ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-397
License No.:	NPF-21
Report No.:	50-397/96-16
Licensee:	Washington Public Power Supply System
Facility:	Washington Nuclear Project-2
Location:	3000 George Washington Way Richland, Washington
Dates:	July 31 through August 9, 1996
Inspectors:	Thomas O. McKernon, Operator Licensing Examiner Gary W. Johnston, Senior Project Engineer
Approved By:	Glenn M. Tracy, Acting Deputy Director Division of Reactor Safety

Attachment:
Partial List of Persons Contacted
List of Inspection Procedures Used
List of Items Opened
List of Licensee Procedures and documents Reviewed During This Inspection

EXECUTIVE SUMMARY

Washington Nuclear Project-2
NRC Inspection Report 50-397/96-16

From July 31 through August 9, 1996, a special inspection was conducted to review two recent events, an early criticality occurring outside the estimated critical rod position tolerance band during startup on June 27, 1996, and a power excursion on July 20,1996, which resulted from the manipulation of the adjustable speed drive system by a nonlicensed person. The inspectors made the following conclusions.

Operations

- The operating crew failed to follow procedures when distracting activities were conducted during the approach to criticality (Section O1.2).
- Multiple procedural violations occurred due to an erroneous control room operator log entry and a failure to use the correct strip chart paper on one of the source range monitor recorders (Section O1.2).
- The shift manager and the control room supervisor failed to use a conservative decision making process, did not exercise good command, control, and communications, and failed to elevate the estimated critical position problem to upper operations management (Section O1.2).

Engineering

- The reluctance of the station nuclear engineers to bring forward to management their initial concerns related to the accuracy of the estimated critical position calculation demonstrated a lack of conservative decision making (Section E1.2).
- The continuing effort to verify the adequacy of the estimated critical position calculations were thwarted by inadequate training in the use of the associated software. Therefore, combined with a lack of proceduralization for estimated critical position calculations, the station nuclear engineers efforts merely continued to reinforce the error in usage of the software (Section E1.2).
- The lack of a reviewed and approved procedure for conducting an estimated critical position calculation contributed to the early criticality event (Section E1.2).
- The lack of an adequate procedure with sufficient controls resulted in a nonlicensed individual operating the reactor recirculation system and affecting reactivity (Section O1.3).

Effectiveness of Licensee Controls and Evaluations

- The licensee's investigations were too narrowly focused and did not identify all facts involved in the events (Section O1.4).

Report Details

On June 27, 1996, the reactor was restarted and subsequently shut down due to an error in calculating the estimated critical rod position. The reactor was restarted on June 29, and the licensee recommenced power ascension and testing of the digital feedwater and adjustable speed drive modifications. On July 20, while at 68 percent power, the plant experienced a short duration 15 percent power transient due to an error associated with adjustable speed drive testing.

O1 Conduct of Operations

O1.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors reviewed the operational aspects of two recent events: an early criticality occurrence; and Reactor Recirculation Control Pump-1A speed transient during adjustable speed drive testing. In the former event, conduct of operations lacked the rigor of command and control required by procedures during the approach to criticality and concerns related to deviation from the estimated criticality band were not elevated to the appropriate management levels. In the latter event, a nonlicensed person inadvertently caused a reactivity transient by erroneously imputing data into the adjustable speed drive system.

O1.2 Criticality Achieved Prior to Minimum Estimated Critical Position

a. Inspection Scope (71707)

On Thursday, June 27, 1996, reactor criticality was achieved prior to the minimum expected point of criticality calculated by the station nuclear engineer. The inspectors reviewed control room logs, facility procedures, data logs, and conducted interviews with key licensee personnel. The inspectors also reviewed the actions of the control room shift operators to ascertain whether their actions contributed to the estimated critical position event.

b. Observations and Findings

Operations Command, Control, and Communications

The inspectors observed that during the estimated critical position event, a number of barriers to effective command, control, and communications were either breached or circumvented:

(1) Initial communications between the backshift shift manager and the onshift station nuclear engineer indicated a low confidence level in the estimated critical position calculation. While the shift manager questioned the results

of the calculation, particularly with respect to its difference from the estimated critical position calculated for the prior initial criticality of June 14, 1996, no compensatory measures of monitoring were deemed necessary. Cautionary actions of Step 4.2.5 in Procedure PPM 1.3.59, "Reactivity Management," were discussed between the station nuclear engineer and the shift manager. This step required that, "If criticality occurs before the Minimum Allowable Critical Position, stop control rod withdrawal, notify the control room supervisor. The control room supervisor should direct the control room operator to drive control rods in the reverse order." Additionally, the control room supervisor erroneously assumed, by review of the station nuclear engineer's estimated critical position memorandum which was addressed to the reactor/fuels engineering manager, that the memorandum had been reviewed by the manager when, in fact, it had not.

(2) The results of subsequent discussions between the onshift station nuclear engineer and the estimated critical position calculation (PowerPlex) software custodian, also a station nuclear engineer, at 0200 hours, indicated that the offshift station nuclear engineer doubted the estimated critical position calculation results. However, the onshift station nuclear engineer did not consider it necessary to elevate the lack of confidence in the estimated critical position calculation up to his management nor did he share the information with the shift manager or the control room supervisor.

(3) At 0533 hours, Intermediate Range Monitor IRM-Det-1C appeared to fail and was declared inoperable by the operators. At the direction of the shift manager, the control room supervisor (also the reactivity manager) diverted his attention to filling out the limited condition of operation log paperwork. This activity and his following preparations for turnover to the oncoming control room supervisor consumed the majority of his attention and focus until the time of turnover. These activities were in noncompliance with the startup Procedure PPM 3.1.2, Revision 31, Step 4.2.2 caution, which stated, that, "During the approach to criticality, avoid activities that can distract the operator at the controls and the control room supervisor." This was an apparent violation of Technical Specification 6.8.1a (50-397/9616-03).

(4) At the time of turnover, the shift technical advisor advised both control room supervisors that the plant was close to going critical. The shift technical advisor returned to the front panel and the reactor operator and shift technical advisor continued to withdraw control rods. The control room supervisors did not stop their turnover and focus on the approach to criticality. This was another example of a failure to adhere to the Reactivity Management Procedure. Procedure PPM 1.3.1, Revision 26, "Conduct of Operation," Step 4.6.1, stated, "During periods when reactivity manipulations are in progress or plant activities which could affect reactivity occur, the control room supervisor shall assume the responsibility of Reactivity Manager. Responsibilities include ensuring a conservative

approach to operations involving core reactivity changes." Procedure PPM 1.3.1, Revision 26, Step 4.6.2 (r) further stated, "Shift turnover of the control room staff is inappropriate when criticality is imminent." This was another example of apparent violation (50-397/9616-03).

(5) During the control room supervisor turnover walkthrough of the control board panels, the oncoming control room supervisor suddenly observed the condition of the plant and the source range monitor neutron level. The reactor operator stated that criticality was imminent. The control room supervisor discussed the condition with the station nuclear engineer and was informed of the deviation from the expected estimated critical position margin. The control room supervisor briefly informed the shift foreman. The shift foreman acknowledged the control room supervisor but did not internalize the information and act upon it. Instead, the shift foreman focused upon conducting the shift briefing while the control room supervisor returned to the at-the-controls area to oversee control rod withdrawals. Procedure PPM 1.3.1, Revision 26, Step 4.6.2b stated, "The Reactor Operator at H13-P603 shall not be distracted by control room activities such as shift turnover, shift brief, or surveillances." The conduct of the shift brief during the approach to criticality was another example of failure to follow procedures and apparent violation of Technical Specification 6.8.1a (50-397/9616-03).

(6) In followup interviews, it was determined that the shift technical advisor who had previously reviewed the estimated critical position calculation did not internalize the information and, as such, did not serve as a barrier to identify and inform the control room supervisor of the out-of-tolerance estimated critical position/criticality conditions.

Actions:

(1) While the shift manager questioned the estimated critical position calculation results when presented the estimated critical position memorandum, cautionary action statements in the startup procedure gave the shift manager confidence in continuing with control rod withdrawal. As discussed above, this action resulted in a failure to follow procedures.

(2) The shift manager directed the control room supervisor to attend to other duties which detracted from his reactivity manager duties and responsibilities. This was an apparent failure to comply with Procedure PPM 3.1.2.

(3) The offgoing/oncoming control room supervisor turnover detracted from the focus on the approach to criticality and an apparent failure to comply with Procedure PPM 1.3.1.

(4) The offgoing/oncoming control room supervisors failed to discontinue their turnover when informed that the reactor was close to criticality.

(5) The shift manager failed to advise his upper operations management that the early criticality was approaching and the minimum estimated critical position criteria would not be met.

(6) The shift manager made a cognizant decision to conduct a shift briefing while the control room supervisor and the reactor operator/shift technical advisor continued to pull control rods. This action was an apparent noncompliance with procedures as discussed above in item (5) of the command, control, and communication section.

(7) The control room supervisor directed the reactor operator to pull control rod 18-47 from step 16 to 26 while the crew monitored the increasing source range monitor count rate. The reactor was then declared critical at 0705 hours, June 27, 1996, with a source range monitor Channel A detector reading $7x10^4$ cps, a reactor period of 345 seconds, and a reactor coolant system temperature of 211 degrees F. In followup reviews of the control room operator logs, the inspectors determined this data was not accurately entered into the control room operator log as required by Startup Procedure PPM 3.1.2, Revision 31, Step 4.2.7 which stated, "Enter the following here and in the control room operator log at the time of criticality . . . Time, Neutron Level, Period, Control Rod Number, Control Rod Position, Coolant Temperature." The control room operator log was annotated as having a neutron level of 5000 cps. This erroneous entry represented a failure to follow procedures and a violation of Technical Specification 6.8.1a (50-397/9616-01).

(8) Additionally, the inspectors identified that the control room operators had erroneously installed and not identified one of the source range monitor recorder's strip chart paper which was of the wrong type. The strip chart paper had a linear scale when the appropriate type was one with a logarithmic scale. Procedure PPM 3.1.10, "Operating Data Logs," Revision 11, stated, "The purpose of recorder charts is to provide operations and management personnel with a permanent record of trends exhibited by specific plant parameters." The source range monitor recorder with the incorrect strip chart paper would not serve the purpose of an accurate historical permanent record. This was a failure to follow procedures and a violation of Technical Specification 6.8.1a (50-397/9616-02).

c. Conclusions

The inspectors concluded that apparent violations of regulatory requirements existed in the operations area of responsibility. The operating crew failed to follow procedures when distracting activities were conducted during the approach to

criticality. The shift manager and the control room supervisor failed to use a conservative decision making process, did not exercise good command, control, and communications, and failed to elevate the estimated critical position problem to upper operations management. Additionally, procedural violations occurred due to an erroneous control room operator log entry and a failure to use the correct strip chart paper on one of the source range monitor recorders.

O1.3 Adjustable Speed Drive Power Excursion Event

a. Inspection Scope (71707)

On July 20, 1996, while performing tests on the adjustable speed drive system to ascertain whether or not electronic resonance of control circuitry might occur at different pump speeds, a contract engineer in the adjustable speed drive room inadvertently caused a 15 percent change in power from 68 to 53 percent and a return to the initial 68 percent power level. The event occurred while efforts were being taken to serve as compensatory measures should an electronic resonance condition appear during adjustment of the reactor recirculation pumps.

The inspectors reviewed the adjustable speed drive event and conducted interviews with key facility personnel. Test procedures and other control processes were also reviewed.

b. Observations and Findings

The inspectors interviewed key operations personnel involved with validation and verification of Procedure PPM 8.3.339, "Test Instructions - Reactor Recirculation (RRC) Adjustable Speed Drive (ASD) and Reactor Digital Feedwater (DFW) Control Power Ascension Test Program," Revision 1. The inspectors noted that the test procedure had been validated for those areas which could be modeled on the plant-specific simulator, but was not validated for test areas related to in-plant local actions such as the input of adjustable speed drive runback values at local panels inside the adjustable speed drive room. Further, discussions with operations personnel indicated that directions for local actions inside the adjustable speed drive room were discussed during the pretest brief in the control room. The procedure did not contain specific steps by which compensatory measures were to be taken should electronic resonance appear. The only written guidance that existed was as an embedded action statement to a caution in Step 8.9 of the procedure. As such, the procedure was inadequate in that it did not contain measures sufficient to preclude manipulation of facility controls as expressly prohibited by 10 CFR 50.54(i), in that, a nonlicensed individual operated the reactor recirculation control system and affected reactivity. This was considered an apparent violation of Criterion V of 10 CFR 50, Appendix B (50-397/9616-05).

In addition, the plant operations committee review of the test procedure had identified a potential problem with the procedure in this area, but had not followed through with sufficient actions to preclude the event from occurring. As such, the licensee had prior knowledge of the potential for the event but did not take sufficient measures to preclude its occurrence. Further, the work control process did not identify the test evolution as a potential problem because it did not have procedural steps to review and, therefore, did not review the task to a level of depth which would have identified a problem with the procedure.

c. Conclusions

The inspectors concluded that the procedure controlling adjustable speed drive testing for local actions in the adjustable speed drive room was inadequate and an apparent violation. The inspectors also concluded that controls and barriers which would have precluded a nonlicensed individual from manipulating reactivity were not established. As a result, a nonlicensed individual was placed in a position in which he alone could, and did, cause an effect on core reactivity.

O1.4 Effectiveness of Licensee Controls and Evaluations (71707)

a. Inspection Scope

The inspectors reviewed the licensee incident review board investigations, followup problem evaluation requests, and conducted discussions with key personnel involved in the events and in the investigation of the events.

b. Observations and Findings

The inspectors noted that the licensee's incident review board findings did not include a number of the discrepancies identified by the inspectors. For example: (1) the erroneous control room operator log entry related to the initial criticality count rate (5000 cps versus 70,000 cps); and (2) the fact that one of the source range monitor recorders had the incorrect strip chart paper installed.

Additionally, the incident review boards did not identify some root causes which the inspectors believed were very relevant. For example, the estimated critical position incident review board focused on the reactor engineering aspects and did not address operations command and control during the events and what barriers were breached or circumvented. The adjustable speed drive incident review board investigation focused solely upon the contract engineer's actions and did not address what barriers in the procedural review process were circumvented. For example, why did the operations review process and work control process not function properly and preclude a nonlicensed individual from even being in a position in which he could affect the manipulation of reactivity?

c. Conclusions

The inspectors concluded that the licensee's investigations were too narrowly focused and did not identify all facts involved in the events.

O5 Operator Training and Qualification (41500)

a. Inspection Scope

The inspectors reviewed licensed operator training related to the approach to criticality. The review included both the initial licensed operator certification program and the licensed operator requalification program, as well as interviews with key training department personnel.

b. Observations and Findings

The inspectors noted that the initial licensed operator certification training included the appropriate knowledge and abilities competencies and these were linked to simulator and classroom training sessions. The licensed operator requalification program was procedurally linked to lesson plans and learning objectives. In the requalification training, the training associated with reactivity focused upon lessons learned from industry events and simulator sessions related to startup of the plant. In the simulator requalification training, operators discussed plant indications during the approach to criticality and then continued with plant heatup operations. As such, not all reactor operators had the opportunity to pull control rods to criticality. However, all operators were involved in training discussions.

c. Conclusions

The inspectors concluded that the operators had the prerequisite knowledge and abilities related to approach-to-criticality operations. However, the inspectors also concluded that because of decreased opportunities for plant startups and because of a greater number of licensed operators in the program, the experience level of operators may not have been as high as it had been in the past.

III. Engineering

E1 Conduct of Engineering

E1.1 General Comments (37551)

Using Inspection Procedure 37551, the inspectors reviewed the involvement of station nuclear engineers in the early criticality and the Reactor Recirculation Control Pump-1A speed transient during adjustable speed drive testing. In the former event, concerns of the station nuclear engineers regarding the results of calculations of the estimated critical rod position and the deviation from the estimated criticality band

were not elevated to the appropriate management levels. In the latter event, a nonlicensed person, a contractor engineer, inadvertently caused a reactivity transient by erroneously imputing data into the adjustable speed drive system. The inspectors summarized other observations related to these events in Sections O1.2 and O1.3 of this report.

E1.2 Criticality Achieved Prior to Minimum Estimated Critical Position

a. Inspection Scope

On Thursday, June 27, 1996, reactor criticality was achieved prior to the minimum expected point of criticality calculated by the station nuclear engineer. The inspectors reviewed control room logs, facility procedures, data logs, and conducted interviews with key licensee personnel.

b. Observations and Findings

The estimated critical position calculated for the June 27, 1996, reactor criticality was performed utilizing the incorrect software flag for the plant condition. The PowerPlex software required that a specific set of conditions be input to solve for the desired parameters. The software accomplished this with a series of flags that were set by the user. The flag setting that caused the estimated critical position calculation to be incorrect was for Xenon dependence. Normally the flag default is -1, which covers most cases for online use. For the case of a plant that had been shutdown for a short period of time, where the Xenon concentration had not decayed fully the flag should have been set to 0.

Discussions with the software custodian, who also conducted the station nuclear engineers training on the PowerPlex software, indicated to the inspectors that he had questioned the vendor about the use of the -1 option. However, the use of the option for the case of a post-trip return to criticality was not a topic discussed and the custodian was left with the impression that the default value of -1 would be used in almost all possible situations. Therefore, when the estimated critical position calculation was done the option of 0 was not selected. When subsequent calculations were conducted, the other station nuclear engineers performed the calculation in the same method.

On June 12, 1996, the first estimated critical position following the refueling outage was performed. This estimated critical position was done using charts provided by the fuel vendor, and no anomalies were found. The estimated critical position was validated using the PowerPlex software, which agreed with the manual calculation. The wrong Xenon dependence flag was set for this calculation, however, the software automatically depletes Xenon for the first run after a refueling. As a result, the station nuclear engineers did not receive prior indication of the error in use of the software.

The reactor scrammed on June 24, 1996, at around 0800 hours. On the following day, June 25, 1996, an initial estimated critical position was calculated estimating 0000 hours that night. The station nuclear engineer recalculated an estimated critical position that night for a 0600 critical time on June 26, 1996. The station nuclear engineer that performed the calculation noted that the result was the same as the previous calculation, which was unexpected. The station nuclear engineer was concerned about the calculation and expressed his concerns to the oncoming station nuclear engineer for the day shift. Additional runs of the software were done, which resulted in the same results. A manual calculation was done which came up with a different result, that later turned out to be more accurate. The manual calculation, however, was discounted because it did not include factors that the PowerPlex software included, particularly the fact that one rod was inoperable and would stay in the core.

Runs on the software of 24 hours after the trip and 36 hours gave the same results. The station nuclear engineers ascribed that the reason for this conclusion was that the Xenon had decayed out of the core by 24 hours after the scram. This was not the case, as subsequent analysis showed that the amount of Xenon would have been nearly equal to equilibrium at the time of the scram, and the 36-hour figure was around half of the equilibrium value. The engineers continued to analyze the differences, requesting assistance from the fuels engineering group to do other calculations. The differences between the calculations of the two groups amounted to about 6 mK, but was discounted. The difference between the June 12, 1996, estimated critical position and the last estimated critical position that was calculated was 16 mK. The engineers became convinced that Samarium poisoning accounted for the difference. This would explain some changes in the expected estimated critical position, however, not to the magnitude that occurred.

On June 27, 1996, the station nuclear engineer gave the estimated critical position to the shift manager. The shift manager questioned the difference between the estimated critical position of June 12 and the new estimated critical position. The station nuclear engineer convinced the shift manager that sufficient independent work was done to justify the estimated critical position. The onshift control room supervisor was not informed of this disparity. The rest of the event process is described in Section O1.2 of this report.

The inspectors reviewed Procedure PPM 1.3.59, "Reactivity Management Program," Revision 1, and noted that step 2.6.3a of the procedure stated that, "An estimated ECP calculation should be performed by the SNE . . . and an acceptable band of delta K/K for criticality should be applied." Procedure PPM 3.1.2, "Reactor Startup," Revision 31, step 4.2.3 further required that the station nuclear engineer, ". . .verify criticality occurs between the Minimum Allowable ECP Limit and the Maximum Allowable ECP Limit." However, no approved plant procedure existed on June 27, 1996, to perform a calculation for an estimated critical position and applied tolerance band, nor were instructions provided within Procedure PPM 3.1.2, "Reactor Startup." The inspectors noted that a draft procedure had existed for

some time but did not include sufficient instructions to preclude the miscalculation of the estimated criticality point. As a result, on June 27, 1996, the reactor was taken critical approximately 4 mK earlier than the minimum allowable estimated critical point limit. The lack of specified procedural guidance was considered an apparent violation of Technical Specification 6.8.1a (50-397/9616-04).

c. Conclusions

The inspectors noted the apparent reluctance of the station nuclear engineers to bring forward to management their initial concerns related to the accuracy of the estimated critical position calculation. Further, their assurance that sufficient independent verification was done led the shift manager to believe the estimated critical position was correct. The continuing effort to verify the adequacy of the estimated critical position calculations were thwarted by inadequate training in the use of the PowerPlex software. Therefore, combined with a lack of proceduralization for estimated critical position calculations, the station nuclear engineers efforts merely continued to reinforce the error in usage of the software.

E5 Engineer Training and Qualification (41500)

a. Inspection Scope

The inspectors reviewed station nuclear engineer training related to the approach to criticality and the use of the PowerPlex software to calculate the estimated critical position. The review included initial training and subsequent refresher training, as well as interviews with the PowerPlex software custodian responsible for providing the training on the use of the software.

b. Observations and Findings

The inspectors noted that, for the initial training, the station nuclear engineers were presented with all the functional attributes of the PowerPlex program. The review of the training indicated that the original training was sufficient and addressed the necessary knowledge and ability factors. However, subsequent training on the software did not include sufficient detail to ensure that changes made to the software by the vendor were addressed. The vendor had recently provided new software with changes to the flag settings related to time dependent Xenon concentration. The effect of the setting of the flag for the case of a cold time-dependent post-trip calculation for a critical rod position was not discussed during training of the station nuclear engineers. As a result, when the calculation for the reactor startup of June 27, 1996, was performed, the error in selecting the flag was repeated consistently. This resulted in each confirmatory calculation being performed with the same conditions set in the program.

c. Conclusions

The inspectors concluded that the station nuclear engineers training on the use of the PowerPlex software was flawed such that the personnel consistently performed the estimated critical position calculations incorrectly.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on August 8, 1996. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered propriety. No proprietary information was identified.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

P. Bemis, Vice President for Nuclear Operations
L. Fernandez, Licensing Manager
G. Smith, Plant General Manager
A. Langdon, Acting Operations Manager
J. Swailes, Engineering Director
D. Swank, Regulatory and Industrial Affairs Manager
R. Webring, Vice President Operations Support
M. Monopoli, Maintenance Manager

NRC

G. Tracy, Acting Deputy Director, Division of Reactor Safety

LIST OF INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
IP 41500: Training and Qualification
IP 71707: Plant Operations

LIST OF ITEMS OPENED

Opened

50-397/9616-01	VIO	Failure to adhere to procedures related to control room operator log entries
50-397/9616-02	VIO	Failure to adhere to procedures related to retention of permanent plant records
50-397/9616-03	VIO	Failure to adhere to procedures related to reactor startup
50-397/9616-04	VIO	Failure to have a procedure for calculation of an estimated critical position
50-397/9616-05	VIO	Failure to have procedure appropriate to circumstances resulting in a nonlicensed person operating the controls of the reactor

LIST OF LICENSEE PROCEDURES AND DOCUMENTS REVIEWED DURING THIS INSPECTION

PPM 3.1.2, Revision 31 , "Reactor Startup"

PPM 3.1.10, Revision 11, "Operating Data Logs"

PPM 1.3.59, Revision 1, "Reactivity Management"

PPM 8.3.339, Revision 1, "Test Instructions - Reactor Recirculation Adjustable Speed Drive and Reactor Digital Feedwater Control Power Ascension Test Program"

PPM 1.3.1 Revision 26, "Conduct of Operations"

Incident Review Board Report for PER 296-0576, "RRC-PUMP-1A Speed transient during ASD testing," dated July 25, 1996

Incident Review Board Report for PER 296-0522, "Criticality Achieved Prior to Minimum Estimated Critical Position (ECP)," dated July 2, 1996

Interoffice Memorandum, Subject: Estimated Critical Position (ECP) for BOC-12, dated June 26, 1996

ENCLOSURE 3

Enforcement Policy: Section V,
"Predecisional Enforcement Conferences"

V. PREDECISIONAL ENFORCEMENT CONFERENCES

Whenever the NRC has learned of the existence of a potential violation for which escalated enforcement action appears to be warranted, or recurring nonconformance on the part of a vendor, the NRC may provide an opportunity for a predecisional enforcement conference with the licensee, vendor, or other person before taking enforcement action. The purpose of the conference is to obtain information that will assist the NRC in determining the appropriate enforcement action, such as: (1) a common understanding of facts, root causes and missed opportunities associated with the apparent violations, (2) a common understanding of corrective action taken or planned, and (3) a common understanding of the significance of issues and the need for lasting comprehensive corrective action.

If the NRC concludes that it has sufficient information to make an informed enforcement decision, a conference will not normally be held unless the licensee requests it. However, an opportunity for a conference will normally be provided before issuing an order based on a violation of the rule on Deliberate Misconduct or a civil penalty to an unlicensed person. If a conference is not held, the licensee will normally be requested to provide a written response to an inspection report, if issued, as to the licensee's views on the apparent violations and their root causes and a description of planned or implemented corrective action.

During the predecisional enforcement conference, the licensee, vendor, or other persons will be given an opportunity to provide information consistent with the purpose of the conference, including an explanation to the NRC of the immediate corrective actions (if any) that were taken following identification of the potential violation or nonconformance and the long-term comprehensive actions that were taken or will be taken to prevent recurrence. Licensees, vendors, or other persons will be told when a meeting is a predecisional enforcement conference.

A predecisional enforcement conference is a meeting between the NRC and the licensee. Conferences are normally held in the regional offices and are not normally open to public observation. However, a trial program is being conducted to open approximately 25 percent of all eligible conferences for public observation, i.e., every fourth eligible conference involving one of three categories of licensees (reactor, hospital, and other materials licensees) will be open to the public. Conferences will not normally be open to the public if the enforcement action being contemplated:

(1) Would be taken against an individual, or if the action, though not taken against an individual, turns on whether an individual has committed wrongdoing;

(2) Involves significant personnel failures where the NRC has requested that the individual(s) involved be present at the conference;

(3) Is based on the findings of an NRC Office of Investigations report; or

(4) Involves safeguards information, Privacy Act information, or information which could be considered proprietary;

In addition, conferences will not normally be open to the public if:

(5) The conference involves medical misadministrations or overexposures and the conference cannot be conducted without disclosing the exposed individual's name; or

(6) The conference will be conducted by telephone or the conference will be conducted at a relatively small licensee's facility.

Notwithstanding meeting any of these criteria, a conference may still be open if the conference involves issues related to an ongoing adjudicatory proceeding with one or more intervenors or where the evidentiary basis for the conference is a matter of public record, such as an adjudicatory decision by the Department of Labor. In addition, with the approval of the Executive Director for Operations, conferences will not be open to the public where good cause has been shown after balancing the benefit of the public observation against the potential impact on the agency's enforcement action in a particular case.

As soon as it is determined that a conference will be open to public observation, the NRC will notify the licensee that the conference will be open to public observation as part of the agency's trial program. Consistent with the agency's policy on open meetings, "Staff Meetings Open to Public," published September 20, 1994 (59 FR 48340), the NRC intends to announce open conferences normally at least 10 working days in advance of conferences through (1) notices posted in the Public Document Room, (2) a toll-free telephone recording at 800-952-9674, and (3) a toll-free electronic bulletin board at 800-952-9676. In addition, the NRC will also issue a press release and notify appropriate State liaison officers that a predecisional enforcement conference has been scheduled and that it is open to public observation.

The public attending open conferences under the trial program may observe but not participate in the conference. It is noted that the purpose of conducting open conferences under the trial program is not to maximize public attendance, but rather to determine whether providing the public with opportunities to be informed of NRC activities is compatible with the NRC's ability to exercise its regulatory and safety responsibilities. Therefore, members of the public will be allowed access to the NRC regional offices to attend open enforcement conferences in accordance with the "Standard Operating Procedures For Providing Security Support For NRC Hearings And Meetings," published November 1, 1991 (56 FR 56251). These procedures provide that visitors may be subject to personnel screening, that signs, banners, posters, etc., not larger than 18" be permitted, and that disruptive persons may be removed.

Members of the public attending open conferences will be reminded that (1) the apparent violations discussed at predecisional enforcement conferences are subject to further review and may be subject to change prior to any resulting enforcement action and (2) the statements of views or expressions of opinion made by NRC employees at predecisional enforcement conferences, or the lack thereof, are not intended to represent final determinations or beliefs. Persons attending open conferences will be provided an opportunity to submit written comments concerning the trial program anonymously to the regional office. These comments will be subsequently forwarded to the Director of the Office of Enforcement for review and consideration.

When needed to protect the public health and safety or common defense and security, escalated enforcement action, such as the issuance of an immediately effective order, will be taken before the conference. In these cases, a conference may be held after the escalated enforcement action is taken.