

Enclosure 1
Handout

Overview of the Proposal to Integrate Traditional Enforcement
into Operating Reactor Assessment Meeting Summary of the
1/14/09 Working Meeting with Stakeholders on Integrating
Traditional Enforcement into Reactor Assessment

Dated January 29, 2009

Overview of the Proposal to Integrate Traditional Enforcement Into Operating Reactor Assessment

Background: SECY-08-0046, "ROP Self-Assessment for CY2007," contained a commitment by the staff to the Commission to explore how traditional enforcement actions could be used more effectively in the Reactor Oversight Process (ROP). This includes a consideration of how certain traditional enforcement items could be used as a more integrated input into the assessment program.

An NRC working group (consisting of representatives from each Region, NRR, and OE) met with the industry on June 17, 2008, to gather industry perspectives on approaches for achieving the outcome described in the SECY.

Final Proposal: The working group has proposed an approach characterized by two specific outcomes. First, the group has proposed that the performance deficiency and the traditional enforcement aspects of the problem to be separated and processed individually and, second, the group proposed a standard for assessing and conducting follow-up on the aspect of licensee performance characterized by traditional enforcement outcomes. The following is a brief description of each.

Separate a performance deficiency from the investigation into traditional enforcement issues (willfulness).

Separating the performance deficiency and the enforcement was used with the Peach Bottom inattentive security officers and with the Davis Besse degraded reactor head issues. In both cases, the approach allowed the performance deficiency to become a more timely input into the action matrix since the finding was not held pending completion of the investigation by the NRC's Office of Investigation into willfulness.

Separating the two aspects ensures that the findings used in the assessment process and the agency activities dictated by the action matrix are reflective of and responsive to current performance. Any associated violations are held and issued only when the investigation is complete. Violations associated with the performance deficiency are not factored into the action matrix. Rather, the investigation and subsequent violations address whether or not there are aspects of licensee performance, such as willfulness, that are the basis for traditional enforcement actions.

The ability to separate the performance deficiency from the subsequent enforcement is not currently in Inspection Manual Chapters 0612 or 0305, but is not precluded. Incorporating this change will make it clear that separating the two is allowed, as long as appropriate coordination is done so that actions within the inspection program will not compromise an ongoing investigation. Both IMC 0612 and IMC 0305 will be revised to reflect the proposed approach when it is adopted.

Inspection follow-up on all traditional enforcement outcomes.

The ROP does not currently require routine follow-up of enforcement actions. In 2008, changes were made to the inspection procedures in response to an NRC Inspector General audit recommendation on Alternate Dispute Resolution (ADR). Regions are

now required to follow-up on ADR confirmatory order items. This proposal would expand that requirement for follow-up to include some level of inspection for all traditional enforcement outcomes.

Using an approach similar to that in the action matrix, a series of inspections with increasing scope is being proposed in response to traditional enforcement results. The proposal would trigger one of three different levels of inspection based on the number and severity level of violations over a specified period of time. However, these inspections would be outside of the action matrix. Inspection to follow-up on enforcement actions could be incorporated into the scope of already planned inspections, including supplemental inspections dictated by the action matrix.

The specifics of the number and level of the violations needed to trigger a follow-up inspection, the window of time to be considered, as well as the level of inspection will be the focus of the working meeting to be held on January 14, 2009.

The attached flow chart illustrates the logic for implementing the proposed changes.

Proposal for Integrating Traditional Enforcement into Assessment

Note 1: TE includes
 - Willfulness
 - Impeding Regulatory Process
 - Actual Consequences

Note 2: Regulatory Process Per Enforcement Policy - page 9
 - incomplete and inaccurate info
 - failure to receive prior NRC approval
 - failure to notify NRC of changes
 - failure to perform 50.59 analyses
 - failure to report
 - etc

Note 3: Decide if PD and TE should be acted on separately. The decision to separate must consider the impact on the investigation of issuing the significance. Decision would be coordinated with OI. Recommend using the ARB as the vehicle for initiating the discussion. Criteria for decision TBD.

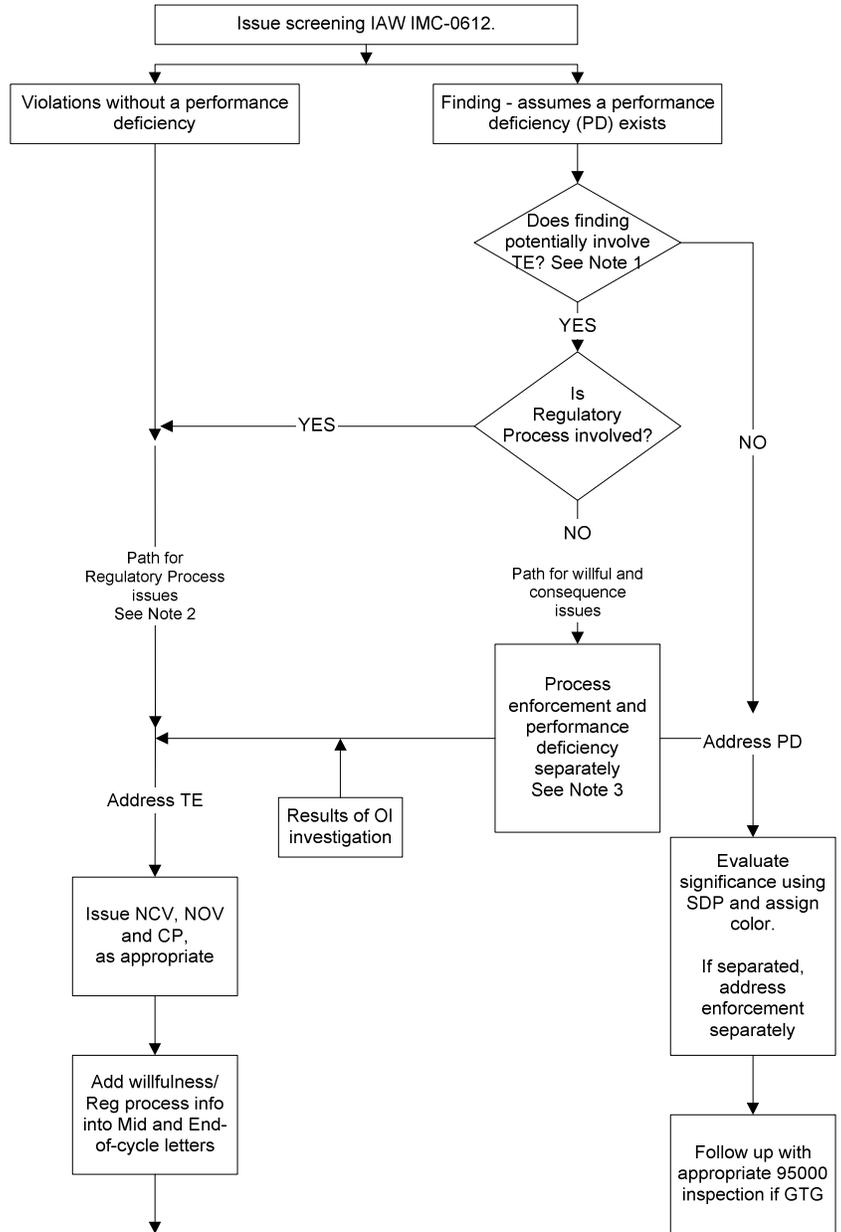
Note 4: If the associated finding is GTG, the 95000 and 92702 inspections can be coordinated.

Proposed Criteria for Triggering Follow-up Inspections:

If 1 or 2 SLIV within time window of X months, then conduct limited scope follow up inspection (<4 hours) of each using '92702 follow up'
 Proposed Focus: implementation of corrective actions

If 3rd SLIV or 1st SLIII within time window of X months, then conduct '92702 Lite'
 Proposed Focus: expands to include licensee identified root cause and extent of condition

If 4th SLIV, or if more than 1 SLIII within time window of X months, or for any violation greater than SLIII, then conduct '92702 heavy'
 Proposed Focus: expands to include some aspects of safety culture



11/20/08

Assumptions to support followup inspections of traditional enforcement:

1. No deviation needed since inspection response to enforcement would be defined.
2. Follow up using 92702 becomes mandatory for all violations.
3. IP 92702 will be revised to provide specific guidance for different levels of response.

Enclosure 2
Participants of
January 14, 2009 Working Meeting with Stakeholders on
Integrating Traditional Enforcement into Reactor Assessment

Dated January 29, 2009

Participants
 January 14, 2009
 Working Meeting on Integrating Traditional Enforcement
 Into Reactor Assessment

Name	Organization
Duane Kanitz	STARS
Jim Peschel	FPL
Justin Wearne	PSEG
Robin Ritzman	FENOC
Gary Miller	Dominion
Jenny Weil	McGraw-Hill
Carrie Safford	NRC
Jim Andersen	NRC
Mike Cheok	NRC
Nathan Sanfilippo	NRC
Ken Buddenbohn	NRC
Keann Raleigh	Scientech
Lenny Sueper	NSPM
Ken Heffner	Progress/NEI
Tom Houghton	NEI
Jerry Bonanno	NEI
Jeannie Rickel	NEI
Nick Hilton	NRC - OE
Bob Hanley	Dominion
Mary Ann Ashley	NRC
Roger Lanksbury	NRC – Region II
Ken O'Brien	NRC – Region III
Dan Holody	NRC – Region I
Pam Cowan	Exelon
Ross Telson	NRC
Carlos Sisco	Winston/Strawn
Nicole Coleman	NRC – OE
Patricia Voss	NRC – OE
Pamela Henderson	NRC
Ray Powell	NRC – Region I
Robert Pascarelli	NRC – NRO
Patrick Boyle	NRC – NRO
Steve Lavie	NRC – NSIR
Rani Franovich	NRC
David Midlik	Southern

Enclosure 3

Handout at January 14, 2009 Working Meeting with Stakeholders
on Integrating Traditional Enforcement into Reactor Assessment

Dated January 29, 2009

DEFINING THE INSPECTION SCOPE

EXISTING OBJECTIVES

92702-01 INSPECTION OBJECTIVES

To determine that adequate corrective actions have been implemented for traditional enforcement actions including violations, deviations, Confirmatory Action Letters (CALs), Confirmatory Orders, and Confirmatory Orders associated with the Alternative Dispute Resolution (ADR) process.

To verify that the root causes of these enforcement actions have been identified, that their generic implications have been addressed, and that the licensee's programs and practices have been appropriately enhanced to prevent recurrence.

95001-01 INSPECTION OBJECTIVES

01.01 To provide assurance that the root causes and contributing causes of risk significant performance issues are understood.

01.02 To provide assurance that the extent of condition and extent of cause of risk significant performance issues are identified.

01.03 To provide assurance that licensee corrective actions to risk significant performance issues are sufficient to address the root causes and contributing causes, and to prevent recurrence.

95002-01 INSPECTION OBJECTIVES

01.01 To provide assurance that the root causes and contributing causes are understood for individual and collective (multiple white inputs) risk significant performance issues.

01.02 To independently assess the extent of condition and the extent of cause for individual and collective (multiple white inputs) risk significant performance issues.

01.03 To independently determine if safety culture components caused or significantly contributed to the individual or collective (multiple white inputs) risk significant performance issues.

01.04 To provide assurance that licensee corrective actions to risk significant performance issues are sufficient to address the root causes and contributing causes, and to prevent recurrence.

95003-01 INSPECTION OBJECTIVES

01.01 To provide the NRC additional information to be used in deciding whether the continued operation of the facility is acceptable and whether additional regulatory actions are necessary to arrest declining plant performance.

01.02 To provide an independent assessment of the extent of risk significant issues to aid in the determination of whether an unacceptable margin of safety exists.

01.03 To independently assess the adequacy of the programs and processes used by the licensee to identify, evaluate, and correct performance issues.

01.04 To independently evaluate the adequacy of programs and processes in the affected strategic performance areas.

01.05 To provide insight into the overall root and contributing causes of identified performance deficiencies.

01.06 To determine if the NRC oversight process provided sufficient warning to significant reductions in safety.

01.07 To independently assess the licensee's safety culture and evaluate the licensee's assessment of its safety culture.

PROPOSED INSPECTION OBJECTIVES

92702 Follow up INSPECTION OBJECTIVES

01.01 To provide assurance that licensee corrective actions to address traditional enforcement violations have addressed the licensee's identified root causes and contributing causes and are being implemented to prevent recurrence.

92702 Lite INSPECTION OBJECTIVES

01.01 To provide assurance that the root causes and contributing causes are understood for an individual escalated traditional enforcement violation or for a group of non-escalated traditional enforcement violations.

01.02 To independently assess the licensee's root cause and extent of condition determination for a single escalated traditional enforcement violation or a group of non-escalated traditional enforcement violations.

01.03 To provide assurance that licensee corrective actions to traditional enforcement violations are sufficient to address the root causes and contributing causes, and to prevent recurrence.

92702 Heavy INSPECTION OBJECTIVES

01.01 To obtain additional information for use in deciding whether additional regulatory actions are necessary to arrest declining performance.

01.02 To independently assess the adequacy of the programs and processes used by the licensee to identify, evaluate, and correct performance issues associated with traditional enforcement violations.

01.03 To independently determine if safety culture components caused or significantly contributed to the individual or multiple traditional enforcement violations.

Enforcement History

EA No.	Plant	SL	Citation	Description	Circumstances	Date
06-152	BEAVER VALLEY	3	NOV-ADR	A replacement component change package was signed knowing that 23/26 required evaluations were not done	willfulness	12/19/2006
04-063	BROWNS FERRY	3	NOV	Procedures for corrections of weld deficiencies were not followed	condition adverse to quality	05/12/2004
06-143	BROWNS FERRY	4	NOV	Direction of unauthorized work (vacuum blasting) resulting and internal contamination	willfulness	04/12/2007
07-012	BROWNS FERRY	3	NOV	Direction of unauthorized work (vacuum blasting) resulting and internal contamination	discrimination	02/05/2007
05-159	BYRON	3	NOV	Falsification of records causing the licensee to miss 27 tech spec required ventilation surveillances	deliberate	11/23/2005
06-272	BYRON	4	NCV	Contractor tried to remove contaminated tool from the RCA	willfulness	12/05/2006
07-280	CALLAWAY	3	NOV	Inattentive security officer	willfulness	03/20/2008
08-042	CALVERT CLIFFS	4	NOV	Failure to report changes to an SRO medical condition	regulatory impact	04/19/2008

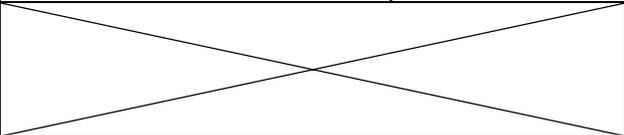
EA No.	Plant	SL	Citation	Description	Circumstances	Date
04-189	CATAWBA	3	NOV	Inaccurate information submitted in a license amendment request.	regulatory impact	01/24/2005
04-236	CATAWBA	4	NCV	Failure to update the FSAR tables	regulatory impact	01/24/2005
07-282	COLUMBIA	4	NCV	Failure to complete portions of rounds	willfulness	12/04/2007
08-145	COLUMBIA	4	NOV	Manager instructed workers to reach across a contamination boundary without getting HP approval	willfulness	06/05/2008
04-133	COMANCHE PEAK	4	NOV	Low level individual failed to get rad protection briefing. Licensee did not make prompt notification	willfulness	07/28/2004
04-109	D.C. COOK	3	NOV	Failure to provide complete and accurate information regarding an SRO license renewal.	regulatory impact	09/30/2004
05-171	D.C. COOK	3	NOV + CP	Incomplete and inaccurate information in response to a SL II NOV related to renewal of an individual license.	regulatory impact	09/22/2005
06-177	D.C. COOK	3	NOV + CP	Decrease in Emergency Plan effectiveness due to removing classifiable conditions from the EAL	potential consequences	10/06/2006

EA No.	Plant	SL	Citation	Description	Circumstances	Date
05-072	DAVIS BESSE	1	NOV	Providing incomplete and inaccurate information in 2 responses to the NRC related to Bulletin 2001-01	willfulness	04/21/2005
04-217	DAVIS BESSE	4	NCV	Failure of a Reg Affairs manager to provide complete and accurate information in at 1997 LER	willfulness	07/28/2005
07-245	DRESDEN	4	NOV	Improper shift turnover	willfulness	11/05/2007
04-053	DUANE ARNOLD	3	NOV	Refuel floor supervisor violated radiation protection procedures by moving irradiated items without HP	deliberate	05/01/2004
06-047	DUANE ARNOLD	3	NOV	Refuel floor supervisor failed to complete pre-move checklist before relocating 3 irradiated fuel bundles	willfulness	05/01/2006
04-138	FARLEY	4	NCV	Falsification of fire watch.	willfulness	08/03/2004
07-078	FARLEY	4	NCV	Failure to conduct a fire watch	willfulness	03/28/2007
06-073	FITZPATRICK	4	NOV	Personal internet use by and SRO and 3 ROs in the control room	willfulness	07/13/2006

EA No.	Plant	SL	Citation	Description	Circumstances	Date
07-029	FITZPATRICK	4	NOV	Violations of tagging or valve alignment by two plant operators	willfulness	05/01/2007
07-056	FORT CALHOUN	4	NOV	Failure to use a dosimeter and failure to sign on to radiation work permit	willfulness	05/16/2007
04-003	GINNA	3	NOV	Unauthorized manipulation of component cooling water heat exchanger valves by the refuel outage manager	willfulness	01/30/2004
08-075	GINNA	3	NOV	Unapproved changes to EALs	regulatory impact	04/07/2008
06-019	HARRIS	4	NCV	Falsification of fire watch records by contractor	willfulness	02/03/2006
07-040	HARRIS	3	NOV + CP	Two contract supervisors provided answers while administering annual security requal testing.	willfulness, regulatory impact	08/30/2007
08-181	HARRIS	4	NOV	security	willfulness	07/03/2008
06-013	HATCH	2	NOV + CP	Failure to keep required records documenting material control and accountability inventories	potential consequences	12/29/2006

EA No.	Plant	SL	Citation	Description	Circumstances	Date
07-092	INDIAN POINT	3	NOV + CP	Failure to implement the requirements of an Order	regulatory impact	04/19/2007
04-170	LA SALLE	4	NOV + CP - ADR	Supervisor and 3 contractors entered high radiation area without the necessary briefing.	willfulness	08/30/2005
06-022	LASALLE	3	NOV	3 workers entered a High Rad Area without signing the RWP and failed to receive the required RP brief	willfulness	03/31/2006
08-170	LIMERICK	4	NCV	Security officer failed to report an arrest	willfulness	08/01/2008
07-130	MCGUIRE	4	NOV	Test supervisor signed off on procedure step requiring reactor operator but is not licensed	willfulness	07/17/2007
05-175	MONTICELLO	4	NOV	Failure to report a valid actuation	regulatory impact	12/16/2005
05-025	NINE MILE POINT	4	NOV	Supervisor compromised an unannounced fire drill	willfulness	08/18/2005
04-018	OCONEE	3	NOV + CP	Change in the facility analysis on a main feed water line without prior NRC approval	regulatory impact	04/08/2004

EA No.	Plant	SL	Citation	Description	Circumstances	Date
06-030	OCONEE	3	NOV	Failures to maintain MC&A inventory records, develop and follow procedures, and conduct inventories as required.	potential consequences	04/06/2006
05-051	PALO VERDE	3	NOV + CP	Failure to perform an 50.59 on procedure change involving draining the containment sump recirculation suction piping	regulatory impact	04/08/2005
05-037	PALO VERDE	3	NOV	Implemented changes to EALs which decreased the effectiveness of the emergency plan.	regulatory impact	06/27/2005
07-162	PALO VERDE	3	NOV-ADR	SRO falsified a record related to steam generator blowdown	willfulness	07/12/2007
05-203	PEACH BOTTOM	4	NCV	Failure to perform 199 fire watches and falsification of associated records	willfulness	05/02/2005
07-053	PEACH BOTTOM	4	NCV	Non-licensed nuclear equipment operator provided inaccurate information on fire protection logs	willfulness	04/30/2007
08-125	PERRY	4	NCV	Entered High radiation area without Radiation work permit	regulatory impact	07/24/2008
05-039	PILGRIM	3	NOV + CP	FOUR issues with licensed staff in CR inattentive, failure to awaken, failure to take follow-up actions re: FFD	willfulness	07/14/2005

EA No.	Plant	SL	Citation	Description	Circumstances	Date
06-301	PILGRIM	4	NCV	Chemistry tech sleeping on a mat in the storage room	willfulness	02/02/2007
05-191	POINT BEACH	3	NOV + CP	EP manager and EP coordinator willfully provided falsified documents to the NRC on an EP drill critique.	willfulness	05/12/2006
06-178	POINT BEACH	2	NOV - ADR		discrimination	01/03/2007
06-274	POINT BEACH	3	NOV	Failure to update the FSAR for 1982 head drop analysis on the vessel	potential consequences	01/29/2007
06-162	PRAIRIE ISLAND	3	NOV	Inaccurate information submitted for 2 individuals applying for a license.	willfulness	09/28/2006
04-228	QUAD CITIES	4	NCV	Control system techs failed to perform independent verification on multiple temperature and pressure indicators	willfulness	12/27/2004
05-095	QUAD CITIES	4	NCV	Failure to survey material before removing from the RCA	willfulness	06/22/2005
07-248	QUAD CITIES	4	NCV	Disconnected an alarm on crane	willfulness	01/30/2008

EA No.	Plant	SL	Citation	Description	Circumstances	Date
04-028	ROBINSON	2	NOV + CP		discrimination	04/07/2004
07-170	SAINT LUCIE	4	NCV	2 contractors used a wrong torque wrench then provided inaccurate info to cover the error	willfulness	10/29/2007
06-205	SALEM	4	NOV	Plant equipment operator falsified information to the control room	willfulness	01/25/2007
07-149	SALEM	4	NOV	Failure to submit required information to support a ISI inspection determination	regulatory impact	08/14/2007
08-164	SEABROOK	4	NCV	Inaccurate experience information on application for an SRO license	regulatory impact	08/01/2008
06-270	SEQUOYAH	3	NOV + CP	Failure to conduct a search before allowing material into the protected area	willfulness	04/23/2007
06-149	SONGS	3	NOV	Leak liquid radioactive solution to the environment during normal conditions incident to transport	potential consequences	09/13/2006
06-084	SONGS	4	NCV	Radiographer failed to follow procedures when individual dosimeter alarmed	deliberate misconduct	11/01/2006

EA No.	Plant	SL	Citation	Description	Circumstances	Date
06-303	SONGS	4	NOV (2)	security	willfulness	03/15/2007
07-147	SONGS	4	NOV	security	willfulness	06/29/2007
07-232	SONGS	3	NOV - ADR	Contract fire protection specialist falsified records for fire watches for 5 years	willfulness	09/27/2007
07-141	SONGS	4	NOV	Unqualified I&C technician inadequately supervised by on-the-job trainer	careless disregard	11/07/2007
05-009	ST LUCIE	4	NOV	Failure to obtain a work package and clearance before doing work but delayed entry into the corrective action program	willfulness	01/31/2005
06-092	ST LUCIE	3	NOV	Unauthorized removal of a security-related item from the site.	willfulness	06/04/2007
07-079	SUMMER	3	NOV	Multiple changes to the emergency action levels without Commission approval	regulatory impact	10/12/2007
04-121	SURRY	4	NCV	Contractor entered the radiologically controlled area knowing that he did not pass radiation worker training.	willfulness	10/18/2004

EA No.	Plant	SL	Citation	Description	Circumstances	Date
05-119	SUSQUEHANNA	4	NOV	Security - NRC identified	willfulness	10/27/2005
07-110	TURKEY POINT	2	NOV + CP	Tampering with weapons and untimely reporting of tampering; incomplete information in report	incomplete info	01/22/2008
07-138	TURKEY POINT 3	3	NOV + CP	Inattentiveness by security officers and others acting as look outs	willfulness	04/09/2008
07-088	VERMONT YANKEE	4	NCV	Deliberate failure to conduct a radiological survey before providing access to a locked high rad area.	willfulness	06/14/2007
06-136	WATERFORD	4	NCV	Inaccurate performance indicator submittal	regulatory process	08/30/2006
08-173	WATTS BAR	4	NCV	security	willfulness	07/03/2008
04-134	WOLF CREEK	4	NCV	Individual failed to follow the RWP prior to entering a high radiation area.	willfulness	08/09/2004