NRC INSPECTION MANUAL

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MANUAL CHAPTER 0310

~~COMPONENTS~~ ASPECTS WITHIN THE CROSS-CUTTING AREAS

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0310-01 PURPOSE

~~01.01~~ The purpose of this Inspection Manual Chapter (IMC) is to provide a listing of cross-cutting aspects that can be assigned to inspection findings in accordance with IMC 0612,"Power Reactor Inspection Reports." Assigned cross-cutting aspects, which are generally associated with the root causes of performance deficiencies, are evaluated to identify themes which are assessed~~The Reactor Oversight Process (ROP) integrates the NRC's inspection, assessment, and enforcement programs. One facet of the ROP is the identification of substantive cross-cutting issues~~ as outlined in IMC 0305, "Operating Reactor Assessment Program."

0310-02 OBJECTIVES

~~02.01 To describe the components directly related to the cross-cutting areas.~~

To ~~provide~~define the cross-cutting aspects that are associated with inspection findings ~~by the inspector~~ and used in the evaluation conducted to identify cross-cutting themes.

0310-03 APPLICABILITY

The cross-cutting aspects described in this ~~inspection manual chapter (~~IMC~~)~~ are applicable to inspection findings identified through the implementation of the NRC inspection program described in IMC 2515, "Light-Water Reactor Inspection Program-Operations Phase."~~applies to all operating commercial nuclear reactors.~~ The contents of this IMC do not restrict the NRC from taking any necessary actions to fulfill its responsibilities under the Atomic Energy Act of 1954 (as amended).

0310-04 DEFINITIONS

04.01 Cross-Cutting Area. Fundamental performance attributes that extend across all of the ROP cornerstones of safety. These areas are human performance ~~(HU)~~, problem identification and resolution (PI&R), and safety conscious work environment (SCWE).

04.02 Cross-Cutting Aspect. A performance characteristic of a finding that is the most significant causal factor of the performance deficiency as described in ~~. Refer to~~ IMC 0612.

~~04.03 Cross-Cutting Area Component. A component that is directly related to one of the cross-cutting areas. The cross-cutting area components in alphabetical order are: Corrective Action Program; Decision-Making; Environment for Raising Concerns; Operating Experience; Preventing, Detecting, and Mitigating Perceptions of Retaliation; Resources; Self and Independent Assessments; Work Control; and Work Practices.~~

~~04.04 IMC 0350 Process. An oversight process that oversees licensee performance, inspections, and restart efforts for plants in shutdown conditions with significant performance and/or operational concerns.~~

04.03 Human Performance. All factors of human action relevant to the safe operation of nuclear power plants.

04.04 Nuclear Safety Culture. The core values and behaviors resulting from a collective commitment by leaders and individuals to emphasize safety over competing goals to ensure protection of people and the environment.

04.05 Problem Identification and Resolution. Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance.

04.0605Safety-Conscious Work Environment (SCWE). An environment in which employees feel free to raise safety concerns, both to their management and to the NRC, without fear of retaliation and where such concerns are promptly reviewed, given the proper priority based on their potential safety significance, and appropriately resolved with timely feedback to employees.

04.06 Safety Culture. That assembly of characteristics and attitudes in organizations and individuals which establishes that, as an overriding priority, nuclear plant safety issues receive the attention warranted by their significance.

0310-05 RESPONSIBILITIES AND AUTHORITIES

05.01 Executive Director for Operations (EDO). Oversees the activities described in this IMC.

05.02 Director, Office of Nuclear Reactor Regulation (NRR). Implements the requirements of this IMC within NRR.

05.03 Regional Administrators. Implements the requirements of this IMC within their respective regions.

05.04 Deputy Director, Division of Inspection and Regional Support (NRR/DIRS). Collects feedback from the regional offices on IMC implementation for consideration as part of the ROP continuous improvement process.

05.05 Director, Office of Nuclear Security and Incident Response (NSIR). Ensures uniform IMC implementation for security related inspection findings.

0310-06 CROSS CUTTING COMPONENTS AREAS AND ASPECTS

Cross-cutting areas contain the fundamental performance attributes that extend across all of the ROP cornerstones of safety. These areas are human performance (H), problem identification and resolution (P), and safety conscious work environment (S). Satisfactory performance within the three cross-cutting areas is essential to the preservation of a healthy nuclear safety culture.

NUREG--XXXX describes the essential traits and attributes of a healthy nuclear safety culture. Those attributes have been incorporated into this inspection manual chapter as a part of the effort to establish a safety culture common languageterms for to be used by both the NRC and the nuclear industry. The following cross-cutting aspects align with the specific attributes defined in the common language document and are categorized under the appropriaterelevant cross-cutting areas. In deciding which aspect is most appropriate to assign to a performance deficiency, inspectors may refer to the attribute examples provided in NUREG-XXXX if the language below is not specific enoughhelpful for the issue in question.

The “Supplemental Cross-Cutting Aspects” listed in section 06.04 do not fall within the three cross-cutting areas that are considered under the baseline inspection program. These aspects are indicators of a healthy safety culture though, and should be considered ~~as part of the~~for supplemental inspections ~~process~~ and when performing safety culture assessments. While they~~re~~ are ~~Attributes from the common language document that are not included as cross-cutting aspects, while~~ important characteristics of safety culture, attributes from ~~the~~ NUREG-XXXX that ~~common language document that,~~ are not included as cross-cutting aspects~~, and~~ are considered to be outside the scope of the reactor inspection program.

Exhibit 1 provides a crosswalk from the original cross-cutting aspects to the new cross-cutting aspects resulting from the common language initiative. Exhibit 2 provides a crosswalk from the common language attributes of NUREG–XXXX to new cross-cutting aspects. The common language attributes also are ~~also~~ provided at the end of the descriptions in sections 6.01 through 6.04 and are subsets of the following traits:

- Leadership Safety Values and Actions (LA)
- Problem Identification and Resolution (PI)
- Personal Accountability (PA)
- Work Processes (WP)
- Continuous Learning (CL)
- Environment for Raising Concerns (RC)
- Effective Safety Communication (CO)
- Respectful Work Environment (WE)
- Questioning Attitude (QA)
- Decision Making (DM)

~~*The following components are the cross-cutting area components (i.e., the components of safety culture directly related to one of the cross-cutting areas). Descriptions of these components provide cross-cutting aspects that may be assigned to findings.* [C1]~~

06.01 Human Performance (H)

H.1	**Resources:** Leaders ensure that personnel, equipment, procedures, and other resources are available and adequate to support nuclear safety (LA.1[1]).
H.2	**Field Presence:** Leaders are commonly seen in the work areas of the plant observing, coaching, and reinforcing standards and expectations. Deviations from standards and expectations are correctly promptly. Senior managers ensure supervisory and management oversight of work activities, including contractors and supplemental personnel[2] (LA.2).
H.3	**Change Management:** Leaders use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority (LA.5).
H.4	**Teamwork:** Individuals and work groups communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety is maintained (PA.3).
H.5	**Work Management:** The organization implements a process of planning, controlling, and executing work activities such that nuclear safety is the overriding priority. The work process includes the identification and management of risk commensurate to the work and the need for coordination with different groups or job activities[3] (WP.1).
H.6	**Design Margins:** The organization operates and maintains equipment within design margins. Margins are carefully guarded and changed only through a systematic and rigorous process. Special attention is placed on maintaining fission product barriers, defense-in-depth, and safety related equipment (WP.2).
H.7	**Documentation:** The organization creates and maintains complete, accurate and, up-to-date documentation (WP.3).
H.8	**Procedure Adherence:** Individuals follow processes, procedures, and work instructions (WP.4).
H.9	**Training:** The organization provides training and ensures knowledge transfer to maintain a knowledgeable, technically competent workforce and instill nuclear safety values (CL.4).
H.10	**Bases for Decisions:** Leaders ensure that the bases for operational and organizational decisions are communicated in a timely manner (CO.2).
H.11	**Challenge the Unknown:** Individuals stop when faced with uncertain conditions. Risks are evaluated and managed before proceeding (QA.2).
H.12	**Avoid Complacency:** Individuals recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Individuals implement appropriate error reduction tools[4] (QA.4).
H.13	**Consistent Process:** Individuals use a consistent, systematic approach to make

[1] See Exhibit 2 for crosswalk from Common Language Attribute to Cross-Cutting Aspect
[2] Adds language from LA.2 example 1 to clarify that this is the appropriate tag for oversight of contractors
[3] Adds language from WP.1 example 1 to clarify that this aspect fully retains what was previously included in H.3(b)
[4] Incorporates language from QA.4 example 5 to clarify that H.12 is the appropriate tag for issues involving a failure to use human error prevention techniques that were previously included under H.4(a)

	decisions. Risk insights are incorporated as appropriate (DM.1).
H.14	**Conservative Bias:** Individuals use decision making-practices that emphasize prudent choices over those that are simply allowable. A proposed action is determined to be safe in order to proceed, rather than unsafe in order to stop (DM.2).

~~Decision Making – Licensee decisions demonstrate that nuclear safety is an overriding priority. Specifically (as applicable):~~	
~~H.1(a)~~	~~The licensee makes safety significant or risk significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained. This includes formally defining the authority and roles for decisions affecting nuclear safety, communicating these roles to applicable personnel, and implementing these roles and authorities as designed and obtaining interdisciplinary input and reviews on safety significant or risk significant decisions.~~
~~H.1(b)~~	~~The licensee uses conservative assumptions in decision making and adopts a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. The licensee conducts effectiveness reviews of safety significant decisions to verify the validity of the underlying assumptions, identify possible unintended consequences, and determine how to improve future decisions.~~
~~H.1(c)~~	~~The licensee communicates decisions and the basis for decisions to personnel who have a need to know the information in order to perform work safely, in a timely manner.~~
~~Resources – The licensee ensures that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety. Specifically, those necessary for:~~	
~~H.2(a)~~	~~Maintaining long term plant safety by maintenance of design margins, minimization of long standing equipment issues, minimizing preventative maintenance deferrals, and ensuring maintenance and engineering backlogs which are low enough to support safety.~~
~~H.2(b)~~	~~Training of personnel and sufficient qualified personnel, to maintain work hours within working hour guidelines.~~
~~H.2(c)~~	~~Complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components.~~
~~H.2(d)~~	~~Adequate and available facilities and equipment, including physical improvements, simulator fidelity and emergency facilities and equipment.~~
~~Work Control – The licensee plans and coordinates work activities, consistent with nuclear safety. Specifically (as applicable):~~	
~~H.3(a)~~	~~The licensee appropriately plans work activities by incorporating:~~ ~~• risk insights;~~ ~~• job site conditions, including environmental conditions which may impact human performance; plant structures, systems, and components; human system interface; or radiological safety; and~~ ~~• the need for planned contingencies, compensatory actions, and abort criteria.~~
~~H.3(b)~~	~~The licensee appropriately coordinates work activities by incorporating actions to address:~~ ~~• the impact of changes to the work scope or activity on the plant and human performance.~~

	● the impact of the work on different job activities, and the need for work groups to maintain interfaces with offsite organizations, and communicate, coordinate, and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance, ● the need to keep personnel apprised of work status, the operational impact of work activities, and plant conditions that may affect work activities, ● the licensee plans work activities to support long-term equipment reliability by limiting temporary modifications, operator work-arounds, safety systems unavailability, and reliance on manual actions. Maintenance scheduling is more preventive than reactive.

Work Practices – Personnel work practices support human performance. Specifically (as applicable):	
H.4(a)	The licensee communicates human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities. These techniques are used commensurate with the risk of the assigned task, such that work activities are performed safely. Personnel are fit for duty. In addition, personnel do not proceed in the face of uncertainty or unexpected circumstances.
H.4(b)	The licensee defines and effectively communicates expectations regarding procedural compliance and personnel follow procedures.
H.4(c)	The licensee ensures supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported.

06.02 Problem Identification and Resolution (P)

P.1	**Identification:** The organization implements a corrective action program with a low threshold for identifying issues. Individuals identify issues completely, accurately, and in a timely manner in accordance with the program (PI.1).
P.2	**Evaluation:** The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance (PI.2).
P.3	**Resolution:** The organization takes effective corrective actions to address issues in a timely manner commensurate with their safety significance (PI.3).
P.4	**Trending:** The organization periodically analyzes information from the corrective action program and other assessments in the aggregate to identify programmatic and common cause issues (PI.4).
P.5	**Operating Experience:** The organization systematically and effectively collects, evaluates, and implements relevant internal and external operating experience in a timely manner (CL.1).
P.6	**Self-Assessment:** The organization routinely conducts self-critical and objective assessments of its programs and practices (CL.2).

~~Corrective Action Program (CAP) – The licensee ensures that issues potentially impacting nuclear safety are promptly identified, fully evaluated, and that actions are taken to address safety issues in a timely manner, commensurate with their significance. Specifically (as applicable):~~	
~~P.1(a)~~	~~The licensee implements a corrective action program with a low threshold for identifying issues. The licensee identifies such issues completely, accurately, and in a timely manner commensurate with their safety significance.~~
~~P.1(b)~~	~~The licensee periodically trends and assesses information from the CAP and other assessments in the aggregate to identify programmatic and common cause problems. The licensee communicates the results of the trending to applicable personnel.~~
~~P.1(c)~~	~~The licensee thoroughly evaluates problems such that the resolutions address causes and extent of conditions, as necessary. This includes properly classifying, prioritizing, and evaluating for operability and reportability conditions adverse to quality. This also includes, for significant problems, conducting effectiveness reviews of corrective actions to ensure that the problems are resolved.~~
~~P.1(d)~~	~~The licensee takes appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity.~~
~~P.1(e)~~	~~If an alternative process (i.e., a process for raising concerns that is an alternate to the licensee's corrective action program or line management) for raising safety concerns exists, then it results in appropriate and timely resolutions of identified problems.~~
~~Operating Experience (OE) – The licensee uses OE information, including vendor recommendations and internally generated lessons learned, to support plant safety. Specifically (as applicable):~~	

~~P.2(a)~~	~~The licensee systematically collects, evaluates, and communicates to affected internal stakeholders in a timely manner relevant internal and external OE.~~
~~P.2(b)~~	~~The licensee implements and institutionalizes OE through changes to station processes, procedures, equipment, and training programs.~~
~~Self- and Independent Assessments – The licensee conducts self and independent assessments of their activities and practices, as appropriate, to assess performance and identify areas for improvement. Specifically (as applicable):~~	
~~P.3(a)~~	~~The licensee conducts self-assessments at an appropriate frequency; such assessments are of sufficient depth, are comprehensive, are appropriately objective, and are self-critical. The licensee periodically assesses the effectiveness of oversight groups and programs such as CAP, and policies.~~
~~P.3(b)~~	~~The licensee tracks and trends safety indicators which provide an accurate representation of performance.~~
~~P.3(c)~~	~~The licensee coordinates and communicates results from assessments to affected personnel, and takes corrective actions to address issues commensurate with their significance.~~

06.03 Safety Conscious Work Environment (S)

S.1	**SCWE Policy:** The organization effectively implements a policy that supports individuals' rights and responsibilities to raise safety concerns, and does not tolerate harassment, intimidation, retaliation, or discrimination for doing so (RC.1).
S.2	**Alternate Process for Raising Concerns**: The organization effectively implements a process for raising and resolving concerns that is independent of line management influence. Safety issues may be raised in confidence and are resolved in a timely and effective manner (RC.2).
S.3	**Free Flow of Information:** Individuals communicate openly and candidly, both up, down, and across the organization and with oversight, audit, and regulatory organizations (CO.3).

~~Environment for Raising Concerns – An environment exists in which employees feel free to raise concerns both to their management and/or the NRC without fear of retaliation and employees are encouraged to raise such concerns. Specifically (as applicable):~~	
~~S.1(a)~~	~~Behaviors and interactions encourage free flow of information related to raising nuclear safety issues, differing professional opinions, and identifying issues in the CAP and through self assessments. Such behaviors include supervisors responding to employee safety concerns in an open, honest, and non-defensive manner and providing complete, accurate, and forthright information to oversight, audit, and regulatory organizations. Past behaviors, actions, or interactions that may reasonably discourage the raising of such issues are actively mitigated. As a result, personnel freely and openly communicate in a clear manner conditions or behaviors, such as fitness for duty issues that may impact safety, and personnel raise nuclear safety issues without fear of retaliation.~~
~~S.1(b)~~	~~If alternative processes (i.e., a process for raising concerns or resolving differing professional opinions that are alternates to the licensee's corrective action program or line management) for raising safety concerns or resolving differing professional opinions exists, then they are communicated, accessible, have an option to raise issues in confidence, and are independent, in the sense that the program does not report to line management (i.e., those who would in the normal course of activities be responsible for addressing the issue raised).~~

~~Preventing, Detecting, and Mitigating Perceptions of Retaliation – A policy for prohibiting harassment and retaliation for raising nuclear safety concerns exists and is consistently enforced in that:~~	
~~S.2(a)~~	~~All personnel are effectively trained that harassment and retaliation for raising safety concerns is a violation of law and policy and will not be tolerated.~~
~~S.2(b)~~	~~Claims of discrimination are investigated consistent with the content of the regulations regarding employee protection and any necessary corrective actions are taken in a timely manner, including actions to mitigate any potential chilling effect on others due to the personnel action under investigation.~~
~~S.2(c)~~	~~The potential chilling effects of disciplinary actions and other potentially adverse personnel actions (e.g., reductions, outsourcing, and reorganizations) are considered~~

	~~and compensatory actions are taken when appropriate.~~

06.04 Supplemental Cross-Cutting Aspects (X) ~~Other Safety Culture Components (O)~~

The supplemental cross-cutting aspects are only to be considered during the conduct of the supplemental inspection program and when performing safety culture assessments. ~~*This section describes components of safety culture which are not associated with cross-cutting areas. These components, when combined with the cross-cutting area components described above for human performance, problem identification and resolution, and safety conscious work environment, comprise the safety culture components. Components in this section are considered during the conduct of the supplemental inspection program, while the cross-cutting area components are considered during the conduct of both the baseline and supplemental inspection programs.*~~ [~~C1~~]

X.1	**Incentives, Sanctions, and Rewards:** Leaders ensure incentives, sanctions, and rewards are aligned with nuclear safety policies and reinforce behaviors and outcomes that reflect safety as the overriding priority (LA.3).
X.2	**Strategic Commitment to Safety:** Leaders ensure plant priorities are aligned to reflect nuclear safety as the overriding priority (LA.4).
X.3	**Roles, Responsibilities, and Authorities**: Leaders clearly define roles, responsibilities, and authorities to ensure nuclear safety (LA.6).
X.4	**Constant Examination:** Leaders ensure that nuclear safety is constantly scrutinized through a variety of monitoring techniques, including assessments of nuclear safety culture (LA.7).
X.5	**Leader Behaviors:** Leaders exhibit behaviors that set the standard for safety (LA.8).
X.6	**Standards:** Individuals understand the importance of adherence to nuclear standards. All levels of the organization exercise accountability for shortfalls in meeting standards (PA.1).

X.7	**Job Ownership:** Individuals understand and demonstrate personal responsibility for the behaviors and work practices that support nuclear safety (PA.2).
X.8	**Benchmarking:** The organization learns from other organizations to continuously improve knowledge, skills, and safety performance (CL.3).
X.9	**Work Process Communications:** Individuals incorporate safety communications in work activities (CO.1).
X.10	**Expectations:** Leaders frequently communicate and reinforce the expectation that nuclear safety is the organization's overriding priority (CO.4).
X.11	**Challenge Assumptions:** Individuals challenge assumptions and offer opposing views when they think something is not correct (QA.3).
X.12	**Accountability for Decisions:** Single-point accountability is maintained for nuclear safety decisions (DM.3).

~~Accountability – Management defines the line of authority and responsibility for nuclear safety. Specifically (as applicable):~~	
~~O.1(a)~~	~~Accountability is maintained for important safety decisions in that the system of rewards and sanctions is aligned with nuclear safety policies and reinforces behaviors and outcomes which reflect safety as an overriding priority.~~
~~O.1(b)~~	~~Management reinforces safety standards and displays behaviors that reflect safety as an overriding priority.~~
~~O.1(c)~~	~~The workforce demonstrates a proper safety focus and reinforces safety principles among their peers.~~
~~Continuous Learning Environment – The licensee ensures that a learning environment exists. Specifically (as applicable):~~	
~~O.2(a)~~	~~The licensee provides adequate training and knowledge transfer to all personnel on site to ensure technical competency.~~
~~O.2(b)~~	~~Personnel continuously strive to improve their knowledge, skills, and safety performance through activities such as benchmarking, being receptive to feedback, and setting performance goals. The licensee effectively communicates information learned from internal and external sources about industry and plant issues.~~
~~O.3 Organizational Change Management – Management uses a systematic process for planning, coordinating, and evaluating the safety impacts of decisions related to major changes in organizational structures and functions, leadership, policies, programs, procedures, and resources. Management effectively communicates such changes to affected personnel.~~	
~~Safety Policies – Safety policies and related training establish and reinforce that nuclear safety is an overriding priority in that:~~	
~~O.4(a)~~	~~These policies require and reinforce that individuals have the right and responsibility to raise nuclear safety issues through available means, including avenues outside their organizational chain of command and to external agencies, and obtain feedback on the resolution of such issues.~~
~~O.4(b)~~	~~Personnel are effectively trained on these policies.~~
~~O.4(c)~~	~~Organizational decisions and actions at all levels of the organization are consistent with the policies. Production, cost and schedule goals are developed, communicated,~~

	~~and implemented in a manner that reinforces the importance of nuclear safety.~~
~~O.4(d)~~	~~Senior managers and corporate personnel periodically communicate and reinforce nuclear safety such that personnel understand that safety is of the highest priority.~~

Exhibit 1 – Crosswalk from Original Cross-Cutting Aspects to New Cross-Cutting Aspects

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Old Aspect	New Aspect
H.1(a)	H.13
H.1(b)	H.14
H.1(c)	H.10
H.2(a)	H.6
H.2(b)	H.9
H.2(c)	H.7
H.2(d)	H.1
H.3(a)	H.5
H.3(b)	H.5
H.4(a)	H.12
H.4(b)	H.8
H.4(c)	H.2
P.1(a)	P.1
P.1(b)	P.4
P.1(c)	P.2
P.1(d)	P.3
P.1(e)	S.2
P.2(a)	P.5
P.2(b)	P.5
P.3(a)	P.6
P.3(b)	P.4
P.3(c)	P.6
S.1(a)	S.1
S.1(b)	S.2
S.1(c)	S.3
S.2(a)	S.2
S.2(b)	S.2
S.2(c)	S.2
O.1(a)	X.1
O.1(b)	H.2
O.1(c)	X.6
O.2(a)	H.9
O.2(b)	X.8
O.3(a)	H-3
O.4(a)	S.1
O.4(b)	H-9
O.4(c)	X.2
O.4(d)	X.10

Exhibit 2 – Crosswalk from Common Language Attributes of NUREG-XXXX to New Cross-Cutting Aspects

Common Language Attribute[5]	New Aspect
LA.1	H.1
LA.2	H.2
LA.3	X.1
LA.4	X.2
LA.5	H.3
LA.6	X.3
LA.7	X.4
LA.8	X.5
PI.1	P.1
PI.2	P.2
PI.3	P.3
PI.4	P.4
PA.1	X.6
PA.2	X.7
PA.3	H.4
WP.1	H.5
WP.2	H.6
WP.3	H.7
WP.4	H.8
CL.1	P.5
CL.2	P.6
CL.3	X.8
CL.4	H.9
RC.1	S.1
RC.2	S.2
CO.1	X.9
CO.2	H.10
CO.3	S.3
CO.4	X.10
QA.2	H.11
QA.3	X.11
QA.4	H.12
DM.1	H.13
DM.2	H.14
DM.3	X.12

[5] Attributes WE.1, WE.2, WE.3, WE.4, and QA.1 are not being used for ROP applications

Attachment 1 – Revision History for IMC 0310

Commitment Tracking Number	Issue Date	Description of Change	Training Required	Training Completion Date	Comment Resolution Accession Number
C1	02/23/10 CN 10-006 ML100290993	Initial Issuance of IMC. Commitment carried forward from IMC 0305 to enhance ROP to more fully to address safety culture (SRM 04-0111)	No	N/A	N/A
	10/28/11 CN 11-023 ML091480473	Revised definition of Cross Cutting Aspect (FF 0310-1558) and Updated Formatting for improved usability (no red line for formatting changes, FF 0310-1478).	No	N/A	N/A
		Revised cross-cutting aspects to align with the safety culture common language attributes of NUREG-XXXX and the Commission's safety culture policy statement..	Yes		

Field Code Changed