# OFFICIAL TRANSCRIPT OF PROCEEDINGS

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REGION IV AND V EVENT : VOLUME II

REPORTING WORKSHOP :

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Champions I Ballroom

Sheraton CentrePark Hotel

Arlington, Texas

Friday, November 9, 1990

The above-entitled matter commenced at 9:00 a.m.

NRC SPEAKERS AND PANEL MEMBERS:

JOHNS JAUDON, Deputy Director, DRS, Region IV

PAT GWYNN, Deputy Director, DRP, Region IV

JACK CROOKS, Trends and Patterns Anal. Branch, AEOD/HQ

EDWARD JORDAN, Director, AEOD/HQ and Chairman, CRGR

BOBBY FAULKENBERRY, Deputy Regional Administrator Region V

MARK WILLIAMS, Chief, Trends and Patterns Anal. Br., AEOD/HQ

ERIC WEISS, Incident Response Branch, AEOD/HQ

STU RICHARDS, Chief, Reactor Projects Branch, Region V

AL CHAFFEE, Chief, Events Assessment Branch, NRR/HQ

NANCY ERVIN, Safeguards Branch, NRR/HQ

JOAN HIGDON, International Safeguards Branch, NMSS/HQ

C O N T E N T S

PROCEEDINGS

9:00 a.m.

MR. WILLIAMS: If you'll take your seats, we will begin. Last night they disassembled the room, so if you had anything left in the room, it's not here today.

They took the name tags for the panel, among other things, so we'll have to identify ourselves in advance of the questions. Standard procedure. You will do the same. We have a new reporter today.

Today we'll cover two areas. Jack Crooks will begin on 50.73. Jack really is going to cover the outlying areas and reporting requirements that drew our attention and he'll talk about some of the generic results of what's coming into the NRC in terms of LERs.

Then we'll have a panel discussion and then move along to the safeguards events discussion after a break, and a panel discussion on that.

With luck, if we meet all our goals, we'll be able to finish each panel discussion and we might be able to leave about 11:30 today.

Does anyone have any questions, burning questions that they'd like to bring up before we start today's session?

[No response.]

MR. WILLIAMS: Okay. With that, I'll introduce

Jack Crooks.

STATEMENT OF

JACK CROOKS

MR. CROOKS: Good morning. Can you hear all right in the back.

[Affirmative responses.]

MR. CROOKS: What I'll be doing is providing you with some background information that hopefully will aid in our discussion. Then what I'm doing is, I will be covering some of the areas the staff is co sidering making changes in.

We said the other day we don' se numbers. In this case I'm going to use numbers to try to give you an idea of what's been reported under each of the reporting criteria. It also gives you a flavor of what the results would be of our proposed minor rule changes.

Some of this information, if you're interested in more detail is also covered in the AEOD Annual Report for 1989, which is NUREG-1272, Volume 4, No. 1. This information comes from that source.

The information that I am presenting, again, gives kind of a broad perspective of what's come in under the various reporting criteria.

It does not convey anything regarding significance of events. That's been discussed before. We're looking at

that on an individual event basis and also on an aggregated event basis.

So the pie charts and tables merely represent percentages of what's coming in under each reporting criteria.

If we could move on to the next slide.

I'll be covering, then, the basic nature of what's coming in through each category. I'll get into the ESF actuations specifically, and also tech spec violation areas specifically.

May I have the next slide?

The points that I want to make on this second slide, you'll see that the technical specifications area and the ESF reporting area are bringing in about 80 percent of the information that's coming in on LERs.

Reports addressing the items that impede the fulfillment of a safety function are about ten percent of what's being reported.

Reports addressing plants being degraded or in an unanalyzed condition are nine percent.

Reports addressing common mode failure related events are about three percent.

Internal and external threats combined are less than one percent.

We haven't received any reports that have come in

under the criteria of airborne releases or liquid releases.

In total, in 1989 there were about 2375 LERs.

Go on to the next slide.

This pie chart gives you an idea of the various systems that have reported under ESF actuation reporting. The percentages here represent the percent of the number of actuations, as opposed to the number of LERs received.

If you look, you'll see that reactor protection system actuations accounted for 23 percent; HVAC systems, 28 percent; and the RWCU, 8 percent.

Now, some other things that we've looked at over the years has been when are these things occurring. About half of the events have occurred during operations. About another third occurred during testing and the remainder were identified during maintenance.

The trend over the years has been that there are fewer actually occurring during operations.

The RWCU and the HVAC areas, as we mentioned earlier, are two particular areas that we were looking at or making minor rule changes to reduce reporting in this area.

Go to the next slide, please.

Here I present information on numbers of LERs involving ESF actuations that were not associated with RPS actuations. We had a total of like 609. There were like 1350-some actuations or system isolations reported in those

LERs.

That shows that the number of LERs that involved a single system ESF -- In other words, it would be an LER that was addressing just a reactor water cleanup system isolation or a control room vent system isolation or some other single system.

With better than two-thirds of the total LERs in these categories, of this about three-quarters of that were unneeded. By "unneeded," we define that as actuations where the measured parameter was not exceeded. Therefore it didn't reach its setpoint band and didn't actuate the ESF.

These would be the ones that were caused by personnel error, some caused by loss of power supply, some other problem other than the system measured parameter being exceeded.

Then I just further broke this down into the HVAC systems and the RWCU, again just to give you an idea what the impact would be from a change in the reporting requirements in this area.

Go to the next slide, please.

We further broke down the LERs involving single ESF actuations for HVAC. In this area you can see that those specifically involving the control room were about 77 and about 66 of those were unneeded.

The thrust of the last two slides is that if we go

through with the minor rule changes, probably the impact will be to reduce reporting in the range of 100 to 150 LERs.

Go to the next slide, please.

This slide merely breaks down in general terms the content of the LERs or the criteria that the LERs have been coming in under on the technical specification violations.

Three-quarters of these involve exceeding the action statements in LCOs or exceeding some limiting condition for operation, such as range of temperature change, things in that area.

The remaining quarter came under variances from surveillance tests, failures to perform the tests on time or items that were related to surveillance tests.

Go to the next slide, please.

People have been interested in what staff initiatives have taken place over the years regarding LER reporting because we do view it and have viewed it as kind of a living type thing where we're looking at what's coming in and trying to see, well, okay, what improvements can we make.

The initial things have been discussed. They were the issuance of the NUREG-1022, which I'm sure all of you are aware of and have been using for guidance. This, plus the original Federal Register notices that were associated with the rulemaking are really the bases for making many of

the interpretations in the rule.

The next document that was issued was NUREG-1022, Supplement 1 and, again as was mentioned, there were workshops held in late '83.

This captured specific answers to specific questions that were asked at those workshops, so that there was a particular focus on questions that were raised by the industry and by licensees at that time.

Then there was another document, NUREG-1022, Supplement 2, which was issued in 1985, that provided the results of the review of a sampling of LERs after the first year that the new rule was in place.

I don't know how many of you were familiar with that. I know some people have used it. It provided guidance primarily on the content of the LERs.

It was an effort that occurred before, what Mark had talked about, where between '86 and '87 we were looking at a larger sample of LERs to see how the quality of the content of the LERs was stacking up against the reporting requirements.

So those were the initial efforts. There was an effort in '87 also where the staff gave consideration -- There was a mention that -- In creating the rule we found that there was a lot of train level information that was needed for probabilistic risk assessment purposes, and also

some other efforts that were trying to focus on risk significant system and component concerns.

So the staff had developed a proposed rule at that time that would have brought in basically a monthly reporting on train level unavailability.

In that reporting we would have been asking for system, sub-system, component involved, duration of train unavailability for each event, and this would have included unavailability for all causes: Preventive maintenance, corrective maintenance, equipment failure, personnel error, et cetera, as well as the corrective actions that were being taken to improve on train unavailability.

The thrust of this is, there still were studies going on related to what was the equivalent system unavailability, because at times the combined train unavailabilities appeared to be exceeding what anyone had expected.

At the same time that we had the train level reporting under consideration, we also had looked at reducing the current reporting under the rule in the engineered safety features actuation area.

What we have looked at here was a reduction in the reporting such that when the systems were not required to be operable, we could --individual event reporting of unneeded actuations would be reduced.

We did try to make some provisions for if there was a high frequency of this type occurrence, that there would be a periodic reporting, be it monthly or quarterly.

We didn't fully develop that but it would have probably been send an LER in once a quarter that addressed in content all of the information that we needed for these ESF actuations.

This proposal, for a number of reasons, did not make the proposed rule stage in mid-1980.

Go to the next slide, please.

The current initiatives that we have under way where, again, mentioned several times, we're considering deleting the event reporting requirements for unneeded reactor water cleanup system isolations or control room emergency vent system actuations isolations.

We may make some provision, again, where there's a high frequency of these things, and there would be some type of reporting in that area, again be it quarterly -- We're just not sure what the number is or anything, but we felt there may be some value to that.

The other thing that we're doing is we are working on preparation of either Supplement 3 to NUREG-1022 or a revision to 1022 that will take into consideration all the issues and the concerns and the questions that had been raised at the four workshops that were just held across the

country.

From a longer-term standpoint, we also are initiating an effort to look and see that the reporting requirements will be meeting our longer-term needs.

In other words, over the last five or six years we've still had the need for operational information for monitoring plant status and feeding back the lessons learned from experience.

There also are some other needs that are coming in because of plant aging, life extension, and some of the information ... we just at this time don't have some of that information.

So we're looking to see, okay, are we capturing the information that we need. This would be a longer-term rulemaking process.

The minor rule changes Mr. Jordan mentioned yesterday, we're talking in terms of months. We also feel that the guidance would be a parallel effort, so that the supplement or revision to the NUREG would come out at the same time as the minor rule change.

That concludes what I have to say at this time. So we can go into discussion.

DISCUSSION ON 50.73 REPORTING

MR. JORDAN: Jack, I think I'd like to raise an issue you mentioned, the needs of the future with regards to

reporting.

We discussed in the previous workshop on backfitting the benefits of PRAs on a plant-specific basis.

I think there is a need in the future for industry and NRC to have information that would lead to an understanding of how well safety systems are performing in a PRA sense.

So I think that's a possibility that certainly I will be looking at for future direction of reporting.

The NPRDS system does not provide data that can be transcribed or transposed into reliability of systems. We tried that and since you don't have the numbers of starts or the duration of unavailability, so many assumptions are necessary that the value of the information is very poor.

So just as maybe a discussion piece, that's an item that I have a long-term interest in. Maybe others on the panel would like to make comments about the overall process.

MR. WILLIAMS: We can talk a little bit about... This is Mark Williams.

Some of the staff concerns in the past have been the way that rulemaking activity would impact a plant's operations.

In other words, when we were considering train unavailability, we wanted train level data, which was

something we had given up in the rulemaking we have now.

We thought it had to be approached very cautiously. One of the problems that we had was that it would tend to drive preventative maintenance programs in a certain way, because once you tested a train or a system and you had to log as down time all the down time since the last surveillance test, or half of that interval, which is kind of standard practice, that might drive frequencies of testing in an adverse way, making it infrequent.

Plus, the other impacts of changing the requirements for reporting or trying to track reliability of systems.

We didn't want to have any effect on plant operations that we really couldn't predict well in advance. So we didn't want to do things that we didn't understand very well.

So when we do change the requirements and we do propose changes, one of the things that we try to look at is what impact will it have on the way that the plants are operated, assuming that changes are made to have the minimum lock on availability of systems and the like.

So we do look at things like that.

Anybody have any comments in that area? Unavailability of train is kind of one of the things the staff keeps going back to time and time again for risk

assessment purposes and indicators.

MR. REEVES: Don Reeves, Nebraska Public Power.

You mentioned, Jack, in the near term, the elimination of certain selected ESFs, being the reactor water cleanup and the control room HVAC.

Are there any other ESF actuations that were considered? I think you mentioned that there were some other considerations, but were discarded for various reasons?

MR. CROOKS: Jack Crooks, AEOD.

We did look at other areas and we still are looking at some of the other areas. What we looked at previously was whether or not to do away with or to back off on the system actuations when the system wasn't needed.

In Supplement 1 we've said if the system is removed from service, that you -- We provided guidance that you didn't need to report ESF actuations when the system was removed from service.

That's still something that we are looking at. The problem is we have found that there are a number of reports that came in under those conditions that did identify things that were of interest.

So what we're doing is, ideally we all like to have a fine line. What we're trying to do is narrow the band that exists for interpretation of the guidance.

MR. WILLIAMS: There had been an earlier rulemaking -- Mark Williams -- where we had considered eliminating the reporting of the ESF actuations when the system wasn't required to be operable, the reporting of ESF actuations when the actuation was part of a preplanned sequence.

What we mean by that, if it's written in the test procedure.

And then the elimination of the reporting when the ESF was an unneeded actuation. An unneeded actuation was when a measured parameter did not reach the setpoint band for that parameter.

In other words, it was not a valid signal, but we're defining that very closely, because if it was a valid parameter or exceeded the setpoint, it may have been not general radiation area but a local source or something that would get a valid signal. But that would have eliminated a lot of reports.

That had some sweeping aspects to it. When you get into some of the very high important systems, like scram breakers and some of the other components, that had some down sides to it.

But we did consider those kinds of generic changes.

MR. REEVES: We still have in the rule preplanned

actuation requirements, but no requirement to report them.

MR. CROOKS: Right.

MR. REEVES: Let me tell you, something that occurs at Cooper Station on a regular basis is Groups 2, 3 and 6 isolations on a scram from power and it turns out pretty much from any power level, full power or during normal shutdown.

We currently have no specific statement in our shutdown procedure to alert the operator, if you will, that these group isolations can be expected.

It's my intention to go ahead and put those kinds of statements in these particular shutdown procedures.

It would then seem to follow in my mind that such isolations would not be reportable in the future.

Would you comment on that?

MR. CROOKS: If I understand you correctly, you're talking about following the scram?

MR. REEVES: Yes.

MR. CROOKS: Is it following the scram, the manual shutdown? You are manually shutting down and you reach a level --

MR. REEVES: We'll shut down to about 20 percent thermal power and disrupt the unit, instead of inserting the throw rods, which is our normal method of shutting down plant.

In those cases we expect anywhere from -- and history has shown we'll get about a 30 to 33-inch shrink in reactor vessel water level. Boom, it's down and it recovers.

MR. CROOKS: Right. I think that's consistent with the guidance that's in the statements of consideration explaining that ESF actuations that were part of a preplanned shutdown procedure did not need to be reported.

In other words, if we're saying don't report the reactor trip under those conditions, then if there's an associated group isolation, it seems reasonable to me and it's my opinion at this point that those would not need to be reported.

MR. REEVES: There's at least one utility that I'm aware of where an individual utility has been given direction by its management to look at system requirements with the plant in shutdown condition and evaluate the feasibility of taking the systems out of service such that if during maintenance or surveillance testing -- not surveillance testing, but most maintenance testing, a spurious actuation that has previously caused the systems to be actuated and resulted in their writing an LER could be avoided.

In other words, to look at taking systems out of service and making them unavailable, the sole purpose being

to reduce reporting requirement.

MR. JORDAN: This is Jordan.

That would bother me, because I think you are affecting safety in that context. If the reporting requirements are driving people to do things like that, then there's a problem with the requirements or the way they're being perceived.

So the reduction of availability takes away some margins that would bother me a great deal.

MR. REEVES: I guess I'm driving back now towards the reporting of the ESF actuations when systems are not needed, which is the case here.

I wonder if further consideration can be given to a plant in the shutdown mode and a reduction in the reporting requirements or elimination of reporting requirements for those systems that are not required to be operable in the tech specs.

MR. WILLIAMS: This is Mark Williams.

What has come up in the past is the significance of certain components in certain systems. That might be okay for some and not okay for others that are very highly significant components or systems.

That's what happened last time, because that was exactly our view. You know, we had thought that we should look at eliminating the reporting of ESF actuations when the

systems weren't required to be operable.

At that time that was part of a packet of stuff that we were moving along. Ultimately, we decided not to do it. There were a number of different things that came up during the process.

But we have looked at that. We have considered it. It's an area that's fertile but it's hard to take on generically for all the components and all the systems, all ESFs.

MR. REEVES: Is there any discussion of that in any kind of an AEOD document that will be available to the industry for industry review?

MR. WILLIAMS: I don't think so.

MR. JAUDON: Let me pose a question to you. Johns Jaudon.

Assuming that you did not have to report systems that were not needed and they were down and one actuates or the actuation is not proper, you don't get the response you expected.

Would you consider that to be reportable? For instance, you had an HVAC actuation, which is sometimes meaningless, and yet the dampers don't operate properly?

MR. REEVES: It would depend upon the circumstance under the present rulemaking.

MR. JAUDON: I was really asking about the

significance, how you viewed the significance of the event.

MR. REEVES: Well, we can take the case, for example, of a diesel generator. If we have a diesel generator that fails to start or if we have a diesel generator that fails during surveillance testing, doesn't perform properly during surveillance testing, we don't always, do not automatically report that, if it's only one and if it's not generic.

Now, if it's potentially something that's going to affect both diesel generators, an engineering situation, then we would report that.

So like I said, it would depend upon the situation at the time.

MR. JAUDON: Thank you.

MR. JORDAN: We've got some more discussion back here, so let's hear from them and then try to get questions.

MR. CHERNOTT: Harold Chernott, Wolf Creek.

To kind of switch gears, a question tying together both workshops here. The additional guidance being represented as possibly a revision in NUREG-1022 or another supplement, will that go to CRGR for a review prior to its issuance?

MR. JORDAN: Most certainly.

MR. CHERNOTT: So it will get a full backfit review prior to issuance?

MR. JORDAN: You bet.

MR. CHERNOTT: Thank you.

MR. GULDEMOND: Mr. Crooks, Bill Guldemond, Comanche Peak.

You indicated a significant percentage of the LERs that you're receiving are for tech spec LCO violations and/or surveillance violations.

What's being done with this information as part of the tech spec improvement program to examine whether or not these violations are avoidable or that the requirements of the tech specs are perhaps overly restrictive?

MR. CROOKS: People in the tech spec groups have that information available and they have looked at it.

In fact, there will be an impact from the tech spec group program that more than likely will reduce some of the reporting because they will be changing some of the LCO time requirements.

Some of the surveillance testing will also be moving out of the tech specs into supplemental documents. So there clearly will be an impact from the tech spec group program.

MR. WILLIAMS: We had done an earlier study of that. For example, we had done a NUREG on all the tech spec violations for three or four years.

It turned out that we had done a prioritization of

those, high, medium and low, and there was an awful lot of fire protection in there, as you would guess.

That was one of the things that went into the pie a couple of years ago, or a few years ago, or three years ago, as the tech spec improvement people were working on it.

We had been working with them. We turned out a report. They used that report in their program.

There will be an impact from the tech spec improvements on the reporting for tech spec violations.

We've also got further guidance coming for the staff in terms of what's a missed surveillance, when that constitutes a tech spec violation and be reportable, and so on.

So within the staff, those activities are coordinated, historically.

MR. WALKER: A comment, for what it's worth. Roger Walker, TU Electric Company.

I've been around a long time and I know and I think you people know a lot of those actions taken were just kind of conservative values, seven days for a pump or thirty days for a pump, and so on.

Giving it back to the tech spec improvement program, it should help the industry.

I'm up here to ask a different question. Unfortunately, I have to direct you back to the area that

you were discussing.

Another utility yesterday asked me to ask a question with respect to the guidance put out on ESF actuation to Region II specifically, but I think it's widely distributed in your July 12th memo.

It's a two-part question, so I'll bring it out just to get it on the transcript.

"In that memorandum providing guidance you stated that if for any reason ESF components are caused to operate, except expected responses from testing, then an ESF actuation did occur and that the quantity of circuitry subject to the signal or the reasons for the actuation are immaterial.

"Individual contacts, relays and other components in an ESF logic circuit can be considered ESF components.

"Did you mean by that that licensees should report the operation of an individual contact without completion of the minimum ESF actuation logic, such as a half scram?"

I think I know the answer to this, Mark, but I'll let you answer it.

MR. WILLIAMS: Yes, a half scram is not a reportable thing. In multi-train systems, we have guidance on the street. So I think the answer to your question is no.

MR. WALKER: I gather what your intent was, I

think, that the system got off for some reason and didn't perform.

Let me ask a second part of the question, since your answer was no.

It's more statement from the utility. "Certain ESF components, such as contacts, relays, pumps and valves, are shared between the normal functions of a plant and the ESF functions.

"As an example, an ESF signal may initiate control room and primary containment isolation and close some ventilation dampers.

"However the same dampers may also be designed to close upon a non-safety-related signal in order to control ventilation for normal operation."

I hate reading.

"In this example, the non-safety-related signal, not the ESF signal, causes the ventilation dampers to close and no ESF actuations occur, such as control room and primary containment isolation.

"Based on your above response..." which was no "...you would not expect the licensee to report the actuation of components if they actuate as designed due to non-safety-related signals and were not the result of a completion of the minimum ESF actuation signal?"

I think the answer is yes?

MR. WILLIAMS: Under all except some conditions. Some dual function components might be tested in a non-safety mode.

What we always focus on and the guidance we've got out is that it's the impact on a safety mode of operation that's important.

So if it's a non-safety signal when you're really testing that component for all its functions and it didn't work, then it would still be relevant to the safety mode.

For dual function components, if you didn't want to inject and you were testing it in some other mode.

MR. HORIN: Just to follow up on that, Roger and I had the same questions. This is Bill Horin from Winston & Strawn.

Given your answers there, I guess just to confirm, there is guidance in the supplementary information provided with 50.72 that says with respect to this criteria that, "Actuation of multi-channel ESF actuator systems is defined as actuation of enough channels to complete the minimum actuation logic. Therefore, single channel actuations, whether caused by failures or otherwise, are not reportable if they do not complete the minimum actuation logic."

My question on that would be, does that guidance continue to be applicable and valid?

MR. WILLIAMS: I think for multi-channel systems,

for the answer to the question he was answering.

I think we just had a situation where somebody used the same guidance where they had multi-train systems or multi-channel systems and they were trying to use the same guidance in a system configuration.

So yeah I would think that would still be applicable for the question you addressed.

Jack, did you have a comment?

MR. CROOKS: Yes. I think the multi-channel actuations came about -- As Roger had mentioned, they really wrote this in to cover the half scram situation, and also other systems where you require at least two different conditions to be satisfied.

If one condition was satisfied and you didn't have the second condition, then you didn't really actuate the engineered safety feature.

Is that clear?

MR. HORIN: That's clearer to me. I don't know if anybody else has any further questions.

MR. CROOKS: That's consistent with this paragraph. Your question came up in Region III.

They basically said this paragraph sounded somewhat convoluted because we were using actuation to define actuation.

The paragraph itself in the Statement of

Consideration probably needed a little bit added to it that would have tied it to this.

They really, I think, were specifically thinking in terms of the two out of four RPS actuation, situations like that.

MR. HORIN: I think the utility's concern was that that guidance could have been applied if read --

MR. CROOKS: Differently.

MR. HORIN: If read strictly to, in effect, contradict the guidance that was in the supplementary information.

From what I gather, you're saying that no, that guidance in the supplementary information is still valid.

MR. JORDAN: Yes.

MR. WILLIAMS: We had gone over that response before it ever went out in two offices and we had both concluded consistent with what the earlier guidance was. At least in our view it was.

MR. FEIST: Chuck Feist, Comanche Peak.

Let me give you a scenario. Let's say we've got a two out of four ESF actuation logic and one channel is out and set to trip. Another channel just fails, doesn't get a true signal, and throws you in an actuation.

So one is out and the other has just randomly failed and you get an actuation. Is that included or not?

MR. WILLIAMS: Yeah, I would say that's reportable.

MR. FEIST: That is reportable?

MR. WILLIAMS: In bypassing, you had an actuation come in on the other one.

MR. FEIST: I'm confused.

MR. WASHINGTON: Steve Washington from Washington Public Power.

I'd like maybe a little bit of clarification on the definition of preplanned. I think our definition has been that it must be -- you must know that an actual actuation is going to occur.

Yet some testing and maintenance could be taking place which has a high probability of it occurring, say an isolation of an air system. You don't know what the leak off that air system is going to be.

Can you write that into your test procedure and say that's a planned actuation?

MR. WILLIAMS: This is one of these situations where we really rely on your judgment. Anything that's part of the preplanned sequence, that's written into a procedure, that says check for an actuation of this ESF logic, whatever it is, that's something that's not reportable.

Then if it's expected as part of shut down, or whatever it is, and it's written into the procedure, that's

not reportable.

We have to rely on your engineering judgment to do that. I think, really, we just rely on that in terms of what's going to be reportable and what's not reportable, and you're the engineer on the job, so you're going to make that decision and we are going to get to second guess it.

MR. GULDEMOND: Bill Guldemond, Comanche Peak.

I think I'm confused. I don't know if I'm wrong in this regard. I guess I've got three questions that I'd like you to answer again, and I'll beg your indulgence in this regard.

One is, is the actuation of an ESF component from a non-ESF source, closure reactor water cleanup isolation valves in response to an ion change or high temperature. Is that viewed as a valid ESF actuation under 50.72?

Two, the condition that Chuck Feist described just a moment ago where he had failure of a single train. Again, the other train was in a trip condition. Is that considered a valid ESF actuation if you have not gotten to a process parameter setpoint that would cause it.

And number three, if you receive a valid ESF actuation signal but the component does not change state, the component, the valve, the pump, whatever it might be, because it was already in a safeguards position, is that reportable?

Just to give an example, containment isolation valve already closed when containment isolation signal received. The valve doesn't change state because it's already in a safeguards position.

MR. WEISS: I'm not sure that I remember the details of each question, but on the first one where you had reactor water cleanup isolation and its closing due to a process parameter saying that the ionization beds [illegible] to be protected from high temperature, that's not an engineered safety features actuation signal.

It would be my judgment that that would not be a reportable ESF item.

Let's see. The last one was, you had....

MR. WILLIAMS: The second was one train was --I think the answers, if I remember, is no, yes, yes.

MR. WEISS: That's what I remembered, too.

MR. GULDEMOND: The question was, if you have one channel in trip, and you receive a failure in the second. In other words, you do not receive a valid initiating signal from the process parameter, yet an actuation occurs.

MR. WEISS: Yes. The answer to that is yes. Let me give you a dramatic example.

An MSIB goes closed because you've got one channel in trip and you get a spike somewhere at a sensing logic because somebody is out doing a surveillance.

Can you imagine us not being interested in that? No, we'd definitely be interested in that.

So the answer to that question is yes.

And the third one?

MR. GULDEMOND: The third one would be if you have a valid actuation signal but the component that is to be actuated is already in the safeguards position.

A closed containment isolation valve receives a containment isolation signal. Is that considered a valid ESF actuation?

In other words, how far does the actuation have to be processed and action occur before specifically --

MR. WEISS: If you get a scram signal and all routes are involved, that's typically been reported in the past. You get an MSIB closure signal and MSIBs are already closed, those are typically reported.

My personal view on that is that that's required by the regulations as they now stand, yet it's fertile ground for an amendment to the regulations.

MR. REEVES: Don Reeves, Cooper Station.

I want to clarify again ESF actuations, reporting of ESF actuations for a non-ESF segment.

I think that the guidance that we had previously received at the utility and the guidance that I thought existed in the letter that went back to Region II, was that

any ESF component that is actuated -- The situation that causes an ESF component to actuate is reportable.

MR. WEISS: That's right.

MR. REEVES: Is my reading of that incorrect?

MR. WEISS: He had a dual function. He had a different case.

You see, this is one of the dangers of providing specific answers to specific questions. We provide a specific answer to a specific question under a specific set of circumstances, and then somehow that's drawn out more broadly.

That can be done with almost every answer we've given today. We told you that if you have a preplanned sequence, it's not reported.

That does not mean that you can go out and write in whenever a LOCA occurs, anticipate that you're going to get low pressure coolant injection, and therefore say that the LOCA is not reportable because it was a preplanned sequence. When we have a LOCA, we have a low pressure coolant injection.

You can make overly broad the specific interpretations that we provide and I'm very uncomfortable in workshops when people give me a very brief description of a specific example that's on the borderline, and then I'm asked to provide a broad answer for it. It's very difficult

to do.

It's much better if what happens back in the office occurs. That is, we sit and we discuss the thing for 20 or 30 minutes. We get all the details on the table. We have applied all the criteria. We see whether any other criteria apply, and then we provide a specific answer.

It happened in the last workshop that when we got into the discussion, in Region III, about what was the purpose of the reporting, that an attorney, I believe it was, got up and asked me why I was asking them to think in cosmological terms, on the one hand, all kind of vague and nebulous, and then I'd get very specific on the other.

It seemed contradictory to him and the point of it was, that if you kept in mind what we're trying to accomplish, it will help you understand our specific interpretations.

For example, we just gave an answer to Mr. Guldemond about when you had one channel in trip and you had a spurious signal, whether that was reportable, and we said yes.

My specific response was, could you imagine NRC not being interested in an MSIV going close to power because you had one channel on trip and another channel was made up spuriously.

There is a good example of how, if you think about

what the NRC is driving at, you'll get the answer to your question.

So on reactor water cleanup, can you imagine anybody in the NRC being interested in the fact that the resin beds are protected from high temperature? No.

But if, on the other hand, you have an ESF actuation, for whatever reason, a guy sweeping the control room happens to catch a lever with his sleeve and all rods go in or all MSIBs close.

Yes, even though that was not a preplanned sequence, even though that is a spurious thing, we would be interested in that.

On the other hand, you know as well as we do that there are many things that just don't constitute big safety problems, spikes at various times, and we're thinking about how to eliminate those sorts of things from the regulation, without throwing out the baby with the bath water, without throwing out what you and I know as engineers are safety significant items.

MR. REEVES: The reason I brought the question up, and I don't mean to be facetious in my response, is that this was the first instance in discussing ESF actuations that I've heard that a non-ESF signal may not be reported.

As I say, in previous guidance to us as a utility and what I thought was the guidance provided in that letter

going back to Region II was that actuation of an ESF component is reportable.

MR. WEISS: That's only for the dual function component.

MR. REEVES: That was not understood in that letter.

MR. WEISS: No, it wasn't addressed in that letter.

MR. REEVES: No, it was not.

MR. WEISS: But the thesis, the thing that prompted that letter, the thesis was that you did not have to report -- The utility contended that you did not have to report engineered safety features actuations in those circumstances where the complete logic sensor and component did not function, and we just can't live with that.

Can you imagine, for example, you having a reactor scram called for, picked up by the sensor, the logic picking up, and the trip breakers failing to open.

Can you imagine NRC not being interested in an ATWS? I mean, it just doesn't make sense. If you keep in mind what we're after, you're going to get the specific answer to your question.

So in general, we are interested in engineered safety features actuations, regardless of where they occur, and there are some exceptions. And one of the exceptions is

where it's totally trivial from a safety point of view.

If you have a dual safety function in a reactor water cleanup isolation valve going closed, and if it's for a non-safety purpose, we're not all that interested in it, which is not to say that if in the process you discover a generic problem associated with pipe cracking or a valve not closing against pressure, we would be very interested in that.

Suppose, for example, that that valve goes closed to protect the resin beds and it fails to go closed because, you discover, there's a design problem with the valve, a maintenance problem. We would be very interested in it because it would have direct implications for safety.

When that valve was called to go closed for a safety reason, it would fail to go closed, and we would want to know about that ahead of time.

We would want to inform all the other plants so that they could have proper LOCA mitigations if they get a rupture in that system.

MR. JORDAN: This is Jordan.

I want to comment on the value of the workshop in collecting these kinds of instances that remain fuzzy. Even after we've given our best shot, they remain fuzzy and there is a need for us to sweep the correspondence that's been provided to utilities into a revised guidance document.

But we're going to try to keep it as simple and practical as possible, because if you get a guidance document that's a foot thick, you're going to be worse off than you were before.

So I want to try to keep with the philosophy and one of the philosophical things I like is, is it of value to you to know about with respect to another utility.

Maybe you learn something from another utility, if that information comes to you through the NRC and input process of reviewing LERs and extracting lessons from them.

To me, that's the bottom line. Do you think it might be of value to others, component level failure or a system level failure?

The whole thing is about feedback of operational information in the context we're talking about here. It's a long way from emergency response type events.

We're really talking about longer-term reviews and extracting lessons and then feeding them back.

MR. HORIN: Let me just ask a brief question. Chuck then has some more specific questions.

Getting back to this guidance memo, I think perhaps where the confusion is arising is that there is a very broad statement that is reportedly quoting the Region II position, and then the statement is made that OEAB agrees with this position.

I think what the problem that people are facing is that if you read that broad statement and try to apply it to some of the other circumstances beyond what was involved here, you get into confusion.

I think what I heard you mention a second ago, and I just want to confirm it is that really this memorandum was focusing on a particular circumstance that utility was facing and the very narrow position that that utility had taken, and wasn't intended to try to apply to all other issues that may arise in this area.

MR. JORDAN: You're right on. Exactly.

MR. WILLIAMS: Incidentally, Chuck, they had taken a specific position on what constitutes the actuation of an ESF.

You need all three elements of the ESF in order to have a valid ESF actuation, and the staff very, very quickly came to a consensus that the staff has agreed with that generically as a position.

On the other hand, case-specific things that we've talked about here still exist in the present regulatory guidance, but our answer was the position put forward by Georgia Power in that letter.

MR. HORIN: So licensees shouldn't try to read this in other areas, such as what we've been talking about today, and instead should still deal with those on a case-

by-case basis consistent with the guidance that's out there.

MR. WILLIAMS: You just have to take what value that provides for that case.

MR. FEIST: Chuck Feist, Comanche Peak.

On this dual function question, see if I can understand. The feedwater steam mitigation line looks and acts a lot like feedwater isolation valve.

So what you would say is if we had a feedwater actuation with a non-safety logic that actuated the feedwater isolation valve and everything worked normally, that wouldn't be reportable, but if the feedwater isolation valve didn't close, that is something that is.

Is that understanding the way you interpret that?

MR. WILLIAMS: My first answer to the question is that it would be reportable, but I'll have to sit down and think about it. Maybe it's not, and rather than give you a quick answer to that, I would have to look at it carefully.

MR. CHAFFEE: Wouldn't that be part of your feedwater isolation --

MR. FEIST: I can't hear you.

MR. CHAFFEE: Can you hear me now?

It seems to me that the reportability of that would probably depend if the feedwater isolation is starving your generators and causing a trip, clearly I would think I would want to know about that.

It depends. You have to take into context what it does to the plant.

MR. FEIST: Well, the actuation doesn't starve the steam generator. The first water -- the upper nozzle or the main nozzle --

MR. CHAFFEE: I can't hear you.

MR. FEIST: It doesn't -- Starving the steam generator doesn't cause -- It starts off feedwater pumps and diverts feedwater into a different nozzle.

This kind of thing only happens during startups and shutdowns.

MR. CHAFFEE: So it would only happen at the time of shutdown?

MR. FEIST: You could be at low power. You could be in mode two.

MR. CHAFFEE: I guess I don't understand quite what you're saying. You have to take the event in total and look at what particular --

MR. FEIST: If the non-safety signal works normally as it's designed and all the equipment works normally, that would not be reportable?

MR. JORDAN: I don't believe it would be reportable. So I agree with you.

MR. FEIST: But if sometning, one of the ESF components didn't work, then that would kick it in.

MR. JORDAN: Yes.

MR. FEIST: That's what I was driving at.

MR. JORDAN: Right.

MR. FEIST: Thank you.

MR. JOHNSON: My name is Alan Johnson and I'm with Arizona Public Service.

I want to change the subject a little bit.

I think, at least on my part, I really more understand your July 12th memo now and feel more comfortable with it, because it really could be interpreted rather broadly.

I want to change it. Earlier you mentioned that you were looking at -- This for Jack Crooks. You were looking at eliminating reporting of control room ventilation.

Are you considering expanding that for generic ventilation? In our case we have a fuel building ventilation, which is the exact same thing, that we would like to see taken out of the rule also in a similar fashion.

MR. CROOKS: We started into that area. I'm not sure right -- We haven't come up with the final words.

Right now the focus is on the control room emergency vent systems.

MR. JOHNSON: Then the other question I have is, as mentioned in the last workshop at King of Prussia, and I

haven't heard anything back about it, but the question on previous similar events.

There's a requirement in there to basically analyze previous similar events, why they occurred. Are you looking at limiting the time frame we have to go back?

Some of us are getting into a situation on an event that happened six years ago and explain why the corrective action for that event didn't prevent this one. It serves no purpose.

MR. CROOKS: This came up in Region III also. I think in Region III we indicated that you have a history and what would be expected would be to go back a reasonable time to see if a previous occurrence was related.

People are saying you sometimes have a 20-year history. We didn't expect you to go back. If there had been 30 previous occurrences, presumably somewhere in there things were changing.

So what you do would be to go back and take the part of that history that would apply to the event that you're reporting.

I don't know whether that -- We haven't drawn a line. Something that is on the record we certainly can look at with the new guidance.

MR. JORDAN: What you're really saying is, use judgment at this point. There isn't a statute of

limitations that we've expressed one way or the other.

So it is an area of discretion on your part. And let me warn you. If we take away your discretion, the regulation and the requirements become larger and more voluminous.

I think in most cases you're better to have your discretion and to apply it. You may get second guessed but it's certainly not going to be an issue regarding enforcement.

How far back you go is based on your own conscience and certainly with respect to system modifications.

Where a system no longer has a problem that it had ten years ago, the statute of limitations has run out on that one. You don't have to go back that far.

So I would urge you to keep the discretion. If there's a real problem, then we'll try to provide more guidance, but the guidance I would provide right now, even within the revision of 1022, is the utility should use judgment on how far back to go.

I would like to hear argument from you as to whether you would prefer having more specific guidance.

VOICE: No.

MR. JORDAN: Okay.

MR. REEVES: Eric, I want to respond directly to

you on your comment that you would be interested in a valve situation, the situation being an ESF component is given an actuation signal from a non-ESF segment and fails to close or fails to actuate.

You would not be interested in the former; i.e., the fact that an actuation signal was given from a non-ESF component -- or a non-ESF segment.

But you would be interested in the situation that the component did not function as it was intended to function.

I guess my comment is, we would report that, if it met the criteria of the rule. It just would not be an automatic report.

For example, if it was an isolation valve that failed to go closed and it was the second isolation valve on the line and whatever caused this one valve not going closed would not affect the second one, we'd not report it.

If it was a pump that failed to start, we'd not report it if we had a redundant pump on the system.

MR. WEISS: Single random component failures are not reportable under the rule.

MR. REEVES: That's just the criteria we'd be applying.

MR. WEISS: The rule, however, says that if you have something generic, it says in the Statements of

Consideration -- Remember my presentation yesterday.

MR. REEVES: Right.

MR. WEISS: The Commission emphasized that if you have something of generic significance, the licensees are encouraged to report those things.

So the point I was trying to make, and maybe it didn't come across too clearly, that if you find that a failure of a component was due to a generic cause --

MR. REEVES: That word didn't apply here, talking about generic cause.

MR. WEISS: Why is that?

MR. REEVES: Well, as opposed to a single random event.

MR. WEISS: A single random event is not reportable. Something that has generic safety significance that would be of interest to other plants so that they could prevent accidents from happening would be reportable.

So for example, you find out that a reactor water cleanup system isolation valve that was supposed to close and protect the resin beds for a non-safety reason, well, it failed to close because of a generic reason, because there was a design defect, a manufacturing defect, or for whatever reason, that's important for another plant.

They may have a loss-of-coolant accident that occurs in their reactor water cleanup system and the

isolation valve between the cleanup system and the RCS fails to functic. for the sam. reason, because they have the same defect in that valve.

You can imagine that we would have expected you to have told us about your discovery.

MR. REEVES: We would agree and I don't think anyone in this room would have disagreed with reporting that situation.

I have one other comment that seems to be a very common thread that folks are making. Frankly, I think most of us in this room like the free and open exchange of information with the NRC and with AEOD and being able to report these things that are going on, in some cases regardless of safety measures.

The reality is that we, in cases where we choose not to report, we are under the threat of enforcement, or feel to be under the threat of enforcement.

When we're in that position, we're going to try to -- I think I can speak for a number of people. We try to adhere to the rule as closely as we can so we meet the requirements of the rule.

That hinders the open exchange. I don't know what can be done to get beyond that kind of philosophy.

MR. GWYNN: I'd like to comment. Pay Gwynn from Region IV.

If you feel under the threat of enforcement because of a specific item that you haven't reported, then I'd suggest that you discuss that with the NRC and we will help you to make sure that you have made the correct judgme:

I think if you look at the enforcement statistics for the Agency with respect to taking enforcement action for failure to report, that you'll find that that's not a very large number of violations in the recent history of this Agency.

MR. REEVES: Unfortunately, Nebraska Public Power District was subject to enforcement action at one time, so we are very conscious of that type situation.

MR. GULDEMOND: Bill Guldemond, Comanche Peak.

During backfitting discussions and some of the discussions yesterday I think there was a consensus reached that we need to maintain an open forum with regard to a variety of issues, reporting being one.

There was some discussion yesterday about how to go about getting questions on reportability answered when we have a specific situation that's unc[illegible].

The conversations were saying, talk to residents, talk to the region, talk to the AEOD.

My question is, what is your preferred method for receiving questions and processing those questions? Is the

preferred method to start with the resident or to go to the region or AEOD?

What is your preferred method of communicating?

MR. JORDAN: The preferred method is with the resident of the region with an NRR. AEOD in this process doesn't have a real regulatory role.

We would be advisory. I'll open something that we've discussed internally with NRR, is establishing a panel that would combine advice that would include a general counsel representative, an AEG representative, an NRR representative and a regional person.

That would then try to keep 1022 alive and current by extending the guidance that's in it, after we revise it, and serve as an advisory panel to the rest of the Agency.

It wouldn't be for utilities to contact directly, but where there's a controversy, it would go to that kind of a panel.

So that's something that we're thinking about more than just a fine idea, but not yet a reality. I think it would help you that there would always be a group of people with some corporate memory that would be able to then give advice.

But clearly, contact is with the region and NRR, if enforcement.

MR. GWYNN: I'd like to add to that. Typically

what you'll find is that the resident inspector will act as a conduit with the region and we will look at the matter to see if in fact the Agency has substantial experience in that area.

If we can, we'll answer the question based on the Agency's experience, and if we can't, we will get NRR involved in the conversation directly and get whatever help we need from headquarters.

MR. JORDAN: I'll admit to one thing. Whenever there is an egregious event, in my view, that the Agency really needed to know about promptly, and I find out about it through some sideways means a week after it happened and the Agency wasn't informed, then I go to the region and say, "Why didn't we get this report?"

The region will go back to the utility with that and we do it with correspondence. So I'm not putting anything in an enforcement type reaction.

But those are for what I would say egregious cases that are one or two a year.

In most cases -- I would say in all cases where there's judgment, where these are in fuzzy regions, those are talked about. They are a matter for discussion.

MR. HANCE: Doug Hance, Gulf States Utilities, River Bend.

I'd like to change the subject a little bit. This

is the issue of type of discovery.

We were engaged in a predicted maintenance activity some time ago and identified a condition as a result of this activity.

Later on we tore the component down and went into an outage. We found there was nothing wrong with it.

If that situation had gone the other way and we had found that the valve was inoperable, how would you apply time of discovery in situations like that?

MR. WILLIAMS: The same way that the tech spec people do. Pretty much exactly the same way.

Make your operability judgment on a component. Now, if you're going to tear it down, once you've arrived at the engineering judgment that the component probably would not have performed its function.

But then, again, if you have a vibration or whatever it is and it's enough to make the call initially, then that would be the time of discovery. It's when the judgment was made.

MR. HANCE: It's a matter of engineering judgment as to when the component would be declared inoperable?

MR. JORDAN: Yeah, your judgment.

MR. WILLIAMS: That's right.

Mr. GULDEMOND: Bill Guldemond, Comanche Peak again.

Rather than ask a question, I'd like to offer an observation with regard to the impacts of some of the reporting. That observation being that it has not been uncommon in our experience when a more significant event occurs and is reported by one of the mechanisms available for us to receive multiple points of contact from the NRC, from the resident inspector, the region, the NRR project manager and occasionally other offices.

It would be beneficial to us, and I think to you, if there were some way to channel those communications through a smaller group of people, not only because from our personal perspective it would be less of an impact on our resources, but on your perspective we think it would aid the correct flow of information so that we didn't get inconsistencies.

I offer that only as an observation for your consideration.

MR. FAULKENBERRY: I would like to address this just a little bit and I'll ask Stu and maybe some other people to address it.

We have had problems in the past with regard to this and it shouldn't happen. We shouldn't bug you people with telephone calls and we shouldn't have half a dozen different people calling you and asking the same questions.

It's a problem. It's a very difficult problem to

resolve. I think we have made some progress in that area.

What we will encourage, of course, is to do your one-hour reporting and report through the headquarters duty officer, et cetera, and inform the resident inspector.

What we at the region will try to do -- It won't always happen but we certainly are conscious of it and we really try to do it very hard -- is to work through our resident inspector and try to get the information from him.

So that is the point of contact. He is trying to ferret out the information and get it back to us.

Sometimes we have a problem. [illegible] either our resident inspector is gone or for some reason we can't work through that mechanism and then you will find some people from the region office calling the control room, calling people at the site trying to get the information that way.

I guess the best way I can answer your question is we're very conscious of it. We don't want to overburden and overload the system, your system.

But the other side of it is that we are pressured to get information. We're pressured to understand the situation and what's going on.

We'll work through the resident to the extent we can, but if that breaks down, sometimes you're going to find we have to call.

Stu, do you have anything to add to that?

MR. RICHARDS: Yeah. I would like to add that, when it isn't working that way, we need to hear about it. We don't always know if you're getting calls from other sources besides the resident inspector.

For the not-so-barn-burning events we try to work through the resident. When it's something that's a larger issue, what we try to do would be to give the licensee some period of time to get their facts together and then get all the interested parties on one large conference call, go through the information, get a feel for where the utility stands and then agree on some other time in the next day or so to get back to you again.

That's worked pretty well, but if you are being flooded with calls, we'd like to hear about it. In this age of regulatory impact, we've been, particularly in the last year, very sensitive, trying to not do exactly what you're describing.

MR. GULDEMOND: Is there anything we can do to facilitate that process by perhaps identifying points of contact for various types of events or events that would aid you in the acquisition of information in situations where you feel a need for timely information.

MR. RICHARDS: One of the things that has worked for some of our utilities is when they recognize that it's an event or an occurrence of significance to the NRC, right

up front they'll say, "This happened and we'd like to set up a conference call with you in four hours, six hours, whatever period of time, to tell you where we stand."

Then the region will take the lead in contacting NRR and any other interested parties and basically arrange our end of the conference call.

If you get any calls in the meantime on your end, if you'll just say, "Hey, six hours from now we're getting together. Join us."

So instead of having a lot of people out there with these individual communications going on, trying to defer everybody to one call has worked well.

If the licensee will recognize that and take the lead, all the better.

MR. GWYNN: Before we go on -- Pat Gwynn, Region IV.

I would like to indicate that Region IV uses a similar process to Region V. If in fact our process is not working, then regional management needs to get that feedback so that we can get the situation under control.

MR. CHAFFEE: I'd like to add one thing. Can you hear me? This is Al Chaffee.

In the Events Assessment Branch, we usually try the same type. When we get a 50.72 in, we typically will wait until we get the region's daily report later that day,

which hopefully will give us additional information and help minimize the need for us to make additional communications.

So NRR also is trying to find ways to minimize the amount of communications going on on a particular thing.

MR. RICHARDS: One other thing I'd like to add. Within the Agency it's become common practice now for the points of contact that talk to the utility to be one, the project manager in NRR, typically communication with your licensee organization and then through the region and the resident on the operations side.

So if you've got a pretty good relationship with your PM and you're getting calls from other parties, I'd just refer them to the PM, particularly if you've already talked to the PM about the issue.

You can just say, "We're talking to the PM about it and we prefer to work through him."

MR. REEVES: I wanted to get back to the concept of ask the resident. I don't want you to take my comments as being negative to the resident inspectors, to their capabilities or to their efforts to try and do their job well.

But one of the things that we discovered when we got together on this LER committee from a variety of utilities was the variety of interpretations that had been provided to the utilities by either the region or the

resident inspectors.

I guess my comment is to come up with a consistent interpretation of the rule or consistent reporting in accordance with the guidance, experience has shown that asking the resident, each individual resident at various points in time over the several years the rule has been in existence has resulted in a variety of interpretations and a variety of reporting philosophies for the utilities.

So asking the residents is not the answer. That should not be. That has been our first stop and I think the experience has shown that we've got an inconsistent application of the rule and inconsistent application of the guidance for reporting.

That doesn't mean that the utility -- We ourselves obviously look at the rules and look at the guidance and come up with our own assessment as to the condition and whether or not it is reportable.

We are that way. We're just as fallible as the inspectors.

To get consistency, we're going to need to go to a central organization.

MR. FAULKENBERRY: Let me try to answer that. Bobby Faulkenberry.

Of course, I have to go back to the beginning. You people certainly have the responsibility to make a

judgment and follow the regulations, what have you.

I think there will always be inconsistencies between various people interpreting the same thing, in effect, as the resident inspector is concerned.

However, I feel that once you people take a cut at it and try to make a determination of whether it's reportable or not, if it's down in the gray area, I would still encourage you to go to the resident inspector, if nothing more to inform him, because we in the regional office, we want information.

But to communicate and inform him and to get his opinion on it, and the way the system works is that if the resident inspector, if it's in the gray area and he's not too sure, he'll call the regional office and he'll talk to his management and get more people involved in it and there will be several people that will come to a collective agreement on it.

So my feeling in that is if that system works, even though that there are maybe some differences in interpretation from, say, one region to the other, one resident inspector to the other, it's going to be down in such a gray area that it's not going to be significant.

It's not going to have any health and safety operational significance. It's not going to be important from that respect.

MR. REEVES: I don't think any of us have any problems with interpreting the rule when the situation is black and white and you don't either.

The problem is in determining whether or not a report is required for the situations that are in a gray area.

So all we're talking about here is guidance to try and clarify the gray area, somehow try to make the gray area go away.

As I'm saying, we've got six years of experience that says that doesn't work. There are individuals out there in industry and in the NRC and we each have our own interpretations.

To me, if it's AEOD and their efforts to provide research from these operating events, they are the guys that would like to have or need to have the information and to me, the clearinghouse for any of those questions ought to go right back to those folks.

What do you really want to have? Is this important enough for a utility to go ahead and write an LER?

MR. WILLIAMS: The staff does call all the staff together. In other words, the regions have contacted NRR, NRR has contacted AEOD and the regions have contacted AEOD. None of this stuff is really done in a vacuum.

MR. REEVES: Well, then, if it's not done in a

vacuum, there should be no inconsistency across the country. It's obvious there is.

MR. WILLIAMS: You're just going to have to live with the inconsistency, because inconsistencies occur over time and I can give you examples of different guidance that occur over a period of months a reportable event is developing, and things like that.

So again, the first contact would be resident, the region, and the regions get NRR, AEOD, and the staff works pretty well among the staff.

It's just a matter of flushing the issue up.

MR. JORDAN: Let me ask a question. How many of these from your utility would you think would occur during a year? How many instances would you need more guidance than you presently have?

MR. REEVES: Oh I'd say the number would range. This year there probably, I don't think, that ma What we've had so far has been rare.

MR. JORDAN: One or two?

MR. REEVES: In past years, three or four maybe. We're not talking about an enormous number.

MR. JORDAN: Because what I was thinking in reaction was that I think the focus really should still remain with the resident, but if the resident makes his initial determination and sends it up the line to get it

verified as being consistent with the policy, maybe that will help solve that problem.

MR. GWYNN: The rest of it really should act as a conduit to [illegible] the information to the regional office.

Unless it's very clear in NUREG-1022 and its supplements and your people just haven't read that information, I wouldn't anticipate that the resident inspector would be making judgments outside the guidance that he's been given.

He would act as a conduit and provide that information to the region so that we could then use a wider base of experience in making those judgments.

That's what I expect would happen

MR. REEVES: Okay. Well, I can't speak firsthand for conversations that go on between the guys calling the shots for the utilities and resident inspectors at other plants. I haven't been there.

But I guess I can tell you what I've picked up from my peers at this conference, and that is that there is a pretty [illegible]e inconsistency.

If in fact all these things were funneled up to a central clearinghouse, the inconsistencies that I hear about wouldn't exist.

Not to say that we'd be in a perfect world. Obviously, we're not going to be there.

The other question I had is, I don't how many resident inspectors there are here, but I'd be concerned if I was a resident inspector and the utility came to me and asked me my interpretation of reportability and non-reportability.

I'd be concerned as the resident inspector of being asked to call the reportability shots for a utility.

Consequently, as a resident inspector, I would back off and I'd say, "You fellows make the decision. We'll follow up."

I would be happy to try and provide as much guidance as I could to the utility and if the guidance was not clear in a particular area, I'd try to funnel that up and get some kind of a judgment from folks within the NRC, rather than the resident.

I don't think you folks want the resident in the position of calling the shots on reportability. I think it's a --

MR. JORDAN: No. Let's do clarify that.

When the resident is called upon by the utility, he's giving his view of what the guidance says.

The utility makes the decision on whether or not to make the report. He's not going to be taking that responsibility.

What you do is discuss it with the inspector and

he agrees or disagrees and then you do what you choose, but he's not making that decision.

MR. LINVILLE: Jim Linville. I'm currently from NRR but formerly with Region I.

I guess that this problem with communications and getting these issues up through the proper chain, I'd encourage you to be open and direct with the resident.

If you're concerned on a particular issue about inconsistency in interpretation, tell him your concern about that and suggest that a conference call be arranged to discuss it.

MR. REEVES: I wouldn't have any hesitancy at all. From my knowledge of people on the LER committee, I don't know a one of them that would be hesitant about talking to the resident.

So it's not as if we're re-inventing the wheel here. As I said, there is a problem. We have a lack of consistency.

It is apparent. It's going to be apparent to these folks up here.

MR. LINVILLE: I think you're going to have that same problem if you're talking to two different people. So to get a number of people involved in the discussions is probably even tougher to try to get consistency.

MR. WALKER I'm Roger Walker, TU Electric.

The way we generally handle it, because I agree with him somewhat. I don't think that I want to have my resident inspector called upon to take an independent interpretation.

What I usually do is go to my resident, if I'm in a gray area, and I say, "This is my interpretation of this. I can see how you could interpret it some other way, but if you disagree with me, let me know. If you want to talk it over with your section chief, let me know."

That usually solves the problem.

MR. WILLIAMS: Let's break. Why don't we be back at a quarter of, on time. Thank you very much.

[Recess, 10:35 a.m. to 10:50 a.m.]

MR. WILLIAMS: We are running a little bit late. We're going to try to pick up some time. So without delay, we'll let Nancy begin.

STATEMENT OF

NANCY ERVIN

MS. ERVIN: I'm going to discuss our regulation that deals with reporting the safeguards events.

For the benefit of those who are not in safeguards, I'll give a brief description and history of the regulation.

Then I'll be discussing some activities that we have ongoing to revise our guidance on reporting of these

events.

The revision is in an effort to eliminate unnecessary reporting and to better clarify reporting requirements.

10 CFR 73.71 requires licensees to report significant safeguards events to the NRC Operations Center within one hour after discovery of each event.

Although this rule covers fuel facilities and transportation of S&M, also some non-power reactors, I'm going to limit my discussion to the power reactors because of the audience today.

These events include acts or attempts to do significant physical damage to a power reactor, including the interruption of normal operations through tampering.

Significant events can also include safeguards system failures, if the failure is not compensated and if it could allow undetected or unauthorized access into a protected or vital area.

The rule also requires licensees to report certain less significant safeguards events in a log for quarterly transmittal to the NRC.

These events include safeguards systems failures that are compensated and that do not immediately endanger the health and safety of the public.

The next viewgraph, please.

73.71 was originally published in 1973. A major revision to the rule was published June 9, 1987, and effective October 8, 1987.

The purpose of the revision was to clarify reporting requirements, eliminate unnecessary reporting and to improve NRC's data analysis system.

Reg Guide 5.62 entitled, "Reporting of Safeguards Events," was revised in November of '87 to clarify the rule revisions.

NUREG-1304, same title, was published in February of '88 to address questions that were discussed at a September 14, 1987, workshop on the revised rule.

Next viewgraph, please.

Prompt notification of safeguards events is very important. We analyze these events for their immediate impact on the safe operation of the plants and the health and safety of the public.

Some of the events may warrant NRC oversight, which can include activation of the NRC Information Assessment Team or the NRC Response Center.

In some cases we may also need to notify other agencies, such as the Federal Bureau of Investigation if sabotage is involved, or the Bureau of Alcohol, Tobacco and Firearms if explosives are involved.

If the event affects other licensees or agencies,

we may issue an immediate generic communication. More long-term feedback would be rule or guidance revision as appropriate.

An example of that is a generic letter that we've recently developed to reduce unnecessary prompt reporting, and I'll be discussing this a little bit later.

Next viewgraph, please.

The loggable or less significant events that we receive each quarter are reviewed to determine if generic safeguards system effectiveness problems exist or are developing.

Our formal long-term analysis is conducted by NMSS and results are forwarded to the licensees. Ms. Higdon will be discussing this analysis system shortly.

We issue generic communications and initiate rule or guidance revisions when necessary, based on a review of these events.

A recent example of a generic communication is Information Notice 90-13, entitled, "Importance of Review and Analysis of Safeguards Event Logs."

This Information Notice was issued to remind licensees of the benefits of meaningful reviews and analysis of the event logs and reports required by 73.71. Also, of initiating prompt, effective corrective measures to prevent recurrence of the identified problems.

It was generated because of concern that some licensees were not analyzing safeguards system problems and the problems were continuing to recur with no apparent measures taken to correct them long term or to get to the root of the problem.

Next viewgraph, please.

About a year ago we initiated a revision to Reg Guide 5.62 and NUREG-1304. The purpose was to incorporate lessons learned from two years' experience with implementation of the revised 73.71 rule.

The revision is also based on our evaluation of the safety significance of all events reported and the immediate actions taken by the licensees and the NRC.

The proposed revision incorporates the appropriate parts of NUREG-1304 into Reg Guide 5.62, and it will result in additional reduced reporting, primarily in the area of the one-hour reports. Also, the fitness for duty events.

It will provide further clarification of the reporting requirements and will address improvements necessary for the event log analysis program.

We intend to issue the revised Reg Guide for public comment within three months after our generic letter gets published.

We also, with respect to the generic letter, which will reduce prompt reports that are coming in that are

unnecessary right now to the Operations Center, it represents a revision to our current policy and it's responsive to the concerns that were raised in the Impact Survey.

We're hoping that that will be published within the next couple of months. It's in CRGR now for review for backfit considerations.

We intend the generic letter to be guidance only. When it's published, no written response will be required and any actions that you take will be strictly voluntary.

The generic letter may be modified in the final revision to Reg Guide 5.62, but that wouldn't be for about another year, because of the lengthy regulatory process involved in revising Reg Guides.

The policy changes that I'm going to discuss with you that are in the generic letter will not be effective until the generic letter is published. Until that time you should continue to follow the current published guidance.

I don't have any viewgraphs on the generic letter and you won't find anything in your packet, because it's pre-decisional.

But what I'm going to do is, I'm going to read you the specific events that we have been getting into the Operations Center as one-hour reports.

Some of them do represent a revision to our

previous position with regard to one-hour reporting. Others are already discussed in our guidance but the guidance wasn't clear enough so there is still some confusion and these events were coming into the Center as one-hour reports.

So when I read the examples to you, you're going to find some of them that actually already are described in the current guidance.

Before I talk about the specific events that are listed in the generic letter, I'll go over some of the more generic policy in the letter.

Our current published guidance suggest that a licensee report system failures within one hour if the event is not properly compensated within ten minutes of discovery.

This is by a licensee employee, contractor or vendor, or within the time that's prescribed in your approved security plan. This is already stated in Reg Guide 5.62.

The generic letter allows you to log the event, even if it takes you more than ten minutes to compensate for it, provided all other aspects of proper compensation as described in Reg Guide 5.62 and the NUREG-1304 are met.

This logging is allowed if extenuating circumstances prevent the compensation within ten minutes of discovery, also provided that there was no malevolent

intent, nothing adverse resulted from the delay, and that the licensee takes appropriate measures to ensure a more timely response or other necessary action in the future.

An example of this type of event would be if an individual fails to notify security promptly of a safeguards event, and this is typically what delays the ten-minute time frame of compensating for the event.

A vendor or someone that's new to the facility might discover something and then not realize that they were supposed to have called security.

In cases where you do have more than a ten-minute time frame on compensating, we'd like you to note the cause of the delay in your log entry.

Another policy change deals with fitness-for-duty events. Significant fitness-for-duty events are now reportable under 10 CFR 26.73, not under 73.71.

Fitness-for-duty performance data must be submitted under the provisions of 26.71 (delta).

In those rare cases where an event with safeguards significance is caused by a fitness-for-duty event, the fitness-for-duty aspect should be reported to the NRC in accordance with Part 26 and the safeguards aspects in accordance with 73.71.

When a telephonic report is required by both rules, you can make one telephone call, if you'd like,

instead of making two, as long as it's made within the one hour which is required by 73.71.

That is your choice. You don't have to. If you want to make the one-hour safeguards report and then make your 24-hour report for the fitness-for-duty, you can do it that way.

Now I'll discuss the events that are listed in the generic letter that can be logged instead of being reported to the NRC within one hour of discovery.

These events have actually been coming into the Center now for three years. We started analyzing these events about a year ago and we had two years of experience then.

So you've got about three years of analyzing the impact and what licensees and what the NRC does with the event when we make the decision to allow them to be logged.

These events can be logged if they're properly compensated in accordance with the guidance provided in Reg Guide 5.62 and NUREG-1304 and the areas of the generic letter that we just discussed.

When there are factors that could change the reportability of the safeguards events, specific factors -- I'll discuss those with that example as we go through.

The first one is a design flaw or vulnerability in a protected or vital area, safeguards area, if the flaws

existed for more than ten minutes.

Previously, if a degradation had existed for more than ten minutes, it was a one-hour report. Now you can log it, as long as you don't find anything adverse when you do your inspection of the event.

The next example is a failed compensatory measure such as an inattentive or sleeping security guard or equipment that fails after being successfully established as an effective compensatory measure for a degraded security system.

If security personnel are ineffective because of alcohol or drugs, the security degradation is reportable under 73.71 and the licensee should include the positive results of the four cause tests in the data submitted under 26.71(d).

The next example is discovery of contraband inside the protected area that is not a significant threat.

For example, such a condition could be the discovery of a few bullets or a weapon that was inadvertently left unattended or unsecured by the security force.

If contraband is found in a vehicle in a parking lot outside of the protected area, you don't have to report the event within one hour. You also don't have to log it.

This is because the contraband was outside of the

PA and, again, this is provided that there is no attempt being made to bring it in, that nothing adverse is discovered as you get into the event more.

The next example is compromise, including loss or theft, of safeguards information that could not significantly assist an individual in gaining unauthorized or undetected access into a facility or in the a of radiological sabotage or theft of S&M.

The next example is loss of all AC power supply to security systems or loss of all computer systems, provided adequate security measures, compensatory measures, can be maintained until the systems are restored.

If a power loss or a computer failure could not enable undetected or unauthorized access, again, you don't have to log it and you don't have to call it in within one hour.

An example of this would be a computer failure would not require reporting if it's negated by an automatic switchover to a functioning backup computer without a time delay.

Also, momentary loss of lighting caused by a power interruption would not require reporting, if the loss could not have allowed undetected or unauthorized access.

Even in the beginning with our guidance, just like on the 50.72/50.7 side, we've allowed a lot of licensee

judgment.

When you report an event to the Op Center within one hour, we expect that to be a significant event, something that could endanger the health and safety of the public or adversely affect the immediate safe operation of a plant.

If you determine that this couldn't happen, then these are the types of events that we would like to see you logging instead of calling in to the Center.

The last group of examples of loggable events deal with partial fail res of an otherwise satisfactory access authorization or access control program.

The first example is a vendor who's been cleared and authorized to receive a badge permitting unescorted access to protected and vital areas, who inadvertently enters the protected area through a vehicle gate without being searched, without being issued a badge.

The licensee discovers the event, searches the individual, issues a badge and takes corrective actions to prevent recurrence.

If you do that, you can log it. You don't have to call in.

If search equipment fails and the licensee does not detect the failure, thereby allowing unsearched individuals to enter the protected area, they can log the

event, as long as nothing adverse is discovered.

That would mean that you didn't know the equipment went down, so chances were that the folks coming through didn't know the equipment was down, either. If you can pull them back and search them, you do that.

But in your final evaluation and your judgment, nothing adverse happened from the event, you can log it.

If you discover that the search equipment fails before anyone goes through unsearched and you immediately use other equipment that's available with the same capability, that would be like your hand-held or walk-through searching devices. If you have one train up and you find out that it's out of service before anyone goes through, you send them through a different train.

That does not require a report. It does not require a log entry. No reporting on that one.

The next example is an individual who's required to have an escort for a particular area, who inadvertently becomes separated from his or her escort, but the escort or another person who's authorized unescorted access recognizes the situation and corrects it.

If the individual separates from his or her escort to use a restroom which has had limited means of egress and the escort remains nearby and has full view of the egress area, no report or log entry is required.

We have gotten these and you don't have to report it and you don't have to log it.

If an employee of a licensee or contractor enters a vital area improperly without realizing that the card reader is processing a preceding employee's card, or if the employee walks in behind another employee without using his key card, tailgating, or using the key card improperly, puts the key card in, doesn't notice the red light and goes in behind the other person, the event can be logged, even if the employee was not authorized access to any vital area, if the improper entry was inadvertent and was without malevolent intent.

If an individual enters a vital area to which he or she is authorized unescorted access by inadvertently using an access control medium, key card or badge, intended for another individual who's also authorized access to the area, again, this kind of event can be logged.

If an individual authorized only protected area access, is incorrectly issued a badge granting vital area access, the event can be logged whether the individual does or doesn't enter VAs, again depending on no malevolent intent and nothing adverse discovered with the event.

If an individual is issued an incorrect badge but he or she cannot reasonably use it. An example of this could be in your path area, if you have a system where you

hand over badges but then they also have to have a pin that they have to put into the key pad in order to get through the turnstile to go into the protected area.

In a case like that, where it's not reasonable that the individual even could have used the badge to get in or to do anything, if that's discovered and it's corrected, you don't have to log it. You don't have to call it in.

The next example is improper control, to include loss or offsite removal of access control media, including picture badges, keys, key cards or access computer codes, that could be used to gain unauthorized or undetected access.

These can be logged as long as they're properly compensated, which includes preventing successful use of the medium and initiation of measures to determine if the medium was used during the period that it was lost or off site.

If the licensee determines that it was used during this period, the event should be reported within one hour from when you discover that it was used.

If you determine that the medium could not have been used to gain unauthorized access or undetected access, you don't have to report it. You don't have to log it.

Situations of this type of event could include the following. If the authorized individual only momentarily takes the badge outside of the PA, immediately discovers

that they've done it, and brings the badge right back in before any compromise could have occurred.

If a badge or a key card is only momentarily misplaced and the event is discovered and corrected before anyone could reasonably use the device for entry, or if the badge was automatically deleted from the system when taken off site, a new badge with a different access code is issued to the individual upon re-entry and the previous access code is not used in another badge, these events would not require any reporting.

The next-to-last example is card reader failure that causes vital area doors to unlock in the open position or to lock in the closed position but with no functioning door alarm.

If the card reader causes the vital area door to lock in the closed position and the alarm functions, no report, no log entry is required.

The last example of a loggable event is incomplete pre-employment screening records. This includes falsification of a minor nature or inadequate administration, control, and evaluation of psychological tests.

Unescorted access of the individual should be canceled or suspended until the identified anomaly is resolved.

If the licensee determines that the unescorted access would have been denied based on the developed information that was missing, then a one-hour report would be required within one hour of discovering the adverse information.

Now Joan Higdon will address the NMSS analysis system.

STATEMENT OF

JOAN HIGDON

MS. HIGDON: Good morning. I'm Joan Higdon from the Division of Safeguards and Transportation and manager of the Safeguards Event Logs Analysis Program.

I'd like to take a few minutes to give you brief background information on our program. Our division has responsibility of conducting and implementing the logs program.

Activities associated with this effort are the review and analysis of reported events in the quarterly logs and feedback to the NRC and the licensee of analysis findings and statistical data.

The goal of this program is to serve both audiences and the logs is one mechanism to be used for improving safeguards system performance.

Emerging from this program are a number of cases where the event lots and feedback data were the bases for

root cause analysis that resulted in improved equipment operation or reduced human error.

We have specific examples of those a little bit later.

Additional staff resources have been dedicated to this program at this time, which will enable our staff to perform a technical analysis of the event data, with the results provided to industry as a companion to the quarterly report.

Each quarter a review and analysis is performed for each quarterly log submittal. Reported events are categorized based on the root cause of each event.

We are focusing on the specific component that failed, type of human error or environmental factors that impact on the functioning of the system.

The results of this review is distributed to each reporting licensee and their facility and appropriate NRC headquarters and regional staff in a quarterly feedback report.

Licensee corporate staff are being added to our mailing list on an as-requested basis. If anyone here is not on our mailing list and wish to be added, please see me after the briefing.

The quarterly report presents statistical data for events reported from each facility with regional and

industry averages.

These numbers, whether event totals or averages, are to be used as a frame of reference for the licensee and NRC staff.

These numbers are not to be interpreted as standards of performance or the norm for any facility, event category or quarter.

These numbers should be evaluated, along with an understanding of a facility's design, equipment, population and other circumstances that affect reporting for each quarter.

Although numbers are useful in doing trend analysis, they can vary substantially from facility to facility, as a result of site-specific characteristics and other factors.

Therefore, emphasis is placed on identifying and evaluating the root cause of unusual trends of reported events.

There is much value in this analysis program for maintaining effective safeguards. The use of the event logs and feedback reports are designed to be a positive approach for improving system performance.

The trending of events from quarter to quarter will focus inspection resources to specific areas that merit closer examination.

Emphases are placed on what the number is comprised of and not just the number.

NRC feedback to industry will give the licensees an opportunity to evaluate written performance and security procedures and to take self-correcting action in areas that are in need of improvement.

The licensees are using the logs and feedback reports as a tool in evaluating their facility's operation.

Where new equipment has been installed or modified or a new security procedure implemented, the quarterly trending will afford the licensee an opportunity to chart its progress.

By comparing their facility's data against industry, this comparison serves as a point of reference in this evaluation.

The event data should be reviewed in conjunction with the previous quarter's data. We are not focusing on statistics for just one quarter, but the trend of reporting of events from quarter to quarter for each facility.

There are cases where the event logs and feedback reports highlighted a need for certain changes at a facility.

Many licensees are performing a root cause analysis based on event logs and quarterly feedback reports.

The analysis findings have resulted in

modifications to certain equipment or security procedures, which improved equipment reliability or reduced human error.

The findings are provided to industry, since it may have application at other facilities.

We want the feedback report to be used as a medium for the exchange of information regarding analysis findings and lessons learned that can have a positive effect on the security program.

Some specific examples of these are where in one particular facility they had the installation of heavy-duty springs on a security doors.

The springs are designed to facilitate the door closing, especially when the door is adversely affected by air pressure.

Another case where a strobe light was installed over a security door and it is designed to turn on while an individual is exiting the door and to turn off only after the door has been shut and the bolt actually in place.

There have been some findings and statistics where these have reduced human error.

Additional staff resources have been dedicated to this program and the data is now undergoing a technical review.

These findings will be issued, along with your quarterly report, focused on specific topics, such as

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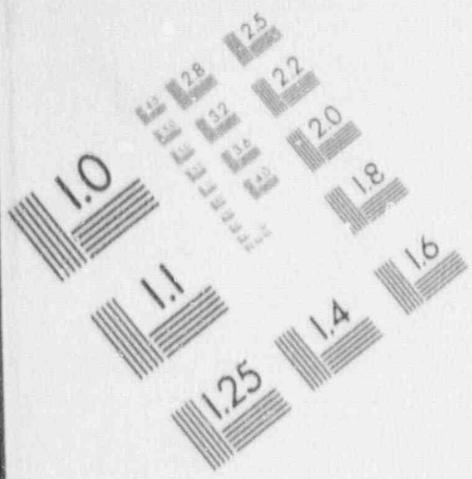


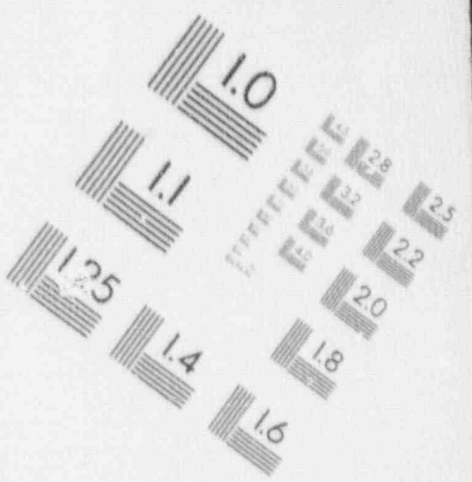


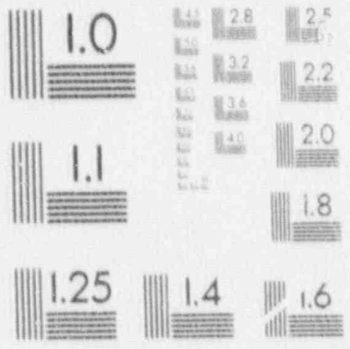


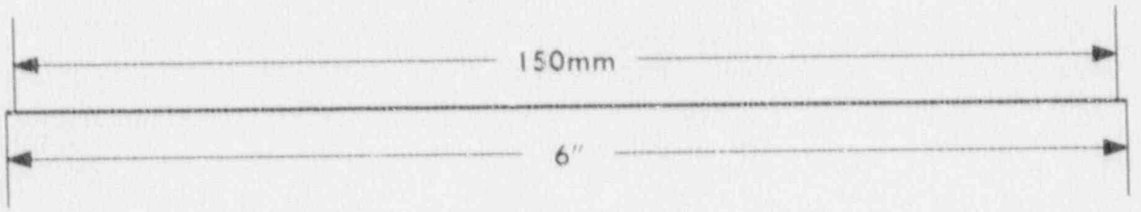


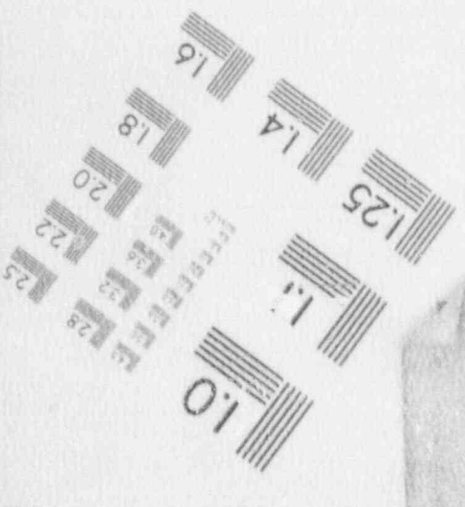


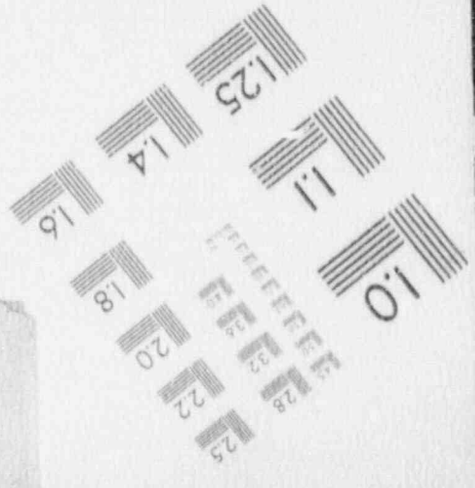

certain equipment performance, environmental influence, and on security procedures that are successful in reducing human error.

In addition, work has begun to normalize the data, grouping like facilities together based on size, population and similar environmental conditions.

Over time, the quarterly report will be revamped to present the data in a manner which reflects site specific characteristics and other factors that impact on that reporting.

Our staff is sensitive to industry's concerns and needs with regard to this program.

We appreciated the opportunity to receive your input at the Orlando meeting. Based on this information, we've made a number of changes in the program, and we're working towards making it a very successful and positive one for both NRC and industry.

Thank you.

MR. WILLIAMS: Questions?

DISCUSSION ON 73.71 REPORTING

MR. GULDEMOND: Bill Guldemond, Comanche Peak.

To what extent is the analysis of data that's received as part of the event log and reports utilized as an input directly into the SAPP process on a plant-by-plant basis?

MR. FAULKENBERRY: Stu, do you want to pick that up?

MR. RICHARDS: I'm not responsible for the safeguards area but I have sat on just about every SAPP board in Region V in the last year or two, and I can tell you that the SAPP boards are very cautious about not applying raw data straight, reaching conclusions.

That's not to say that there wouldn't be some kind of a mention of how many loggable events were received. I think there's some discussion of the number of safeguards events, but the board tries to consider the significance.

Frequently we have a lot of discussion about what it means. So it may not necessarily come through in the written product, but I can assure you that we try very hard to stay away from just using numbers and stick to significance in reaching some kind of conclusion on performance.

MR. GULDEMOND: So the process is consistent with the utilization of performance indicator data relative to SAPP?

MR. RICHARDS: I think so. In the SAPP process we're not supposed to apply numbers to reach a conclusion. It's significance of events and how it relates to overall performance.

But I think we'd be wrong not to consider that

information as part of the process.

MR. GULDEMOND: Thank you.

MS. BRITT: Kathleen Britt, Comanche Peak.

Could you clarify the circumstances which would lead us to be responsible for a fitness-for-duty report as well as a 73.71 report and how this could come about without specifically conflicting with 26.73, and also considering that 26.73 report is a 24-hour report, whereas the 73.71 report is a one-hour report?

MS. ERVIN: An example might be where you have a guard that's posted as a compensatory measure for a degraded safeguards barrier, and the guard is under the influence of drugs or alcohol and can't perform and then something adverse happens as a result of that.

The one-hour report for the safeguards would be 73.71. If there was something adverse that happened on the safety side, it might fall under the 24-hour reporting.

Your fitness-for-duty would be a for-cause test. If the event involved like a control room operator and a security type event was also involved with it, then you might have your 24-hour report that would be a call in for a fitness-for-duty.

And you could take care of both of them by the one-hour report, if you chose to. It would be unusual.

That's why we said in those rare cases, because

it's not that it won't ever happen.

It was a question that was -- Loren Busches is the fitness-for-duty expert in NRR, and it was a question that had come up with licensees several times.

So we wanted it in the generic letter.

MS. BRITT: Doesn't 26.73 specifically say that you only make reports under that rather than --

MS. ERVIN: I can't hear you.

MS. BRITT: Does 26.73 not specifically say that you make reports under Part 26 rather than 73.71?

MS. ERVIN: This is for the reports that are reportable strictly under 26. If you have a joint report, Loren said the 26 would be called in with that data and then the 73.71 under 73.71.

It's really more like two separate events. We're just saying if you want to save making two calls, you can call under the one-hour 73.71 report.

MR. WILLIAMS: If there's no other questions, maybe we can reconstitute the LER panel and have a wrap-up question or if Ed has some closing comments on that, we can move to that.

SUMMARY DISCUSSION

MR. WILLIAMS: I guess the first thing is we would like to hear some closing comments from you, anything that you think is worth mentioning.

One of the things that occurs to me throughout these workshops is that we seem to be focusing on the fringe areas of reporting more than we are on what might be fundamental problems or fundamental areas of concern.

There's a few reasons for that that I can see, but do any of you have an idea of a major area, a fundamental question that you have on reporting that's not one of these definitional areas or fringe areas, that we didn't cover during the workshop that you think really needs to be addressed?

MR. BRANCH: Steve Branch.

It's not really a fundamental question. It's more of a procedural question under 50.9.

50.9 states that, "Reports should be made to the Regional Administrator." Is the intent there that the Regional Administrator be personally notified or is it possible to notify the deputy administrator or a section chief or resident?

MR. FAULKENBERRY: That's used in kind of a broad sense. When you say notify the regional administrator, that means notify someone in the regional office, generally a management official of the regional office.

MR. BRANCH: That would not include, then, the resident inspector?

MR. FAULKENBERRY: I guess it could.

Okay. Ed answered the question, no, it should be the regional office.

MR. BRANCH: I'm sorry?

MR. FAULKENBERRY: No. It should be someone in the regional office specifically.

MR. BRANCH: Thank you. And also, one further followup. Should the 50.9 notification exclusively reference 50.9?

MR. WILLIAMS: I think that's appropriate.

MR. JORDAN: Yeah. What we want to try to protect you and us from is a passing comment about the problem and then a month later the comment, "We reported that on August 21st. Don't you remember? We wrote it down in the..." That won't work.

So it's important to say, "This is a report in response to the requirements of 50.9," blah, blah, and even subparagraphs, if appropriate, so that we are sensitized and you know exactly what you are reporting.

MR. BRANCH: Thank you.

MR. WILLIAMS: The other thing that seems to be coming up and last year it came up on one plant in the east is that there's a potential use -- Some people are trying to use 50.9 rather than 72.73.

If it's reportable pursuant to the discussions we've had over the last day here, then 72.73 is the right

means to do it.

50.9 does not have all the content requirements that 73(d) does and the like, so we really prefer and we'll ask for 73 reports and 72.

Any other wrap-up questions or statements? Don?

[Laughter]

MR. REEVES: Let me just go on record as stating that I think the LER committee would appreciate working very closely with the NRC in trying to come up with improved guidance for LERs.

We have talked about that several times during this workshop.

MR. WILLIAMS: For my own part, I'm not really sure about the charter of that committee. Cindy originally explained this is an LER/JCO committee.

MR. REEVES: That's correct.

MR. WILLIAMS: That was initiated by Georgia Power, I think. She had to leave. She was working in that area for Georgia Power, I think.

MR. REEVES: Well, she apparently is in the licensing group at Georgia Power and she is involved in preparing LERs and JCOs.

MR. WILLIAMS: Is there a term that this committee will exist for?

MR. REEVES: It was created under the auspices of

the prime reps of BWR Auxiliary Group and was funded for this this year and there apparently either h[illegible]seen or will be a funding request submitted for next year, which my understanding is will be within regional groups.

MR. WILLIAMS: Well, maybe you could advise us of the membership in a letter.

MR. REEVES: Sure.

MR. JORDAN: We've got that.

MR. WILLIAMS: We've got all that? Okay.

MR. CHERNOTT: If I could interrupt a second. Harold Chernott, Wolf Creek.

One thing to note here is that group has not received endorsement of all the other owners groups yet. As such, it represents a subset of the total industry at this point.

MR. JORDAN: I'd like to make a comment about that. When the NRC does seek comments on a particular policy or rule change, we do it publicly. So when we send something out, it will go to all utilities and to UCS and anybody else and everybody else.

So it would be an open communication. The Advisory Committee Act prevents us from working with only one group.

So we appreciate the offer and I'm sure that we will take you up on it. But we also provide it universally.

MR. REEVES: I agree and I will say that the participation -- An invitation has been extended to all the owners groups to support that function, to participate in the function.

At this stage, with no request for any supplementary funding, whatever costs are involved is underwritten to this date by the BWR Group.

Participation of all utilities has been encouraged and requested.

MR. JORDAN: From my personal viewpoint I think that committee has done some very useful work and I appreciate your initiative.

MR. WILLIAMS: Thank you, Don.

Maybe the panel has closing comments. Johns, would you like to bat?

MR. JAUDON: [Shakes head]

MR. GWYNN: I have no comments.

MR. WILLIAMS: Jack.

MR. CROOKS: I just wanted to extend again a thank you for the comments that are on the record.

We will take them and our plans are to go over all the workshops, as I mentioned before, pull out the key issues and then develop new guidance and possibly a slight rule change.

MR. WILLIAMS: Ed.

MR. JORDAN: I, too, want to thank the participants, the host region, Region IV, for putting together the facilities, and the court reporter for taking down this material, and indicate that the record will be available through the Public Document Room, and then make a couple of comments.

I think the first one will be that generally, the NRC is satisfied with the level of reporting in terms of the events that are reported. We're getting about the right set.

Failures to report are generally isolated and the NRC handles them on a case-by-case basis. We have inconsistencies we'd like to improve.

We want to leave room for judgment and I think this workshop has sort of reinforced that.

There certainly is a need to adjust the reporting requirements and the guidance, and I'll go a step further than Jack Crooks did and say we will issue revised guidance and we will promulgate a minor rule change in order to make those clarifications.

I think the safeguards and security area is to be commended for having gotten theirs to the point of very near issuance and I think that will help you as well as helping the Commission.

We do expect this change in minor rulemaking and

guidance to eliminate many of the non-usable reports, non-usable to you and to us.

Certainly, you've helped identify the areas that need revision.

I want to remind once again, the industry shouldn't arbitrarily change, based on discussions of guidance we've had here or owners group guidance or others, the existing reporting requirements until it in fact has been sent out.

So please take under advisement the proposed changes are not yet amendable.

I would reinforce my statement about important stuff. I think that's the essence of what all of us want, is that people that are developing reports have a philosophy of why the report is being issued.

It's to provide for the industry the material that may benefit them and prevent them from having to learn about a problem independently.

We really want to have a collective learning process and reduce the numbers of events and errors. I think that's fundamental.

So if you have that bottom line as a basis for making a determination, I think that helps a lot.

The value of closer communications is just evident from our discussions. The NRC, I think, has not done as

good a job as we should in having these kinds of discussions with you and getting down to cases.

I told the backfitting workshop, and I would say it again here, that the next workshop we have in this regard we will make it up in terms of case studies.

We will provide some marginal event scenarios and then break up into groups and classify them and find out why we have problems with our determinations.

So I think that will be a beneficial way of treating it.

The one question that was raised that was unique in my previous involvement, and that was whether the NRC industry may be missing important information related to defects identified in dedication of commercial grade components.

This is an identification process the utilities have and there is certainly a great deal more of that going on based on vendors no longer providing quality grade equipment.

So I certainly have a question in my mind as to whether that change in the present mode of reporting is missing some important generic information.

So we'll be working with you utilities to try to understand whether there's a problem there that we need to do something about.

Okay. I think I've covered everything. I would say that there is an attempt on our part to make those revisions both to the guidance and the rule and send it out and we'll be interacting with you on a public basis.

Thank you.

MR. FAULKENBERRY: I think from the region's perspective, I would encourage you to go back and think in terms of the intent of the rule to communicate the information that is of concern to us, from both a generic and specific standpoint.

Certainly, we in the regions are probably looking at reporting information from a little bit different perspective than headquarters, but we've got a concern to understand and know what's going on and to stay on top of it.

I would hope that when we get down in these gray areas you've expressed concerns about, really what should be reported and what shouldn't at some low levels, that if you apply that criteria: Does it have safety significance; is it something that the NRC needs to know with regard to evaluating condition of the powerplant and the operational safety of the powerplant; or do other utilities need to know this information from the standpoint of preventing possible problems or getting out of possible problems.

I would think that would cover most of the things

that are of concern to us.

I would also hope, too, that if you apply that criteria way down into the fuzz and into this gray area and it has no safety significance, that we in regions from an enforcement standpoint wouldn't get too hung up with regard to trying to catch you on some very, very gray area.

So that's the message I would put across, is to try to apply the criteria of the importance and safety significance.

MR. WILLIAMS: The thought that came to my mind during all these workshops is the root cause analysis that's demanded by the LER process.

It seems to me that the questions on LER reporting that are not in the fringe areas, the ones that really do have potential for enforcement followup, given an event may arise, precursor events that were found and not reported, whatever the case is, these problems arose from inadequate root cause analysis.

The root cause analysis that's demanded by you in your day-to-day work is really a key to understanding the events and understanding the goal of the whole mission of LER reporting.

LER reporting is a followup activity to feed back information to others.

The root cause analysis that you require will go

ahead and satisfy a lot of the questions that have been raised throughout the workshops, all four workshops.

So I just place the emphasis on the root cause analysis. Then once that is thoroughly done, it seems much easier to make a determination and the evaluations of significance, and a lot of these fringe areas will fade away given a thorough understanding of the events.

So I think that's where we really need to focus and then the reporting would follow that.

Eric, do you have any comments?

MR. WEISS: No, thank you.

MR. WILLIAMS: Al?

MR. CHAFFEE: No.

MR. WILLIAMS: Thank you very much.

[At 11:45 a.m., the workshop in the above-entitled matter was closed.]

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REPORTER'S CERTIFICATE

This is to certify that the attached proceedings before the United States Nuclear Regulatory Commission in the matter of:

NAME OF PROCEEDING: REGION IV AND V EVENT REPORTING WORKSHOP, Volume II

PLACE OF PROCEEDINGS: Arlington, Texas

DATE: November 9, 1990

were held as herein appears, and that this is the original transcript thereof for the file of the United States Nuclear Regulatory Commission taken by me and thereafter reduced to typewriting by me or under the direction of the court reporting company, and that the transcript is a true and accurate record of the foregoing proceedings.

Gay E. Denton

GAY E. DENTON

Official Reporter

Ann Riley & Associates, Ltd.

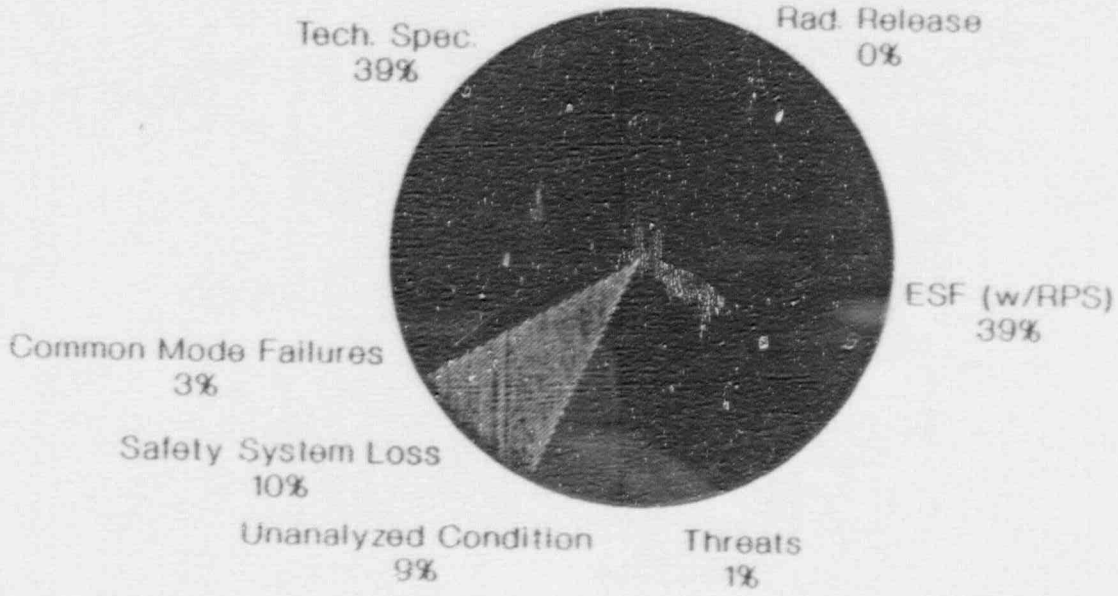
(4)

# LICENSEE EVENT REPORTING WORKSHOP

## SESSION #2

## "RULEMAKING/GUIDANCE REVISION"

# 1989 LER DISTRIBUTION
## REPORTING CRITERIA



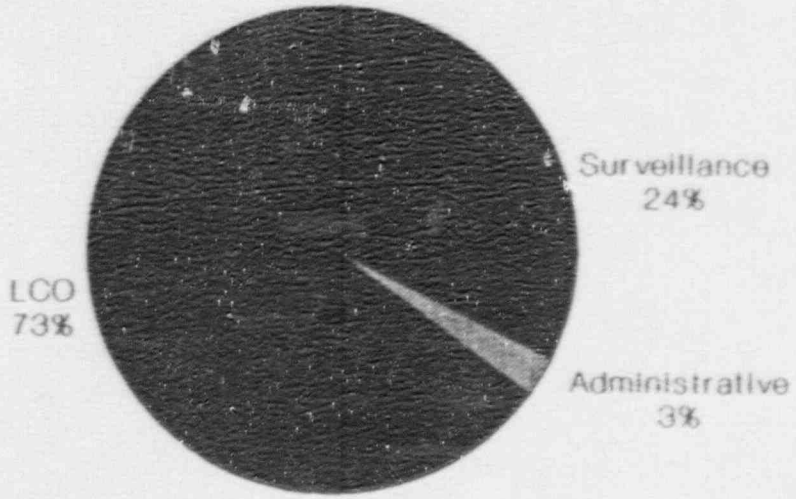
# 1989 ESF LERs (WITHOUT RPS)

- **TOTAL LERs: 609** [1358 ACTUATIONS/ISOLATIONS]

| | TOTAL | UNNEEDED* |
|---|---|---|
| - LERs WITH SINGLE ESF | 432 | 325 |
| HVAC SYSTEMS: | 158 | 132 |
| RWCU SYSTEM: | 48 | 34 |

* MEASURED PARAMETER DID NOT REACH SETPOINT BAND.

# 1989 TECHNICAL SPECIFICATION LERs
## VIOLATIONS




I & C Systems - 43% of LCOs and 42% of Surveillances

# Current Staff Initiatives

## Near-Term

- Elimination of selected ESFs
  - Unneeded[1] RWCU isolation or Control Room HVAC actuations
- Issuance of additional guidance (Nureg 1022 Supp. 3)

## Long-Term

- Systematic Re-evaluation of Requirements
- Probable Rule Change

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[1] Unneeded actuations are those that are spurious or occur when the measured actuating parameter(s) did not reach the set-point(s) band.

# REPORTING OF SAFEGUARDS EVENTS 10 CFR 73.71

## Summary of Regulatory Base

- Significant Events
  - –Prompt Reporting/1 Hour
  - –NRC Operations Center
- Less Significant Events
  - –Record in Log/24 Hours
  - –Log to NRC Quarterly

(5)

# HISTORY

Originally Published 1973

- Major Revision on June 9, 1987 to:
  - –Clarify Reporting Requirements
  - –Eliminate Unnecessary Reporting
  - –Improve NRC's Data Analysis System

RG 5.62, "Reporting of Safeguards Events"

- Revised November 1987
  - –Clarified Rule Revisions

NUREG–1304, "Reporting of Safeguards Events"

- Published February 1988
  - –Documented Questions Discussed at September 14, 1987, Workshop

# 1-HOUR REPORTS

Purpose

- Prompt Notification
  - –Significant Events
- Safe Operation of Plant(s)
- Health and Safety of Public
  - –May Warrant NRC Oversight

NRC Use of Information

- Immediate Analysis
- Notification to Other Agencies

NRC Feedback

- Oversight if Appropriate
- Immediate Generic Communication if Appropriate
- Rule/Guidance Revision as Appropriate

# LOGGABLE EVENTS

Purpose

- Notification Quarterly
  - –Less Significant Events
- Safeguards System Effectiveness

NRC Use of Information

- Long–Term Analysis

Feedback

- Analyses to Licensees
- Generic Communication as Appropriate
- Rule/Guidance Revision as Appropriate
- IN–90–13, "Importance of Review and Analysis of Safeguards Event Logs"

# ON-GOING ACTIVITIES

Revision to RG 5.62

- NUREG-1304
- Incorporate Lessons Learned/ 2 Year's Experience

Generic Letter

- Policy Revision
- Eliminate Unnecessary Reporting

Responsive to Impact Survey

- Impact Survey Considered in Revision to RG 5.62 and Generic Letter

(6)

# Safeguards Event Log Analysis Program

## 10 CFR 73.71 Reporting of Safeguards Events

Office of Nuclear Material Safety and Safeguards
Division of Safeguards and Transportation
Joan Higdon (301) 492-0477

# Safeguards Event Log Analysis Program

- Analysis of Reported Events
- Use of Event Data by NRC/Licensees
- Program Results
- New Initiatives

# Analysis of Reported Events

- Categorization of safeguards events
  - Specific failed component
  - Type of human error
  - Influences by environment
- Quarterly Feedback Report to NRC and licensees
  - Statistical data for hardware system/ human error events
  - Results of licensee self-assessment
  - Identifies factors impacting licensee reporting

# NRC Use of Event Data

- Identify indicators of possible system/program weaknesses
- Provide feedback to licensees for maintaining effective safeguards system performance
- Provide input for NRC inspection planning

# Industry Use of Event Data

- Perform self-assessment of a facility's security equipment and procedures

- Compare facility data against industry

# Program Results

Event logs and feedback data bases for root cause analysis performed by licensee and NRC which resulted in:

- Improved equipment reliability
  - Card Readers
  - Computers
  - Perimeter detection system
- Reduced human error
  - Lost badges
  - Badges taken off site
  - Badges incorrectly issued
  - Unsecured door events

# New Initiatives

Analysis to determine correlations between event data and facility design, equipment and special circumstances

- Normalization of data
- Root cause analysis