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## INSPECTION PROCEDURE 95001

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### SUPPLEMENTAL INSPECTION RESPONSE TO ACTION MATRIX COLUMN 2 INPUTS

Effective Date: August 24, 2016

PROGRAM APPLICABILITY: 2515B, 2201B

CORNERSTONES: ALL

INSPECTION BASIS: This procedure provides the supplemental **inspection** response to Action Matrix **Column 2 inputs** as described in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," and IMC 0320, "Operating Reactor Security Assessment Program". The **governance** provided in this procedure was developed with consideration of the following boundary conditions:

- Supplemental inspections will **only** be done for **significant (i.e. greater-than-green) findings and performance indicators (PIs)**;
- The baseline inspection procedure (IP) 71152, "Problem Identification and Resolution" is independent of the supplemental response;
- The inspection requirements contained in this procedure will be completed **when Action Matrix Column 2 inputs are identified** and are the same regardless of whether the issue originated from **PIs** or inspection findings; and
- **Once an Action Matrix Column 2 input is identified, its removal (e.g. PI returning to green) does not negate the requirement to satisfy the objectives and requirements of this IP prior to returning to Action Matrix Column 1.**
- New examples of performance issues resulting from supplemental inspections will be **dispositioned and documented as** in the baseline inspection program **allowing for differences specified in this procedure.**

## 95001-01 INSPECTION OBJECTIVES

- 01.01 To **assure** that the root causes and contributing causes of *individual and collective (multiple white inputs)* [C2] significant performance issues are understood.
- 01.02 To *independently assess and* [C2] **assure** that the extent of condition and extent of cause of significant *individual and collective (multiple white inputs)* [C2] performance issues are identified.
- 01.03 To **assure** that corrective actions **taken to address and preclude repetition of** significant performance issues are **prompt and effective**.
- 01.04 To **assure** that corrective plans direct prompt actions to effectively address and **preclude repetition of** significant performance issues.

## 95001-02 INSPECTION REQUIREMENTS

The following inspection requirements relate to the minimum set of information that the NRC will generally need to acquire in order to ensure that the **inspection objectives** are **satisfied**. While these inspection requirements do not necessarily represent licensee **regulatory obligations**, the **licensee's** evaluation **and implementation are expected** to address each of the inspection requirements. It is recognized that the depth of the **licensee's** evaluation may vary depending on the significance and complexity of the issue. In some cases, the answers to specific inspection requirements will be self-evident with little additional review or analysis required by the inspectors.

NRC inspectors **are not required** to perform an independent evaluation of the performance issue nor **may they** merely verify that an evaluation has been performed **and translated into corrective plans and actions** without assessing adequacy. Rather, inspectors **shall** sufficiently challenge aspects of the **licensee's** evaluation, **corrective plans, and actions** to ensure that the cause(s) of the performance issue have been **correctly** identified and **that** appropriate corrective **plans and actions** are in place to promptly and effectively address and preclude repetition of significant performance issues.

*While the inspection requirements are generally written to address individual performance issues, this IP may also be used to assess the adequacy of the licensee's evaluations associated with multiple performance issues associated with transition to Action Matrix Column 2. [C2] This inspection may reference rather than replicate portions of recently completed inspections that document satisfaction of the objectives and requirements of this IP. When performed in connection with a second White input in the same cornerstone as the first, the inspection must evaluate the adequacy of the licensee's common cause analyses in order to consider the potential for programmatic weaknesses in the licensee's performance. [C2]*

The inspection report associated with a supplemental inspection performed in accordance with this IP **must** contain the **NRC's** assessment of the **licensee's** evaluation for each inspection requirement. The results of this inspection **must** be documented in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix C, "Guidance for Supplemental Inspection Reports."

Significant weaknesses or omissions in the licensee's analysis, plans, and actions to address the performance issue(s), including weaknesses involved with the failure to identify the safety culture traits described in NUREG-2165, "Safety Culture Common Language," referenced in IMC 0310, "Aspects Within Cross-Cutting Areas" [C1] or to perform an adequate evaluation of the performance issue, may be subject to additional agency actions, including: (1) those specified in IMC 0305; [C1] (2) additional enforcement actions; or (3) an expansion of this procedure as necessary to independently acquire the information necessary to satisfy Section 95001-01 inspection objectives or Section 95001-02 requirements. An expansion of this IP may be necessary if inspectors need to independently evaluate the performance issue(s) or safety culture aspects as a result of the licensee not performing its' own analysis. Inspectors are not expected to perform this evaluation as a separate supplemental inspection.

Failure to satisfy Section 95001-01 objectives or Section 95001-02 requirements must result in an expansion of this IP through continued or follow-up IP 95001 inspection. The IP 95001 inspection occurrence must be held open until the requirements and objectives are all satisfied for the issue(s) triggering the inspection. If this inspection reveals licensee performance demonstrating the need to open a parallel PI finding or to hold the triggering finding open, an inspection report must be issued which describes specific licensee deficiencies and clearly states the necessary licensee actions required to meet all pending supplemental inspection objectives and requirements. Refer to IMC 0305 for additional guidance on parallel PI findings and holding open findings in the Action Matrix. When continued and follow-up inspections are performed, the inspection scope is normally limited to verifying only the licensee's actions necessary to meet the remaining unmet supplemental inspections objectives from the previous inspection efforts. Additionally, the licensee shall be given reasonable opportunity to correct any identified deficiencies prior to initiation of this inspection procedure or any re-inspection. A final supplemental inspection report must be issued when all inspection objectives and requirements are met.

Significant weaknesses in the licensee's actions to address individual or multiple performance issues do not provide the assurance level required to meet the inspection objectives defined in Section 95001-01 and requirements defined in Section 95001-02. These weaknesses might include but need not be limited to substantial inadequacy in the (a) evaluation of the root cause(s), (b) determination of the extent of the performance issue(s), or (c) actions taken or planned to correct the issue. General weaknesses associated with the licensee's evaluation of the performance issue must be briefly described in the transmittal letter and documented as observations in the summary of findings and details sections in the inspection report.

New or additional performance issues identified during this supplemental inspection including those identified by the licensee during their evaluation, must be inspected under the applicable inspection procedure(s) and screened in accordance with IMC 0612, Appendix B, "Issue Screening."

The following inspection requirements apply to both single inspection findings and to PIs that might represent more than one independent event (e.g. multiple scrams). Unless a second White input occurs in the same cornerstone, the inspection must be accomplished either by independently evaluating each occurrence or by collective evaluation as appropriate. It is expected that the licensee's evaluation will address each of the occurrences when multiple occurrences exist and will address the potential for programmatic weaknesses when a second white input occurs in the same cornerstone. [C2]

02.01 Problem Identification

- a. Determine that the evaluation documented who identified the issue(s) (i.e., licensee-identified, self-revealed, or NRC-identified) and under what conditions the issue(s) was (were) identified.
- b. Determine that the evaluation documented how long the issue(s) existed and prior opportunities for identification.
- c. Determine that the evaluation documented significant plant-specific consequences, as applicable, and compliance concerns associated with the issue(s).

02.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

- a. Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.
- b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.
- c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.
- d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem.
- e. *Determine that the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture traits in NUREG-2165, "Safety Culture Common Language," referenced in IMC 0310, "Aspects Within Cross-Cutting Areas."* [C1]
- f. *Examine the common cause analyses for potential programmatic weaknesses in performance when a licensee has a second White input in the same cornerstone* [C2].

02.03 Corrective Actions Taken

- a. Determine that appropriate corrective actions are specified for each root and contributing cause or that the licensee has an adequate evaluation for why no corrective actions are necessary.
- b. Determine that corrective actions have been prioritized with consideration of significance and regulatory compliance.
- c. Determine that corrective actions taken to address and preclude repetition of significant performance issues are prompt and effective.
- d. Determine that each Notice of Violation (NOV) related to the supplemental inspection is adequately addressed, either in corrective actions taken or planned.

## 02.04 Corrective Action Plans

- a. Repeat 02.03.a. and 02.03.b. for Corrective Action Plans.
- b. Determine that corrective plans direct prompt actions to effectively address and preclude repetition of significant performance issues.
- c. **Determine that appropriate** quantitative or qualitative measures of success have been developed for determining the effectiveness of **planned and completed** corrective actions.
- d. Determine that **each** Notice of Violation (NOV) **related to** the supplemental inspection **is adequately addressed in corrective actions taken or planned.**

## 02.05 Evaluation of IMC 0305 Criteria for Treatment of Old Design Issues

This part of the IP is to be implemented when the licensee has requested credit for self-identification of an old design issue and when sufficient information was not previously available to allow the NRC staff to determine whether the finding met the old design issue criteria in IMC 0305. IMC 0305 allows credit to be given to licensees for self-identification of certain old design issues, such as those pertaining to engineering calculations, engineering analyses, associated operating procedures, or plant equipment installations. In such cases, the inspectors should evaluate whether the performance issue meets the criteria in IMC 0305 to determine if the issue is an old design issue.

## 95001-03 INSPECTION GUIDANCE

### General Guidance

This IP is used to assess the adequacy of the **licensee's** evaluation, **corrective actions, and corrective action plans in response Action Matrix Column II inputs.** As such, a reasonable time (generally within 30-60 days) should be allowed for the licensee staff to complete **an** evaluation, **develop, and begin implementation of corrective action plans.** **While** corrective actions **need** not be completed **prior to** commencement of this supplemental inspection, **the** inspection should not be scheduled until the licensee has completed its problem identification, evaluation, and corrective action plan. In the event that the licensee has not defined their corrective action plan within a reasonable time, regional management should prompt the licensee to provide the basis, including **significance** insights, for the delay. Implementation of **planned** corrective actions may be verified during subsequent baseline inspections, such as the PI&R biennial team inspection performed in accordance with IP 71152.

The following guidance is provided to help the inspector fulfill the specific inspection requirements contained in Section 95001-02. It is not intended that the inspector verify that the **licensee's** evaluation contains every attribute contained in the inspection guidance section. The intent is that the inspector uses the guidance sections of this procedure to look for weaknesses in the **licensee's** evaluation that might indicate an issue associated with one of the inspection requirements.

### 03.01 Definitions

Root Causes are defined as the basic reasons (e.g., hardware, process, or human performance) for a problem, which if corrected, will **preclude repetition** of that problem.

Contributing Causes are defined as causes that by themselves would not create the problem but are important enough to be recognized as needing corrective action. Contributing causes are sometimes referred to as causal factors. Causal factors are those actions, conditions, or events that directly or indirectly influence the outcome of a situation or problem.

Repeat occurrences are defined as two or more independent conditions resulting from the same basic cause(s).

Common Cause is defined as multiple failures (i.e., two or more) of plant equipment or processes attributable to a shared cause.

Extent of Condition is defined as the extent to which the actual condition exists with other plant processes, equipment, or human performance.

Extent of Cause is defined as the extent to which the root causes of an identified problem have impacted other plant processes, equipment, or human performance.

Consequences are defined as the actual or potential outcome of an identified problem or condition.

### 03.02 Problem Identification

The evaluation should state how and by whom the issue was identified. If the licensee **did not** identify the problem at a precursor level, **evaluate the cause**. Specifically, the licensee's failure to identify a problem before it **became more** significant may indicate a more substantial problem. Examples include the licensee's failure to: (1) enter a recognized non-compliance into the corrective action program; (2) raise safety concerns to management; or (3) complete corrective actions for a previously identified problem that resulted in further degradation. If the NRC identified the white performance issue, the evaluation should address why the licensee's processes, such as peer review, supervisory oversight, inspection, testing, self-assessments, or quality activities, did not identify the problem.

- a. The evaluation should state when the problem was identified, how long the condition(s) existed, and whether there were prior opportunities for correction. For example, if a maintenance activity resulted in an inoperable system that was not detected by post-maintenance testing or quality assurance oversight, the reasons that the testing and quality oversight did not detect the error should be included in the problem identification statement and addressed in the root cause evaluation.
- b. The evaluation should address **significant** plant-specific consequences of the issue. A plant-specific assessment may better characterize the **significance** associated with the issue due to the generic nature of the PIs. For conditions that are not easily assessed quantitatively, such as the unavailability of security equipment, a qualitative assessment

should be completed. The evaluation should also include an assessment of compliance. As applicable, some events may be more appropriately assessed as hazards to plant personnel or the environment. The **inspector's** review of the **significance** assessment should be coordinated with a senior reactor analyst.

### 03.03 Root Cause, Extent of Condition, and Extent of Cause Evaluation

- a. The **licensee's** evaluation should generally make use of systematic methods to identify root and contributing causes. The root cause evaluation methods that are commonly used in nuclear facilities include:
  1. Events and causal factors analysis – to identify the events and conditions that led up to an event;
  2. Fault tree analysis – to identify relationships among events and the probability of event occurrence;
  3. Barrier analysis – to identify the barriers that if present or strengthened would have prevented the event from occurring;
  4. Change analysis – to identify changes in the work environment since the activity was last performed successfully that may have caused or contributed to the event;
  5. Management Oversight and Risk Tree (MORT) analysis – to systematically check that all possible causes of problems have been considered;
  6. Critical incident techniques – to identify critical actions that if performed correctly would have prevented the event from occurring or would have significantly reduced its consequences;
  7. Why Staircase – to produce a linear set of causal relationships and use the experience of the problem owner to determine the root cause and corresponding solutions; and
  8. Pareto Analysis – a statistical approach to problem solving to determine where to start an analysis.

The licensee may use other methods to perform root cause evaluations. A systematic evaluation of a problem using one of the above methods should normally include:

1. A clear identification of the problem and the assumptions made as a part of the root cause evaluation.

For example, the evaluation should describe the initial operating conditions of the system or component identified, staffing levels, and training requirements as applicable.

2. **The prompt** collection **and** verification of data and preservation of evidence to ensure that the information and circumstances surrounding the problem are fully understood. The analysis should be documented such that the progression of the problem is clearly understood, any missing information or inconsistencies are identified, and the problem can be easily understood by others.
3. A determination of cause and effect relationships resulting in an identification of root and contributing causes that consider potential hardware, process, and human performance issues. For example:
  - (a) Hardware issues could include design, materials, systems aging, and environmental conditions;
  - (b) Process issues could include procedures, work practices, operational policies, supervision and oversight, preventive and corrective maintenance programs, and quality control methods; and
  - (c) Human performance issues could include training, communications, human-system interface, and fitness for duty (which includes managing fatigue). See IP 93002, "Managing Fatigue," for guidance on the requirements of 10 CFR Part 26, Subpart I – Managing Fatigue.
- b. The root cause evaluation should be conducted to a level of detail that is adequate for the significance of the problem. Different root cause evaluation methods provide different perspectives of the problem. In some instances, using a combination of methods helps ensure the analysis is thorough. Therefore, the root cause evaluation should consider evaluating complex problems, which could result in significant consequences, using multi-disciplinary teams and/or different and complimentary methods appropriate to the circumstances. For example, problems that involve hardware issues may be evaluated using barrier analysis, change analysis, or fault trees.

The depth of a root cause evaluation is normally achieved by completely and systematically applying the methods of analysis described in Section 03.03.a and by repeatedly asking the question "Why?" about the occurrences and circumstances that caused or contributed to the problem. Once the analysis has developed all of the causes for the problem (i.e., root, contributing, and programmatic), the evaluation should also look for any relationships among the different causes. The depth of the root cause evaluation may be assessed by:

1. Determining that the questioning process appeared to have been conducted until the causes were beyond the **licensee's** control.

For example, problems that were initiated by an act of nature, such as a lightning strike or tornado, could have the act of nature as one of the causes of the problem. The act of nature would not be a candidate root cause, in part, because the licensee could not prevent it from happening again. However, a **licensee's** failure to plan for or respond properly to acts of nature would be under management control and could be root causes for the problem.

2. Determining that the problem was evaluated to ensure that other root and contributing causes were not inappropriately ruled out due to assumptions made as a part of the analysis.

For example, a root cause evaluation may not consider the adequacy of the design or process controls for a system if the problem appears to be primarily human performance focused. Consideration of the technical adequacy of the assumptions used in the root cause evaluation and their impact on the root causes would also be appropriate.

3. Determining that the evaluation collectively reviewed all root and contributing causes for indications of more fundamental problems with a process or system.

For example, a problem that involved a number of procedural inadequacies or errors may indicate a more fundamental or higher level problem in the processes for procedural development, control, review, and approval. Issues associated with personnel failing to follow procedures may also be indicative of a problem with supervisory oversight and communication of standards.

4. Determining that the root cause evaluation properly ensured that correcting the causes would **preclude repetition** of the same and similar problems. Complex problems may have more than one root cause as well as several contributing causes. The evaluation should include a process to verify that corrective actions for the identified root causes do not rely on unstated assumptions or conditions that are not controlled or ensured.

For example, root causes evaluations that are based on normal modes of operation may not be valid for accident modes or other “off normal” modes of operation.

5. Determining that the evaluation appropriately considered other possible root causes. Providing a rationale for ruling out alternative possible root causes helps to ensure the validity of the specific root causes that are identified.

- c. The root cause evaluation should include a proper consideration of prior occurrences of the same or similar problems at the facility and knowledge of prior operating experience. This review is necessary to help develop the specific root and contributing causes and also to provide indication as to whether the issue is due to a more fundamental concern involving weaknesses in the **licensee’s** corrective action program.

- d. The licensee’s root cause evaluation should:

1. Broadly question the applicability of other similar events or issues with related root or contributing causes.

For example, root cause evaluations associated with outage activities and safety-related systems could include a review of prior operating experience involving off-normal operation of systems, unusual system alignments, and infrequently performed evolutions.

2. Determine if previous root cause evaluations and/or corrective actions missed or inappropriately characterized the issues. Determine those aspects of the corrective actions that did not **preclude repetition** of the problem.

For example, the evaluation should review the implementation of the previously specified corrective actions and a reassessment of the identified root causes to determine process or performance errors that may have contributed to the repeat occurrence.

3. Determine if the root cause evaluation for the current problem specifically addresses those aspects of the prior root cause evaluation or corrective actions that were not successfully addressed.

For example, if during the review of a tagging error that resulted in a **mispositioned** valve the licensee determines that a previous similar problem occurred, and the corrective actions only focused on individual training, then the root cause evaluation for the repeat occurrence should document why the previous corrective actions were inadequate.

4. Include a review of prior documentation of problems and their associated corrective actions to determine if similar incidents have occurred in the past. For example, the licensee staff should consider the following during their review of prior operating experience: internal self-assessments; maintenance history; adverse problem reports; and external databases developed to identify and track operating experience issues. Examples of external databases may include Information Notices, Generic Letters, and vendor/industry generic communications.

The inspectors should discuss the problem and associated root causes with other resident, regional, or headquarters personnel to assess whether previous similar problems or root causes should have been considered.

The root cause evaluation should include a proper consideration of the extent of condition and the extent of cause of the problem and of whether other systems, equipment, programs, or conditions could be affected.

1. The extent of condition review should assess the degree that the actual condition (failed valve, inadequate procedure, improper human action, etc.) may exist in other plant equipment, processes, or human performance.
2. The extent of cause review should assess the applicability of the root causes across disciplines or departments for different programmatic activities, human performance, or different types of equipment.

For example, the licensee's fire protection staff considered that the root causes identified for the misalignment associated with the safety injection system could potentially affect fire suppression systems since the systems shared a common tagging and alignment method. As a result, feedback was provided to the

incident review committee to include modification of the fire suppression system control procedure and provide formal training to all fire protection personnel.

The extent of condition review differs from the extent of cause review in that the extent of condition review focuses on the actual condition and its existence in other places. The extent of cause review should focus more on the actual root causes of the condition and on the degree that these root causes have resulted in additional weaknesses.

e. *The root cause evaluation should include a proper consideration of whether a weakness in any safety culture component was a root cause or significant contributing cause of the performance issue (PI or inspection finding), and if so, that weakness should be addressed through adequate corrective actions. Therefore, for each performance issue that prompted this inspection, consider whether the performance issue, the licensee's evaluation methodology, results obtained using that methodology, or any related circumstance indicates that a weakness in any safety culture component could reasonably have been a root cause or significant contributing cause of the performance issue. If so, then for each such weakness, determine if the licensee considered in their evaluation if the weakness was a root cause or significant contributing cause of the deficiency and documented that consideration in their evaluation. [C1]*

f. **No additional guidance.**

#### 03.04 Corrective Actions

The licensee's corrective actions (**taken and planned**) to the root and contributing causes should:

- a. Address each of the root and contributing causes and any weakness associated with the extent of condition and extent of cause of the performance issue. The corrective actions should be clearly defined. Examples of corrective actions may include but are not limited to modifications, inspections, testing, process or procedure changes, and training. The proposed corrective actions should not create new or different problems as a result of the corrective actions. If the licensee determines that no corrective actions are necessary, then the basis for this decision should be documented in the evaluation.
- b. Include consideration of the **licensee's significance** assessment results of the issue in prioritizing the type of corrective actions chosen. Attention should be given to solutions that involve only changing procedures or providing training because they are sometimes overused. In such cases, consideration should be given to more comprehensive corrective actions such as design modifications. The corrective action plan should also include a review of the regulations to ensure that it achieves compliance if compliance issues exist.
- c. Be assigned to the appropriate individuals or organizations to ensure that the actions are **promptly planned and completed**. The licensee should also establish a formal tracking mechanism for each of the specific corrective actions.

- d. Establish **appropriate quantitative or qualitative measures** to validate the effectiveness of **completed** corrective actions **to address and preclude repetition of significant performance issues**. Effective methods **might** include but are not limited to assessments, audits, inspections, tests, trending of plant data, or follow-up discussions with plant staff.
- e. **In the case of** an NOV that directly corresponds with the performance issue that was the basis for- **or otherwise directly related to** the supplemental inspection, address the reason for the violation, corrective actions that have been taken and the achieved results, corrective actions that will be taken, and the date when full compliance was or will be achieved. The adequacy of the corrective actions should be reviewed in accordance with the guidance above to determine if they address the violation.

### 03.05 Evaluation against IMC 0305 Criteria for Treatment of Old Design Issues

When this part of the IP is implemented, the inspection report should contain a discussion of why or why not the performance issue is or is not being considered as an old design issue. For those cases where the issue is not being considered, the discussion can be brief. For those cases where the performance issue is being considered as an old design issue, a more detailed discussion should be documented in the inspection report that explains how each of the four criteria contained in IMC 0305 were met. A synopsis of this discussion should also be contained in the summary of findings and cover letter of the inspection report. Additional guidance pertaining to the treatment of old design issues is contained in IMC 0305.

#### 95001-04 RESOURCE ESTIMATE

It is estimated that this procedure will take approximately 40 hours to complete for **one** white issue **and approximately 120 hours to complete for two white issues**. The inspector(s) assigned should be familiar with the discipline associated with the subject of the **licensee's** evaluation. This resource estimate may vary depending on the effectiveness of the licensee's corrective action program and the complexity of the issue.

#### 95001-05 PROCEDURE COMPLETION

Meeting **both** the inspection objectives defined in Section 95001-01 **and requirements defined in Section 95001-02** of this IP will constitute completion. A failure to satisfy this IP's inspection objectives **and requirements** will normally result in a continued or a follow-up inspection under this IP and may result in holding open the associated performance issue past four quarters in the Action Matrix or opening a parallel PI finding. Refer to IMC 0305 for additional information.

#### 95001-06 REFERENCES

IMC 0305, "Operating Reactor Assessment Program"

IMC 0310, "**Aspects Within** Cross-Cutting Areas"

IMC 0320, "Operating Reactor Security Assessment Program"

IMC 0609, "Significance Determination Process"

IMC 0612, "Power Reactor Inspection Reports"

IMC 0612, Appendix C, "Guidance for Supplemental Inspection Reports"

| IMC 2201, "Security Inspection Program for Commercial Nuclear Power Reactors"

| IMC 2201 Appendix B, "Supplemental Inspection Program"

IMC 2515, "Light-Water Reactor Inspection Program - Operations Phase"

| IMC 2515 Appendix B, "Supplemental Inspection Program"

IP 71152, "Problem Identification and Resolution"

IP 93002, "Managing Fatigue"

| NUREG-2165, "Safety Culture Common Language"

END

Attachment 1 – Revision History for IP 95001

Commitment Tracking Number	Accession Number Issue Date Change Notice	Description of Change	Description of Training Required and Completion Date	Comment and Feedback Resolution Accession Number (Pre-Decisional, Non-Public)
N/A	04/03/00 <a href="#">CN 00-003</a>	Initial Issue.	Yes	
N/A	03/06/01 <a href="#">CN 01-006</a>	Incorporated minor changes to better define "extent of condition" and to reference IMC 0610 guidance for documenting the results of the inspection.	No	
N/A	01/17/02 <a href="#">CN 02-001</a>	Revised to include minor editorial changes.	No	N/A
N/A	<a href="#">ML031570251</a> 05/23/03 <a href="#">CN 03-016</a>	Clarified guidance on extent of condition review and add guidance for evaluating whether credit should be given for "old design issues."	No	N/A
C1	<a href="#">ML061560516</a> 06/22/06 <a href="#">CN-06-015</a>	Incorporate safety culture initiatives described in, Staff Requirements - SECY-04-0111 – "Recommended Staff Actions Regarding Agency Guidance in the Areas of Safety Conscious Work Environment and Safety Culture" dated August 30, 2004.	Yes 07/01/06	<a href="#">ML061570117</a>
N/A	<a href="#">ML062890448</a> 10/16/06 <a href="#">CN-06-027</a>	This IMC has been revised to incorporate comments from the Commission in which the term public confidence has been change to openness	No	N/A

Commitment Tracking Number	Accession Number Issue Date Change Notice	Description of Change	Description of Training Required and Completion Date	Comment and Feedback Resolution Accession Number (Pre-Decisional, Non-Public)
N/A	<a href="#">ML080040263</a> 04/09/09 <a href="#">CN 09-011</a>	This IP has been revised to address the following ROP feedback forms: 95001-1121, 95001-1122, 95001-1123, 95001-1126, 95001-1127, 95001-1133, and 95001-1243. This revision: clarifies that all safety culture components should be considered; removes discussion pertaining to PI fault hours and NEI 99-02; updates the NRC's goals to reflect the Strategic Plan for FY 2008-2013; references IMC 0612 for documentation guidance; updates old design issue guidance; clarifies expansion of the IP; adds guidance to follow-up on NOVs; and expands the list of root cause evaluation methods.	No	<a href="#">ML083220122</a>
N/A	<a href="#">ML092680661</a> 11/09/09 <a href="#">CN 09-026</a>	Added reference to IP 93002, "Managing Fatigue"	No	N/A
N/A	<a href="#">ML102020522</a> 02/09/11 <a href="#">CN 11-001</a>	Defined procedure completion criteria and added reference section. Reworded for clarity (feedback form 95001-1534). Added guidance for issuing inspection reports for held open and parallel PI findings.	No	<a href="#">ML110120516</a>

Commitment Tracking Number	Accession Number Issue Date Change Notice	Description of Change	Description of Training Required and Completion Date	Comment and Feedback Resolution Accession Number (Pre-Decisional, Non-Public)
C2	<a href="#">ML15223B348</a> 08/24/16 CN 16-021	<p>Incorporated Staff Requirements Memorandum, SECY-15-0108 “Recommendation to Revise the Definition of Degraded Cornerstone as used in the Reactor Oversight Process” direction to revise IP 95001 to include additional resources [Increased from “approximately 40 hours” to “approximately 40 hours to complete for one white issue and approximately 120 hours to complete for two white issues”] and guidance to be used to review licensee common cause analyses when a licensee has a second White input in the same cornerstone in order to consider the potential for programmatic weaknesses in a licensee’s performance. [C2]</p> <p>Also simplified the IP title; formatted to support navigation pane; incorporated language consistent with 10 CFR 50 Appendix B Criterion XVI (e.g. “prompt” vs. “timely” and “preclude repetition” vs. “prevent recurrence”); addressed ROP Feedback Form 95001-1797 and partially addressed ROPFF 95001-2009; updated safety culture terminology to conform to IMC 0310 revision per ROPFF 95002-2144.</p>	No	<a href="#">ML16146A656</a> 95001-1797 <a href="#">ML16147A119</a> 95001-2009 <a href="#">ML16147A135</a> 95002-2144 <a href="#">ML16147A146</a>