NRC action to be taken. However, the STARS alliance believes that NRC management should continuously monitor the implementation of this process. The implementation of the process has at times resulted in a perception by some licensees that the action taken may not have been merited based on their understanding of the issue and the application of the Action Matrix to it.

(12) Is the ROP understandable and are the processes, procedures and products clear and written in plain English?

Comments:

The ROP procedures and products are generally clear and understandable. The ROP process can be complex and does require significant Licensee resources to maintain a working level understanding. An example of complexity is the section of Manual Chapter 0305 that discusses repetitive degraded cornerstone status. (Refer to page 18 section b.4, "Multiple/Repetitive Degraded Cornerstone Column"):

> "Assessment inputs result in a repetitive degraded cornerstone (2 white or 1 yellow input for five or more consecutive quarters), multiple degraded cornerstones, multiple yellow inputs or a red input. Regarding repetitive degraded cornerstone, if the only greater than green findings in the fifth quarter have been held open greater than four quarters, the repetitive degraded cornerstone does not apply. If, however, one of the greater than green findings

is still within the original four quarters and one or more findings has been held open greater than four quarters, the repetitive degraded cornerstone does apply. In this instance, the plant would stay in the Multiple/Repetitive Degraded Cornerstone column until there was only one greater than green finding, regardless of the length of time the findings have been opened."

This discussion is complex. While earlier sections of Manual Chapter 0305 define inputs to the Action Matrix as findings and PIs the discussion in this paragraph after the first sentence limits the inputs to findings.

The Emergency Preparedness SDP is not clear and lends itself to multiple interpretations, which makes its use unpredictable. The STARS alliance suggests reworking the SDP to assure uniform interpretation between the NRC and the Licensees is achieved.

(13) Does the ROP provide adequate assurance, when combined with other NRC regulatory processes, that plants are being operated and maintained safely?

Comments:

The STARS alliance strongly agrees that the ROP provides adequate assurance, when combined with other regulatory processes, that plants are being operated and maintained safely.

(14) Is the ROP effective, efficient, realistic, and timely?

Comments:

For the most part, the ROP is effective, efficient, realistic, and timely. However, some areas could be improved.

The current Component Design Basis Inspections (CDBI) are consuming substantial Licensee resources. There appears to be a significant opportunity to improve the efficiency of this process by applying more discipline to maintaining the schedule. The number and significance of the findings to date do not support the level of resources the inspection requires. The STARS alliance is encouraged by recent ROP realignment efforts and concurs with the recommendation to extend the frequency of these inspections to three years, from the current two year frequency. The STARS alliance remains concerned the scope of these inspections is not commensurate with Licensee performance and is overly burdensome. Additional efficiencies could be realized by forming permanent inspection teams to conduct the inspections.

Occasionally, inspection exit meetings are significantly delayed in time from close of inspection activities onsite, resulting in additional inefficiencies in the process.

Consideration should also be given to extending the assessment frequency for Licensees with good performance to annual and retain the six month assessment period for Licensees with substantive cross-cutting issues or who are in a degraded

cornerstone. In some cases, the mid-cycle assessments consume resources unnecessarily for both the NRC and Licensees.

The ROP is not realistic when it comes to incorporating plants that were mothballed years ago and are now being brought on line (or new plants) into the ROP. These plants will experience a "shakedown" period when they are first brought on line. The current ROP thresholds were based on a mature fleet of plants with several years of operating experience. A realistic process needs to be developed for bringing these plants into the ROP.

(15) Does the ROP ensure openness in the regulatory process?

Comments:

The ROP process, with its many public meetings and opportunities for involvement, does ensure openness not available in the previous process. However, improvements could be made in soliciting stakeholder feedback when revising or developing regulatory documents such as Inspection Procedures, Manual Chapter guidance, or Regulatory Issue Summaries (RIS). As the agent for the industry, NEI routinely requests the opportunity to review draft documents and provide feedback in a public venue. However, the NRC is reluctant to share draft information, particularly in the areas of Inspection Procedures and changes to Manual Chapter guidance. RIS 2007-21 "Adherence to Licensed Power Limits", was recently issued without stakeholder feedback. The RIS resulted in unintended consequences – the RIS removed guidance that the industry used for maintaining average full power operation without providing or specifying alternative guidance. If stakeholder feedback had been solicited before the RIS was issued, the unintended consequences may have been avoided.

Another area that is not open but sometimes used for ROP issues is the Task Interface Agreement (TIA) process (NRR Office Instruction COM 106). This process is really designed for internal use by the NRC. When the TIA process is used to resolve questions that an inspector may have as a result of an inspection issue, the process is not open to Licensee input and as such only the inspector's question is considered. Licensees in many cases are unaware that the TIA process is being used and are not able to ensure that the question being asked by the inspector contains all relevant facts and information. In the interest of promoting consistency and reducing unintended consequences, the TIA process should be more open to stakeholder input and feedback.

(16) Has the public been afforded adequate opportunity to participate in the ROP and to provide inputs and comments?

Comments:

The public has been afforded adequate opportunity to participate in most of the ROP and to provide inputs and comments by way of the public monthly ROP meetings, annual ROP feedback surveys, and the annual assessment public meetings. This is not the case however in the area of Physical Protection. The Physical Protection area of the ROP is not open to the public, which is appropriate in most cases. However, program

and process changes should go through a change management process (similar to ROP). Security-related information could be addressed by limited membership attendance as appropriate.

(17) Has the NRC been responsive to public inputs and comments on the ROP?

Comments:

The NRC has been responsive to public inputs and comments on the ROP. The NRC published a response to the 2006 ROP survey in which comments received were dispositioned. The STARS alliance supports the NRC publishing a response and encourages a published response by the NRC for these and any future ROP survey comments submitted.

(18) Has the NRC implemented the ROP as defined by program documents?

Comments:

For the most part, the ROP is implemented as defined by program documents. However, the STARS alliance is concerned that in isolated cases, regional inspectors may be receiving guidance from individuals at NRR via informal communication channels. The primary concern is this approach does not result in durable documented guidance which in turn promotes regulatory inconsistency.

(19) Does the ROP result in unintended consequences?

Comments:

In some cases, the ROP as implemented has resulted in unintended consequences. One example is the issuance of RIS 2007-21. This RIS was intended to address intentional abuses of average full power operation but in some cases resulted in plants de-rating the power level at which they were licensed to operate because of lack of appropriate guidance.

Questions related to the safety culture aspects of the ROP.

(20a) Do the ROP inspection and assessment safety culture enhancements help to focus Licensee and NRC attention on performance issues associated with aspects of safety culture?

Comments:

More time is needed to fully assess the effectiveness of the safety culture enhancements. However, an initial observation is only four or five aspect bins are being used to any great degree. If the entire set of Safety Culture bins were used it would

better focus Licensees and NRC attention on performance issues associated with aspects of safety culture. Additionally, interpretation of implementing procedures (i.e. assignment of cross-cutting aspects) has varied across the regions. This variance along with the practice of assigning of cross-cutting aspects without the benefit of a completed evaluation by the Licensee has resulted in inconsistencies or changes in assignments. It has also resulted in the assignment of cross-cutting aspects for issues that are really minor in nature which in turn results in a disproportionate number of plants with substantive cross-cutting issues.

The threshold of four aspects is inappropriate to assign a substantive cross-cutting issue. This threshold should be used to perform a more in-depth evaluation in that area to determine if a substantive cross-cutting issue exists. The existence of four issues out of a population of thousands of issues identified in a typical corrective action program is not statistically significant. The low threshold for assigning a substantive cross-cutting issue coupled with unclear criteria for clearing a substantive cross-cutting issue creates significant uncertainty.

(20b) Do the baseline Identification and Resolution of Problems inspection procedure (71152) and the special inspection procedures (93800 and 93812 respectively) provide an appropriate level of guidance on safety culture aspects and on the consideration of causal factors related to safety culture?

Comments:

The elements and structure of the safety culture guidance found in these inspection procedures and guidance incorporated by reference provides an adequate level of guidance for evaluating causal factors related to safety culture.

(20c) Do the supplemental inspection procedures (Inspection for One or Two White Inputs in a Strategic Performance Area (95001), Inspection for One Degraded Cornerstone or any Three White Inputs in a Strategic Performance Area (95002)) respectively provide an appropriate level of guidance to evaluate whether safety culture components have been adequately considered as part of the Licensees' root cause, extent of condition, and extent of cause evaluations and to independently determine if safety culture components caused or significantly contributed to the risk significant performance issues?

Comments:

There has been insufficient experience with 95001 and 95002 inspections and the application of the safety culture components to provide a meaningful answer. There is, however, a disconnect between corrective action programs and the 95001 and 95002 procedures. Corrective action program requirements do not include assessment of the safety culture components in the assessment of root and contributing causes as a normal matter of course. In many cases the root cause investigation may be complete before the determination of significance is completed. In these cases the licensee either has to go back and assess the root cause to apply safety culture components or allow the NRC to do that as part of the inspection process. For example, root cause

investigators are not typically trained to assess whether safety conscious work environment was a contributor to an event.

(20d) Does the procedure for a Supplemental Inspection for Repetitive Degraded Cornerstones, Multiple Degraded Cornerstones, Multiple Yellow Inputs, or One Red Input (95003) provide an appropriate level of guidance to independently assess the Licensee's safety culture and evaluate the Licensee's assessment of their safety culture?

Comments:

For years the industry has been performing safety culture assessments using accepted survey techniques. In the 95003 process as modified to incorporate the safety culture assessment, the acceptability of these long-accepted techniques is now being questioned. For example, survey techniques that have been relied upon previously are now being questioned for their statistical validity. An inspection procedure is not the appropriate place to establish standards for survey instruments.

(20e) Do the ROP inspection reports clearly describe inspection finding cross-cutting aspects?

Comments:

The inspection reports identify cross-cutting aspects and tie the aspect to the associated finding through its relationship to the cause of the performance deficiency. Additionally, an alpha-numeric numbering scheme is used to clearly identify the cross-cutting aspect that has been assigned. Aside from clearly identifying and describing the assigned cross-cutting aspect, there are times when a safety culture aspect is assigned without the benefit of the Licensee's evaluation. In some cases this results in inconsistencies or changes in assignments, usually during the assessment process, that are not apparent to the Public (and sometimes the Licensee) because the inspection report or some other form of communication is not issued to document the change. When an assigned cross-cutting aspect is changed, the issue should be re-exited and the inspection report updated before the assessment report is issued.

(20f) Do the Operating Reactor Assessment Program (0305) cross-cutting components and cross-cutting aspects provide an adequate coverage of the cross-cutting areas?

Comments:

Cross-cutting components and cross-cutting aspects provide adequate coverage of the cross-cutting area. However, the majority of the assigned findings with cross-cutting aspects generally use four or five bins. The original process was detailed and appeared to be designed for a more complex analysis of the safety culture for issues that rose to a significance level that warranted such analysis. Focus should be on the cause of the performance deficiency and the most appropriate cross-cutting aspect that was a

significant contributor to the finding. If there was no aspect that was a significant contributor or the performance deficiency was not indicative of current performance, then no aspect should be assigned. Implementation of Manual Chapter 0612 Appendix E is not consistent – finding classification of issues that resulted in no consequences are not consistently being classified a minor and are being tagged with an aspect - usually in one of the four or five most used bins. This practice is diluting the effectiveness and consistency of the assessment program.

(21) Please provide any additional information or comments related to the Reactor Oversight Process.

Comments:

Some Licensees have remained in column 3 or 4 of the Action Matrix for a long time (more than three years) and the Commission recently expressed the need to evaluate the reasons why. The ROP program does not provide a early release path from column 3 or 4 and in effect aggravates the condition by mandating the number of quarters that greater than green findings stay active in the Action Matrix and forcing three-year PIs to stay active with no method to reset the Action Matrix inputs (findings and PIs) after a reasonable amount of time if effective corrective actions have been implemented and the performance issues have been addressed. If the Commissioners are concerned with the amount of time a Licensee remains in column 3 or 4 of the Action Matrix, the ROP should provide clear exit pathways from these columns and a method to reset the long term indicators and findings if the issues have been resolved.

When the Safety Culture program was conceived, greater than three aspects in a common bin were considered significant enough to identify a plant as an outlier. Since the program has been implemented, the percentage of findings with cross-cutting aspects has increased to nearly 100 percent. As a result, the greater than three threshold is no longer valid in identifying statistical outliers. Originally the new program would conceptually spread the binning of aspects out; instead more aspects are being identified and binned in four or five commonly used bins.