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	REGION III BACKFITTING	WORKSHOP
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6	R	amada Hotel O'Hare
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11	PARTICIPANTS:	
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13	Bert Davis, Administrator, Region III	
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## PROCEEDINGS

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[9:00 a.m.]

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MR. NOVAK: Good morning. My name is Tom Novak. I'm with the Office of Analysis and Evaluation of Operational Data. We have the smallest office in NRC, so we have to say that very slowly and often just so people don't forget about us.

8 It's a pleasure to be in Chicago and to have an 9 opportunity to participate in this workshop. I will be the 10 moderator this morning and this afternoon, which means I try 11 to keep us on schedule, recognize the people in the audience 12 so that your questions can be asked, and hopefully make sure 13 we give you the best answer we can.

Before getting started, I'd like to just get through a few little incidentals. One, there will be a transcript of this meeting and all of the other meetings that we've held, so that the record will be clear on that point. Also, we would like everyone that's here to, if you haven't already during the break, please sign in, because that list of attendees will also be part of the record.

Before we get started, I will introduce some of the people to you. At least you will recognize some and others will be strange to you, people here on the panel. There are no volunteers on this panel. Let me first start from the right. You do know Bert Davis, Regional Administrator of Region III. To his right is Bruce Jorgensen, who is currently the Senior Resident and Braidwood, and I've been informed, recently promoted and will be working out at Glenn Ellyn. Congratulations, Bruce.

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5 To his left is Bruce Burgess, who is a Section 6 Chief in Region III. To his left is Eric Weiss, who you may 7 not recognize. Eric is with the Incident Response Center. 8 He's responsible for the operation of that facility and 9 he'll be talking to you this morning about that activity.

To his left is Denny Ross, who many of you know. He is currently the Deputy Director of the AEOD. I'll keep it short. To my left is Al Chaffee. Al is currently the Chief of the Events Analysis Branch in the Office of NRR. Al was formerly in Region V, worked actively in the Vogtle/IIT and, as far as I know, never did get back to California. But we're happy to have him in Bethesda.

17 To Al's right is Jack Crooks. Jack is a Section 18 Chief in our Trends and Patterns Branch and he'll be talking 19 to you about 50.73. To Jack's right is Jack Rosenthal. 20 Jack is the Chief of the Reactor Operations Analysis Branch 21 in AEOD, and he'll be also talking to you about event 22 reporting. To his right, many of you know, I'm sure, Ed 23 Greenman, who is a Division Director in Region III.

24 What we're going to do is pretty much stick to our 25 agenda. We've got, I think, a good agenda. We'll be

1 talking about event reporting, 50.72, 50.73, and then we'll 2 spend some time this afternoon on safeguards, which I think 3 will be of interest to you. So we're hoping you'll stay 4 with us for the entire session.

Why I think AEOD is here today is because we're 5 basically the office responsible for the Incident Response 6 7 Center. We're also responsible for reviewing operating 8 experience. We really are the office that came out of the Kemeny Comrission and other commissions, the Rogovin 9 10 Commission which said you need an independent office to look at operating experience. So our job has been to review 11 operating experience, and you've seen many pieces of our 12 13 work over the last several years.

I would just as soon get started. I'm going to ask Bert Davis to come up and offer a few comments on event reporting and, as well, if he could, to give us some information on the meeting yesterday at the Commission regarding the reg impact study. Bert was a focal point in that effort and I'm sure he'll have some comments.

I might mention, though, Bert, when were at Atlanta, we introduced Stu Evenetter and he came up and said welcome to the home of the 1996 Summer Olympics. So you've got a hard act to follow here. I'm sure Chicago has got something to offer. Bert?

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MR. DAVIS: Well, I can tell you one thing. Every

Friday afternoon, the Regional Administrators and the Office Directors in Washington have a telephone call, and Stu Evenetter last weekend was talking about the hurricanes and flooding in Region II and the concerns about the plants, and I told him we had sunny weather in Region . I that day. So it's not all bad.

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It's a pleasure for me to be here this morning to 7 add my welcome to you to the Region III workshop on event 8 reporting. During the regulatory impact survey, there were 9 many concerns raised with respect to the event reporting. 10 11 These included the effect of such reports on the shift crew, too low a threshold for reporting, changing NRC 12 13 interpretations on reporting by regions and by resident inspectors, problems with informal reports requested by 14 resident inspectors, even whenever everybody thought the 15 16 reporting threshold prescribed by the regulations was already too low, and the effect on the public of a large 17 number of reports being interpreted as another emergency at 18 the nuclear power plants. 19

20 So reporting came in for a large number of 21 comments, and I think the results of that report are largely 22 responsible for this meeting here today. Tom asked me to 23 day a few words about the Commission meeting yesterday. Jim 24 Taylor, Tom Murley, and I, plus a couple of Tom's key people 25 met with the Commission yesterday to discuss the regulatory

impact survey.

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It's kind of interesting. The Commission was the 2 last one to have a formal presentation given to them. I've 3 given presentation on the regulatory impact survey so many 4 times I can dream it now and not have to worry about 5 preparing anything. But they hard it formally for the first 6 7 time, and the reason it was delayed was that we wanted to have an action plan on what we intended to do with respect 8 9 to the comments received.

10 So if you haven't read the Commission paper that 11 was prepared to talk about the NRC's action plan, you may 12 want to get that and take a look at it. You will have the 13 opportunity to comment on it because it is going to go out 14 for public comment before it's fully implemented.

There were three key issues that the staff has 15 recommended, not to belittle this effort today, but the 16 backfit workshop yesterday and this reporting workshop today 17 are also actions being taken by the Commission to respond to 18 19 the comments received. But the three major actions that are being proposed are, first, a scheme by which the NRC would 20 entertain from licensees a schedule for implementing 21 regulatory requirements and regulatory initiatives. 22

This will give you an opportunity to merge into your overall schedule those things that we want done and those things that you want done and hopefully will result in

both of us working and implementing those issues that have the biggest safety payoff. So that's the first major initiative that NRR will be working with you on.

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4 The second major issue was to control the number of major team inspections that are done at a licensee's 5 facility in a given SALP cycle The mechanism for 6 7 controlling that is now in what we call our field policy manual. It will be controlling team inspections, plus major 8 other activities, including visits by NRC folks to your 9 facility. Basically, the way that will work is that we will 10 11 try to control the team inspections, and by that we mean a 12 team of four or more people being there for a week will be defined as a team inspection, try to control those to be no 13 14 more than four a year at a licensee's facility.

15 Now, that does not include any IITs or AITs that might come up as a result of events. The rechanism will be 16 17 that anyone in Headquarters that wants to do either a major visit that will perturb you or a team inspection, they have 18 19 to coordinate that with the Project Manager. The Project 20 Manager then coordinates it with the region and the region 21 has the overall responsibility to make sure, through our master inspection planning system, that there's not an undue 22 impact on you. 23

24 So if we see that Tom Novak wants to come out and 25 do a big human factors evaluation or something and there are

already three or four major team inspections, we'll have to look then at the three or four that are already scheduled as compared to what Tom wants to do, and somehow determine what is the more important and drop something that is not as important. So that's the second major initiative.

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The third major initiative that we are going to be 6 taking is to come up with some means of controlling the 7 informal requirements or backfits that you claim, licensees 8 claim are being imposed on you by inspectors and other folks 9 in the NRC. We will be conducting training sessions with 10 our people to enhance their interpersonal skills, enhance 11 how they should look at things, how they should talk to you, 12 what they should expect from you, and we will also be taking 13 steps to make sure that there is more interaction and more 14 15 oversight by regional managers to assure that we don't have people who are out there unnecessarily ratcheting you into 16 things that you don't think are necessary, but that you do 17 anyway because you don't want to get a bad SALP score. 18

19 So those are the three major initiatives that 20 we'll be developing ways to implement. The Commission was 21 very interested in this yesterday. We had a meeting that 22 was scheduled to last an hour-and-a-half and it lasted about 23 two hours and a half. They were very interested, had some 24 good comments, had some good suggestions for the staff, and 25 I'm sure they'll be keeping an eye on how we implement all

of this.

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Just a couple more words and then I'll let you get on with the business today. There were, as I said, a large number of comments regarding reporting and, as a result of that, I certainly think that this workshop today is very important and appropriate. This is your chance to give us your views and comments. As Tom said, they are being transcribed so that they can be evaluated.

As I'm sure you know, the reports that you do provide to us are carefully evaluated not only by the regions, but by Headquarters, and there is important information obtained. Our goal is to use that information properly and to share it with all of you so that the operation of nuclear power plants will be improved throughout the country.

16 I personally believe that the reporting requirements at this point do need to be reviewed and 17 appropriate changes made. I think there are obviously, in 18 19 my view, reports that are made that are unnecessary, that take a lot of your time and take a lot of our time, and I 20 think it's appropriate for us all to look at this now, and I 21 think it's timely. It's been a long time since TMI and the 22 reporting requirements that were developed after that. I 23 24 think it's appropriate at this point to take a look at that and see what we can do to enhance it so that we'll all spend 25

more of our time on things that are significant.

I sure hope that out of this session today and the NRC's reaction to it that we will come up with better reporting requirements.

Thank you.

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MR. NOVAK: Thank you, Bert. What we would like 6 to do now is move into the first subject matter in this 7 workshop, and that has to do with 50.72 reporting. We've 8 asked Al Chaffee from the Office of NPR to give you a 9 10 summary of exactly what is the process involved with the 50.72 reporting. Then, after that, we'll have a break, and 11 then we'd like to entertain some questions. So our format 12 13 is to let the speaker go through his material first, and then have enough time so people can ask the questions of the 14 panel. So we'll try to follow that today. Al? 15

MR. CHAFFEE: Good morning. My name is Al Chaffee, as Tom said, and I've been in the Events Assessment Branch for about a month, so I'm somewhat new to this. I was asked to come here and talk about exactly how we use your 50.72s, what we do with them, and some of the actions that come out of reviewing the 50.72 process.

Having come from the region, I didn't have a full appreciation for what goes on both in AEOD and NRR in reviewing the 50.72s. In the ... h I've been here in Washington participating in this, what I've found and

hopefully what you will see is that there is a lot of good effort going on in taking the 50.72s that are provided by the industry and reviewing those and determining which ones are really significant and helping to use that information to try to figure out and correct problems that are being encountered within the industry.

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So today what I will do is I will attempt to take you through and into the world that I'm now in of reviewing 50.72s and talking about how we use that information. I will also touch a little bit on some of the problems we see in event reporting, with Eric Weiss talking in more detail about some of the problems that exist in reporting 50.72 information.

Before I get into some of the details, let me just 14 briefly review what 50.72 is. 50.72 requires licensees of 15 power facilities to notify the NRC Operations Center using a 16 17 red phone for specified types of events at operating reactors. These 50.72 reports, they then initiate the 18 beginnings of shor -term evaluation of various events that 19 occur in the country. Then, as the slide shows, 50.73 also 20 exists and it requires a report to be written. 21

As you all are familiar, that report comes in some 30 days after the event. That ends up being a record of the event, in much more detail, and is used, as I'll talk about later, by various groups to do various types of trends and

patterns evaluations.

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It's also interesting that these 50.73s are also used by both -- besides the NRC, it's also used by INPO and by foreign governments to review the various events that are going on within this country.

This next slide shows the organizations that are 6 7 involved in reviewing 50.72s. On the left, AEOD is very much involved in the review of 50.72s, as well as NRR, and, 8 on the far right, the regions. We all are involved in that 9 process. On the lower left, the Operations Center, that is 10 the location that first receives the 50.72s. The Operations 11 12 Center is manned 24 hours a day by trained professionals and 13 they basically receive the 50.72s, and they make the first 14 determination, which is how quickly or in what fashion that 15 information that they've received needs to 'n disseminated 16 to various portions of the agency.

They may, for example, make the determination that they need to contact a senior NRR manager immediately; for example, if it was an unusual event or an alert. They also make determinations in regards to what other organizations might need to be contacted outside of the NRC.

Next, the regions are also notified about all 50.72s. Those reports typically come from the Operations Center. They contact the Regional Duty Officer, and then the regions, as I will talk about a little bit later, they

followup all the 50.72s of the plants, mainly focusing on how the licensee is dealing with it and what type of corrective action they're taking relative to the specific event.

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5 Then in NRR, in the middle of the slide, down on 6 the lower left, the Events Assessment Branch, this group, 7 which I head up, takes the lead in doing a fairly detailed 8 review, short-term review of the events, focusing on types 9 of followup actions that might be necessary to gather more 10 information or possibly leading to decisions like generating 11 notices or bulletins or generic letters.

12 Also, to the right, in NRR, the projects people, 13 they also followup 50.72s, and in some of the latter slides 14 here I will show how all these groups interact together. 15 Projects follows the 50.72s to keep abreast of problems that 16 are going on in the various plants. All of these groups 17 work together and we'll show how that comes about as I talk 18 through the next couple of slides.

This slide, which is not your next one, but the one after that, basically shows what the reporting requirements are. The first item up there, events requiring declaration of an emergency classification, this is the highest priority area of concern for the NRC. Basically, when you make your 50.72, if you tell the Operations officer that you have an unusual event or an alert, at that point,

people have to try to make a determination as to whether or not they man the Operations Center or not and how that information is going to flow within the organization.

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The other items in here which are various other criteria that we report, I'm not going to talk about those in detail because, in cheory, many are very familiar with those and I'd rather spend the time talking about how we use the information and how we evaluate it.

9 The next slide goes through and shows a flowchart 10 of how we actually evaluate 50.72s. In the upper left of 11 the slide, you can see the licensee notifications coming 12 into the Operations Center. Once they come in, the third 13 block down, again, the Ops officer, he has to make a 14 determination as to whether or not he needs to notify the 15 emergency officer immediately or not.

16 The emergency officer in the NRC is a senior 17 executive service manager within NRR. Typically he's at the Assistant Diractor or higher level. These people are on-18 call 24 hours a day and the watch rotation rotates every 19 20 week. What happens is if the Operations Center receives, for example, an unusual event, he would call this emergency 21 officer and the emergency officer would then make a 22 23 determination as to whether or not he needed to perhaps evaluate the need to man the Operations Center or perhaps 24 needed to call higher levels of management to make them 25

1 aware of a significant event.

2 In addition to that decision process, the Operations officer also, for every 50.72, fills out a word 3 processing system form which identifies each 50.72 and puts 4 5 a sequential number on each one. So every 50.72 gets a number attached to it. Then it's these 50.72 little forms 6 that we have that are then the initiator for a review 7 8 process that the Events Assessment Branch, which I happen to 9 head up, takes the lead in.

10 On the next couple of slides, as I get to them, 11 we'll talk about in detail the type of reviews that we do in 12 the Events Assessment Branch. One thing that is interesting 13 about -- as you're going to see as we talk about this, is 14 that the Events Assessment Branch itself is made up of 15 roughly 15 people. They're all engineers and they have a 16 variety of technical backgrounds.

17 So the 50.72s that you submit are being reviewed 18 by roughly a dozen people in the Events Assessment Branch 19 with a variety of backgrounds. This helps assure that we're 20 better able to detect and weed out the significance of 21 particular 50.72s relative to other occurrences or what it 22 may have in terms of technical merit.

It's also interesting that of all the 50.72s that are submitted, a large percentage of them, roughly 90 percent of them, after we initially review them, we decide

that there's no followup action necessary to be taken. That is they don't result in a notice. There is no need for us to gather additional information. I understand that many of them are stand-alone specific events associated just with the given site.

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Also, as you can see under the daily review of operational events, we do not only just look at the 50.72s, but we also look at other documents. The regions put out daily morning reports and we review those. They also put out PNs and the project managers put out daily highlights. So all of these different documents are reviewed, and we'll talk about that in detail, by the Events Assessment Branch.

What this next slide shows is that, the first 13 bullet, basically 100 percent review of the 50.72s and the 14 dailys and PNs. What we do is we get from the Operations 15 16 Center, they put together all the 50.72 notifications and those are electronically transmitted to NRR in the morning, 17 about 7:00 Eastern time. We take those, myself and a couple 18 of other individuals, and we sit down and we review these 19 20 reports, plus the morning report from the day before, and also PNs, with the goal being that by 8:15 each morning we 21 prepare a short briefing for high levels of NRC management, 22 mainly at the Division Director level, and this 8:15 phone 23 call, everybody calls in to a bridge, and for about five or 24 ten minutes we go through and talk about the most 25

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significant events that have occurred in the past 24 hours.

Typically, we start out with about 15 events and by the time we get ready to make the phone call, we're usually down to two or three or four. Then after we've finished with that phone call, the next thing that occurs is at 8:50 each morning, we have a meeting, which is the next bullet on the slide. At this meeting -- down at the bottom.

At this 8:50 meeting, we have an opportunity to 8 provide a synergism effect of a lot of different 9 organizations that are involved in 50,72s. On this call, we 10 have the Events Assessment Branch which heads up the 11 discussion. We also have the Generic Communications Branch 12 13 represented. We also have AEOD represented in rapport with the Operations Officers, and also the Patterns and Trends 14 15 Branch. We also have the Vendor Inspection Branch and we 16 also have Projects. We all sit down at this phone call and, 17 again, we talk about -- first we talk about any followup we've had from the previous day's events. 18

We also talk about the events we've received in the past 24 hours. What we try to do in this meeting is focus on the need for additional information, focus on potentially additional followup action, possibly may decide that we need to go out and get a little more information because we believe it may result in a notice or possibly a bulletin or a generic letter going out.

We also talk about, in some cases, if it's a particularly complex event, we might talk about the need for possibly having an AIT, an augment inspection team, or possibly an IIT. So, again, this meeting which happens every day provides an opportunity for a lot of different people to participate in a process of evaluating these events and trying to decide what actions would be appropriate.

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9 Then, again, by the time we get to the 8:50 phone 10 call, typically we've filtered out 80 to 90 percent of the 11 notifications as not being needed for any further followup 12 and we just focus on those that are of significant interest 13 to us.

Again, the primary goal of all this activity or 14 objective is to determine the basic factual information. 15 Again, this slide just reemphasizes the type of information 16 or the type of methodologies that we use to try to determine 17 the facts. Again, we have a 50.72, which is a written 18 19 document. We may decide that there's a need to call the region or possibly have the resident provide information 20 21 through the region on a particular event to further 22 determine what the facts are that are associated with a particular event. 23

Again, if it's a complex event, we may decide, the agency may decide to use an augmented inspection team or an

incident investigation team to go out and look at a
 particular event.

3 As this daily process continues, it culminates each week in what's called a Tuesday and a Wednesday 4 briefing. The Tuesday briefing, which is at 1:15, this is 5 essentially a dry run for the Wednesday briefing, but it 6 7 also serves as a working meeting. Branch Chiefs from the technical side of NRR, as well as Project Managers and other 8 people that are involved in following certain events will 9 meet on Tuesday and will talk about the need for possible 10 long-term followup actions, and we'll also dry run the 11 briefing that's going to occur on Wednesday. So it's more 12 of a working type meeting.

Then on Wednesday at 11:00, we have a meeting 14 which is focused at the Division Director and above level. 15 We also have Commissioners' assistants, and we also have all 16 17 five regions patched in by phone. So here we have a meeting 18 once a week, on Wednesday at 11:00 Eastern time, where the significant events, it's usually two or three, or none if 19 there's nothing to talk about that week, that are discussed. 20 21 Basically, the entire NRC that's involved in operating 22 reactors is involved and has an opportunity here or participates in the briefing of a significant event that has 23 occurred someplace in the country. 24

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What we do in this meeting is besides making

people like Tom Murley and others more familiar with the particular event, sometimes coming out of this, people begin to develop plans of action that they might want to take in terms of dealing both with the specific event or perhaps as a generic problem and they may initiate action coming out of the meeting to take a look at perhaps some generic activities that need to be done.

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These briefings are typically a half-an-hour, 8 sometimes an hour, but more likely half-an-hour in length. 9 The attendance at them varies, again depending on how 10 significant the events are. The one we had last week, we 11 happened to be talking about the results of several AITs, so 12 we had a small room, roughly a guarter of the size of this 13 filled with about 40 different people that were very 2.4 interested in what was going on. So it depends. 15

The next slide that we have is a slide that just 16 touches on some of the problems that we are aware of that 17 exist in the area of 50.72 reporting. I am sure that you 18 are aware of many of these. The rule requires report of 19 some events that are minor in significance. For example, I 20 think all of us are aware that people make reports when they 21 have inadvertant ESF actuations of ventilation systems due 22 to spurious types of conditions, like reactor water cleanup 23 may start and, for no legitimate reason, but just perhaps a 24 25 spurious signal of some sort.

1 We also have reports that are made for scrams that 2 occur while plants are shut down with the rods fully 3 inserted. So we recognize that there are some reports that we raceive that are not of significant interest to us. 4 Also, we're aware that the definition of what is an ESF 5 system differs from plant to plant. I'm told at some plants 6 7 the diesels are not considered ESF systems. So how those 8 problems with those components are reported can differ from 9 other plants.

Also, what constitutes -- for example, what is an 10 11 ESF actuation. Different people have different 12 interpretations of what is considered an ESF actuation. Do 13 you have to have the actual sensor that's detecting the condition cause the actuation or could you have it actuated 14 15 somewhere intermittently in the electronic circuitry? Do the components have to operate or not? There are different 16 17 interpretations that exist.

Also, serious degradation events, safety -- what does the word serious mean? Different people have different interpretations on that. What's an unanalyzed condition? Again, different people have different thresholds as to what they think is an unanalyzed condition. Some people make those determinations more quickly than others.

Also, different licensees have different
sensitivity to events or conditions that could prevent the

fulfillment of a safety function. All these types of things are different types of problems that we're aware of. Eric Weiss later today will talk about, I guess after I'm done, will talk a little bit about some examples of some of these.

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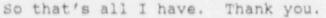
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Some of those reports that we get are not as 5 helpful to us as we would like. Also, in the handouts here, 6 7 there are a couple more handouts on the next slide here, but I'm not going to talk about all of these in much detail. It 8 9 focuses on -- in fact, the next slide, eleven, it talks about event assessment and it talks about some of the 10 11 criteria we use in terms of what things we will followup on. For example, if we have a safety-significant event, there's 12 some criteria included in here what we consider to be 13 safety-significant, and we'll follow up on those. 14

Events that are not understood, if we don't have 15 16 enough information, we'll follow up on those as well to get additional information. So, again, what our branch is doing 17 and what AEOD is doing is basically taking these 50.72s and 18 trying to glean from them problems that are being reported 19 by the industry in the hopes that we can better detect the 20 early indications of a problem, maybe generic. Sometimes 21 50.72s give us information for a Part 21 type form. The 22 other thing we do with this information is try to determine 23 quickly if, for example, we ought to have a notice put out. 24



MR. NOVAK: Thank you, Al. Eric Weiss is going to follow up now, giving you a little bit more information on some of the things that we see and do not see, in a sense, in terms of 50.72 reporting.

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MR. WEISS: Good morning, Al Chaffee told you how 5 important your 50.72 reports are and what they're used for. 6 7 I'm going to try and identify some problem areas, specifically what we're getting reported versus what we 8 expect to get reported when we wrote 50.72. My focus will 3 be on 50.72, but since, as you know, many of the words are 10 very similar or the same in 50.73, there will be some 11 12 validity for 50.73, as well.

13 There are about 3,000 calls made to the Operations Center each year, about 2,400 under 50.72. Out of that 14 many, I would say only a few events go reported each year. 15 So I don't want to leave you with a wrong impression. When 16 I get done, you may have the impression that I'm describing 17 a huge problem, but I'm not. I'm going to give you my 18 recollection over the past eight years of those types of 19 things that have gone unreported that should have been 20 reported, but that doesn't mean that we have an enormous 21 problem. 22

23 Six out of 2,400 is not a big percentage. I might 24 also caution you by whatever I say really doesn't change the 25 rule. Sometimes I am misinterpreted. But what you hear

here will be one man's opinion of what I expected to have reported when we wrote 50.72. I'm not speaking to change the rule.

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4 Consistency, I would say, is our biggest problem 5 with 50.72. As Al alluded to earlier, there are different 6 thresholds and we get different licensees with different 7 sensitivities, because we intentionally wrote the rule with 8 engineering judgment in mind. We didn't intend to be 9 terribly prescriptive. We intended to rely on your 10 judgment.

But notwithstanding that, you'll forgive us if 11 we're somewhat surprised when certain things aren't 12 reported. This first slide shows a number of those things 13 that have gone unreported over the past eight years, and 14 it's interesting to note that with the exception of the ESF 15 actuations and arguably the emergencies, none of these 16 things are explicitly mentioned. We thought that they'd be 17 captured or covered by the reporting criteria that we wrote 18 at the time. 19

Let me begin by addressing the anticipated emergencies. It was some years ago, I was sitting in Dr. Rossi's office when someone ran in and said that there was a plant that was in an unusual event or an alert, I forget which, and the Executive Director for Operations, our top executive officer, was very much interested in it. We knew

nothing about it and we called the plant and, indeed, they were about to declare an emergency or had, and the time clock had not run out.

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As a matter of fact, the plant knew for some days 4 5 that they were going to be in an emergency. They had detailed hydrographic information that indicated that the 6 7 water level from the river would overtop portions of their facility. So they knew when they would be in an unusual 8 event and they knew when they'd be in alert, but they hadn't 9 reached that water level yet or, if they had, the clock 10 11 hadn't run cut, and so they hadn't told us.

We would have expected the licensee to call us ahead of time on that. Why? Because the NRC needs time to get prepared. We have responsibilities to notify other Federal agencies. We have people that we call into the Operations Center and Headquarters, and the region, I'm sure, brings people into the Incident Response Branch, and all of these things ta<sup>5</sup>, time.

19 So we would have anticipated that licensees would 20 tell us about such things ahead of time, but it doesn't 21 always work. Now, what would cause you to report such a 22 thing? Well, the regulations prescribe that notification 23 should be made as soon as possible and in no case later than 24 one hour after the occurrence of the event. We thought that 25 those words would have caused licensees to call us not when

the one-hour or four-hour clock ran out, but as soon as possible.

What did we have in mind when we said as soon as possible? Well, we had in mind that your first responsibility, of course, is to keep the plant safe, and we didn't want the notification process to interfere with the safe operation of the plant. So we used the words as soon as possible meaning that as soon as you got the plant stable, as soon as you could spare the hands at the control panel, you'd pick up the red phone and tell us about it.

11 The second category of things that surprises us is 12 large spills. If I had to pick one thing over the past year 13 or so that has surprised us, this would be the category. 14 Well, spills, to begin with, is somewhat of a loaded term. 15 It sounds almost insignificant to say spill. But spills, 16 large spills in particular are often more serious than they 17 first appear, particularly to people in the plant.

18 Why? Well, because there may be EQ questions for 19 equipment that was wetted or submerged. It may not be 20 totally known the extent to which equipment was wetted or 21 submerged. A second reason is that there's tremendous 22 interest right now in NRR on intersystem LOCA implications, 23 and many of these spills have implications for intersystem 24 LOCA.

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To give you a perspective on that, I would say

that anytime you get water from the primary system, from the reactor vessel and its associated piping, outside of containment and on the floor of the turbine building or the aux building, you'll have some people in NRR looking at that event for its intersystem LOCA implications, which is to say I'm driving at the same thing Al Chaffee was.

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7 It's not necessary that the event be significant 8 for your plant. Your plant may be perfectly safe. The 9 spill may have been inconsequential for your plant, but 10 there are a large body of people in Headquarters that study 11 events for their generic implications.

The third reason that spills are somewhat 12 interesting to people in Headquarters is because that 13 occasionally they have implications for fuel uncovery. Very 14 rarely, of course, am I thinking of something in the vessel 15 or pool. That is very remote, as we all know, but sometimes 16 there's at least the hypothetical possibility that a bundle 17 transient being manipulated in the pool could become 18 uncovered. If that were the case, you'd have a very 19 difficult situation. It would be very difficult to recover 20 from an irradiated fuel element exposed inside containment. 21

The next category of things that have gone unreported over the years and have generated intense interest on some occasions, some very special inspections, have been the so-called inadvertant criticalities. What do

I mean by that? I've heard some people, both within and outside the Commission, say, well, gee, every criticality is inadvertant to some degree, we never hit our estimated critical position exactly, what do you mean.

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What we mean by that is those instances in which a non-licensed operator has manipulated the control or a trainee has manipulated the controls under improper supervision, inadequate supervision, or where rods have been pulled out of sequence, or there has been a substantial difference between the estimated critical position and what was achieved.

12 The next category are the small water hammers and 13 small fires. Again, I would say that these are events that 14 often have more widespread implications and consequences 15 than the first few indications would suggest. Sometimes as 16 a result of a water hammer or a fire, you find a new 17 mechanism for producing a water hammer hasn't occurred 18 before, or at least not to our knowledge.

Perhaps it would have been more serious under a different set of circumstances, either at your plant or maybe it's impossible that it could have been more serious at your plant. Perhaps these circumstances would have occurred at another plant and would have caused severe damage at another plant. So when there is a fire or a water hammer, we're somewhat surprised when we're not called.

The next category, overpressurization, and you might add the words over-temperature, have also caused intense interest on occasion. We've had a number of AITs for such events. I might say what do we mean by overpressurization? Well, I would say that once you've exceeded the value in the FSAR, you've got our interest. It sometimes happens that licensees point to engineering studies after the fact which show design margin in piping that would have accommodated the overpressurization.

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But if, for example, you get reactor pressure out in the suction side of RCSI, then that would certainly peak our interest. Again, you might suspect and be correct that the reason is it has intersystem LOCA implications and even if it's not significant for that plant, perhaps there's another plant that doesn't have the design conservatism in the RCSI suction pipe, just to mention a specific example.

17 Also, another category of things that go 18 unreported are the potential generic events. Let me give you a specific example. There was a plant that had an event 19 20 where they notified the vendor within a day or sc. They 21 notified the plant management within a day or so. The vendor issued a rapid communication service information 22 23 letter very rapidly and it took three or four days for the NRC to learn about the event. 24

We would expect that if you see generic

implications to an event, that we would be called. That is one of the underlying themes of 50.72 and 50.73. I think after having heard Al talk and some of our later speakers speak, you understand why, because we're writing notices and we're writing bulletins and generic letters in an attempt to head off events at other plants or perhaps even more serious events at other plants by informing them of their vulnerability and hopefully getting them to address the situation before it becomes serious.

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I might also mention that ESF actuations, which Al 10 11 has addressed to some extent, have been a problem. The definition of what is an ESF, and what is an ESF, as Al 12 alluded to, is also a category. I might point out, too, 13 that voluntary reports are encouraged, as outlined in NUREG-14 1022 on Page 10. If, for some reason, you find a 15 potentially generic situation that you don't think is 16 strictly reportable, we would encourage you to report it. 17 We think that that enhances the safety of the nuclear 18 industry by us being able to inform other licensees of 19 potentially serious situations before they occur. 20

And when we wrote the rule, the Commission directed us to include language in the rule that says -- in the statements of consideration in the rule, finally it should be noted that licensees are permitted and encouraged to report any event that does not meet the criteria

contained -- and here they're quoting the LER rule --50.73(a), if the licensee believes that the event might be of safety significance or of generic interest or concern.

4 Before leaving this slide, I'd like to make one 5 other point, and that is that events may be significant in the aggregate even if they're not apparently significant 6 individually. Al's group and Jack Rosenthal's group, who 7 you will hear from later, look at events in the aggregate. 8 9 When they see a number of events occurring of a particular type, it's very often a clue to them that something is 10 11 wrong.

12 The event in itself may not mean a lot, but if you 13 see all of the solenoid valves, we'll say, of a particular 14 type failing, well, it doesn't take a lot of insight to see 15 that there may be a problem there. It might be worth 16 looking into to see if there's a manufacturing defect or 17 installation problem or whatever.

18 So it would be too far to say just because you 19 don't immediately see the safety significance of what is 20 reported, to say that, ipso facto, it's insignificant. 21 Notifications of NRC response of groups and you might add 22 states, locals, are often untimely or have an incorrect 23 threshold. Let me try and give you what I think is the 24 correct threshold.

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We need to know about any event where the public,

the media, the state or local government, or another Federal agency perceives a safety problem, even if that perception is wrong. No one's interest is served, not the licensee's, rot the public's, not the NRC's, if the NRC is not aware of events that cause public concern. The public, the Congress, 5 and other Federal agencies depend upon the NRC to know what 6 is going on, and we can only hold the public's trust when we 7 can address their concerns. 8

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9 So I'm struck by the irony of what we have in the way of reporting. Some plants will report a sea turtle in 10 the traveling screen and there's another plant that not too 11 12 long ago had a steam generator tube leak in which they held 13 not one, but two press conferences. The locals around that 14 plant were notorious for their concern about nuclear power 15 and were calling the NRC Operations Center and painting the 16 worst possible picture, and we were telling them, no, we have no such report. 17

We quickly lost credibility with the locals. 18 19 Other Federal agencies wanted to know what's going on. We 20 have memoranda of understanding and agreements with other 21 Federal agencies to keep them informed, and we weren't telling them anything. A few days later, the licensee said, 22 23 well, we see now that it was reportable because we really did exceed our tech spec limit. We didn't think we had 24 25 steam generator tube leakage at the time it exceeded tech

specs, but now we see that it did.

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2 Well, that's too late. I would submit that as 3 soon as you have a press release, you really should have had 4 time to call the NRC under the "as soon as pract.cal" phrase. We need to know about these things so that we can 5 6 hold the public trust and address their concerns. The 7 Commissioners, the Commissioners' assistants and other high 8 level officials of the agency must be able to, say, for example, speak to ABC News if they contend that Plant X is 9 10 melting. Even if it's a totally trivial event and the most trivial occurrence happened there, we have to be able to 11 12 address those situations.

13 Deficiencies are not always reported when found by NRC personnel, such as by inspection teams or residents. 14 You still need a red phone call when you have a reportable 15 event. 50.72 requires that the NRC Operations Center be 16 called even if NRC personnel discover a reportable 17 condition. Now, why is that? Because we have an obligation 18 to inform the other Federal agencies and people within the 19 Commission. We have a complex set of procedures. It takes 20 people about two weeks to learn everybody who needs to be 21 notified and how to do it. 22

I sometimes get called by an office within the NRC
and occasionally I get complaints even from outside the
Commission, why weren't we informed. You have a memorandum

of understanding with us. You have a procedure that says that my office, which is a very important office, has very important functions, was not informed on this. Then I have to report, well, we weren't informed.

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So it's important that that red phone call get made so that the procedures that are laid out that have evolved over the years get properly implemented. I might also point out that once an event is reportable, it must be described completely, even if the description of the circumstances of that event would not otherwise have been reportable.

There was a plant some years ago that had a scram 12 13 and said it was a normal scram, and then when the resident 14 came to work the next day, he found that a large fraction of 15 the rods had stuck all the way out of the core. Al Chaffee's boss, Dr. Rossi, has told the Operations officers 16 to ask on every scram did all the rods go in, did aux 17 feedwater start. We used to tell Ern's that, well, they 18 said the scram was normal, but over the years, we've become 19 skeptical and some of the more serious events have not been 20 adequately described. 21

22 So if you have, for example, a non-safety grade 23 pump that's helping mitigating the consequences of an event, 24 you should tell us that you're using that non-safety grade 25 pump, even though the start of that non-safety grade pump

wouldn't have been reportable in itself. If you have a number of systems that are unavailable that otherwise would have been available to deal with a serious event, you should tell us about that sort of thing, because it helps us draw a complete picture and understanding what's really going on in connection with the reportable event.

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I might say that one category of things that frequently is a problem are the health physics type events because the people in the control room are very 57 in experts at reactor systems, but sometimes we have a problem with the event where they say that we have a release offsite of the vent stack monitors pegged off-scale high or there are so many counts per minute.

That isn't an adequate description. We need to 14 have it put in the context of, for example, what percent of 15 16 tech spec limit that is or what does count per minutes mean. I mean, it varies on the efficiency of the detector. So the 17 health physicists aren't too happy with us when we call them 18 the next morning and we tell them that there was a release 19 that exceeded the limits and we don't know what it was, 20 other than it was pegged off-scale high. 21

I might also mention that 50.72, Paragraph C, requires a followup report to give us additional information should it be particularly relevant. For example, if you had a scram and then three of four hours later you discover,

oops, the MSIVs didn't close and they should have; and, oops, we have a release off-site, but we didn't know about it at the time. We need the complete description of the event. So 50.72(c) requires that you give us a call back and tell us about these additional details.

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6 Required oral reports are sometimes made to other 7 NRC personnel rather than the Operations Center. As I 8 outlined before, we have a complex set of responsibilities, 9 both within the agency and with other Federal government 10 agencies to keep them informed. If these procedures at to 11 work, we just have to be notified.

I might make an additional comment here. We've been told that on occasion some licensees have used 50.9 in lieu of 50.72. 50.9 is not really a substitute for 50.72. 50.9 says if you find something that's not otherwise reportable, tell the region about it; and, by all means, do, but don't report something under 50.9 that is really reportable under 50.72 and forget to make the 50.72 call.

19 There was an important point made by another 20 speaker at one of the previous workshops that I think bears 21 reporting. That is that we can get bogged down into the 22 exact nuances of the meaning of certain words in 50.72 and 23 that may be counterproductive. The important point to keep 24 in mind is what we're after. The events of safety 25 significance; safety significance for your plant or for

other plants.

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If you think about what we're interested in in terms of plant-specific and generic significance, I think you will go a long way towards understanding the wording of 50.72.

6 This whole presentation is a condensation of one 7 that ordinarily takes about 40 minutes and 30 slides, and I 8 had deleted this slide, but it keeps coming back to haunt 9 me. So I'm including it. The potentially generic problems 10 are not consistently reported because the intent of 11 50.72(b)(2)(iii) is not always understood. The words "alone 12 could have been prevented" need to be explained.

13 Specifically, you'll recall these come out of a 14 reporting criteria that says "any event or condition that 15 alone could have prevented the fulfillment of a safety 16 function of structures of systems that are needed to," and 17 then it lists a bunch of things, A, B, C, D. The words 18 "could have prevented" refer to three things.

19 They refer to common cause problems, human factors 20 problems, and generic problems. When we wrote the proposed 21 rule, we didn't have the word "alone" next to it and we got 22 public comment that said what do you mean by that; gee, 23 hypothetically, any event could be reportable if you just 24 say "could have prevented." All I've got to do is imagine 25 the additional failure. I mean, the clock falling off the

wall; gee, what if it hit this switch and that caused the MSIVs to close at full power. That clock falling off the wall would be reportable. It's serious.

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So we included the word "alone" to refer to those 4 things that alone by themselves were enough to give you a 5 common cause problem. Now, the specific example that we 6 mentioned in the statement of consideration was you go out 7 and you find a gump with a wrong lubricant in it, and that's 8 why the pump failed. Well, one single failure, as you know, 9 is not reportable under the LER rule or F0.72. You've got 10 to have loss of a safety function, loss of a whole system. 11 Probably two pumps in most cases, unless it happens to be a 12 single-train system like HPSI or HPSIS. 13

14 Well, you go out and you find the other pump that is still working also has the wrong lubricant in it, and 15 maybe you put that wrong lubricant in there because it was 16 17 supplied by a rendor who made a mistake, or you were following an incomplete set of instructions or a vague set 18 of instructions. There you go. There you've got something 19 that along rould have prevented the fulfillment of the 20 21 safety function. You might have lost all low pressure safety injection because you got this wrong lubricant in all 22 of your low pressure safety injection pumps. 23

24 That's what we mean by "alone could have 25 prevented." I get asked that question frequently, so I

threw it in. Anyway, I thank you for your attention and I will look forward to your questions during the panel session.

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Mk. NOVAK: Thank you, Eric. We're going to take a break in a couple of minutes. Let me just mention two points. What we would like to do in the next session is have a panel discussion. We'd like audience participation. The whole idea of this event workshop is to get your input.

If you have a comment you want to make, please 9 make it. It doesn't have to be a question. If you have 10 some operating experience regarding 50.72 reporting and you 11 think we should focus on that point more, bring it up. 12 That's the whole point of the discussion. What we're going 13 to do when these four workshops are complete is we're going 14 to put out some additional guidance in the area of 50.72 and 15 16 .73.

We're also going to look hard at some minor rule changes that we can make to remove the need to report certain things that we have judged to be not of safety significance. So we do need your input. We'll also be mentioning things that aren't being reported today that we t'ink have safety significance.

I think if you've got some ideas in this area, I know it sounds like, well, why would I want you to report something you don't currently have to report. But, really,

I think we've seen a maturity in this area of reporting because what we do collect and review is of interest to you. The whole concept of event reporting is to be able to provide feedback.

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I think from this morning's session you see that 5 we don't take 50.72 lightly. There is a lot of work that 6 7 goes on each and every day with 50.72 reporting. The people that man the Operations Center are thoroughly screened to be 8 sure that we put very good people in there. They are 9 trained in Chattanooga so that they understand to a certain 10 degree the kind of plant that you're operating, and their 11 intent is to be responsive.e. 12

13 So we take this effort very seriously and I'm sure 14 you do. So what we'll do is we'll take about a 15 minute 15 break. We'll try to get back here at 20 minutes after the 16 hour. We'll pick up with audience participation. If you 17 don't want to give a question, if you're prepared to write 18 one out, give it to me and I'll be gl>2 to read it and we'll 19 carry on that way. So it's your choice. Thank you.

[Brief recess.]

21 MR. NOVAK: Now, if anyone has some questions or 22 would like just to start off by making a general comment 23 with regard to 50.72 reporting, or even as to 50.73, have at 24 it, because this is why we're here.

MR. HARRIS: I've got a couple of questions. Ray

Marris from Pennsylvania Power and Light. I'll start now and give other people a chance and come back up later.

The first question I have has to do with the part 3 of 50.72 that talks about unanalyzed conditions that 4 significantly compromise plant safety and conditions outside 5 the design basis. The reason I'm asking that is our 6 resident has taken +- outside the design basis, does not 7 have a qualifier of significance and has told us anything 8 for any reason outside the design basis is an LER and a 9 50.72 report regardless o significance. And we've taken 10 the position that's not the case, and I'd like to know 11 specifically what the panel thinks. 12

Maybe I can give you an example. You gave an overpressure event where you -- let's say you have an overpressure event where you exceed your design pressure by five pounds. That's reportable. Let's say you have an analysis that's done inside a house where you conclude that minder unusual circumstances, under an unusual event, you could possibly exceed your design basis by five pounds.

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Now, there's a test of significance and judgment
and the rule says use judgment.

22 MR. WEISS: That's right. The rule does say to 23 use judgment. We intentionally put judgment into the rule 24 instead of a set of prescriptive criteria so that we could 25 get at things that we as engineers could agree had safety

significance. There are some things in the rule that are more or less prescriptive. If you have a scram, you're going to call that in.

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We fundamentally made that philosophical choice when we wrote the rule. Now, to help you out specifically, what I find difficult to do is to take words in the abstract and to give you a flat out statement that all such things that fit a particular category or categorically reportable are not reportable.

10 What I do as a practical matter and what Jack 11 Crooks does on a day-to-day basis is when we're called by a 12 licensee or a region, we say let's discuss the specific 13 issue at hand. And when Jack or I listen to this 14 description, it will typically take maybe 15 minutes, 30 15 minutes, what we're looking for is the safety implications, 16 three types of safety implications.

We're looking at did it make your plant unsafe; 17 18 did it -- in other words, the second category is was there an emergency involved. The third category is the hard one, 19 20 that's the generic one. That's the one that Al Chaffee's group makes a living out of, and Jack Rosenthal's group, 21 22 too. I tried to include that in my speech where the way we resolved this question in another region was to say if you 23 think as engineers about whether the particular event or 24 condition had safety significance either for your plant or 25

for another plant, then you'll know whether it was reportable or not.

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3 Now, as engineers, over the years we have more or 4 less concluded that certain things aren't all that significant, like the spurious reactor water cleanup 5 6 isolations. Despite having looked at eight years of data on 7 that, nobody sees any tremendous safety significance to those. It's difficult to say that a reactor water cleanup 8 9 isolation is out of hand, not reportable or insignificant 10 form a safety point of view because what about the case where they really have the LOCA that's occurring out of the 11 reactor water cleanup system, and you get the isolation 12 13 signal and the thing fails to isolate.

Well, okay, that's one reactor water cleanup 14 isolation signal we'd want to hear about, even though it 15 didn't go to completion. Also, the control room ventilation 16 isolation is another category most people can concede are 17 not that reportable. But I'm not dancing around the issue. 18 What I'm trying to tell you is that given any category of 19 event, no matter how trivial or how significant, I can turn 20 it the other way around just by adding additional details. 21

22 So whenever I take these calls, I say let's hear 23 the whole story rather than part of the story, and we look 24 for the safety implications of it. If we can agree as 25 engineers that it's insignificant from a safety standpoint,

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then I think we can agree as engineers that we don', want to hear about it, it's not reportable.

The example I heard in the lobby that bothers some utilities is all rods are inserted and you get a scram signal. Most of those we don't want to hear about. They don't have any implications. But what about the plant that found that their DB-50s hung up a little bit, they looked at the alarm printer and found that the DB-50 treakers had bad maintenance procedures, wrong lubricants being applied.

Well, the NRC turned around in a hurry and put out generic correspondence to tell other licensees that there may be a generic problem with that particular breaker. What about the one -- the one that is my favorite is the BWR that said that they were doing scram time testing. That's not a big deal. The plant is safe, it's shut down, why are you interested in this.

Well, probing questions by the Ops officer found 17 out that ultimately it was due to bad parts kits. Well, 18 that plant was still safe. It doesn't matter that their 19 whole warehouse is full of bad parts kits for the scram 20 sclenoids. It doesn't matter, right? That plant is safe. 21 22 But what about the plant, the BWR that's operating on 100 percent power? There's a plant out there with bad scram 23 solenoid parts and they're operating at 100 percent power. 24 Are they going to have an ATWS? 25

1 So I would say the short answer to your question 2 is call us, talk to us in detail, either with us in 3 Headquarters or in the region, and if we can agree as 4 engineers that there is no safety significance to a certain 5 type of event, then it's not reportable. If you feel that 6 your resident is being overzealous, that's a matter to 7 address with the regional management.

8 MR. NOVAK: I would like to -- again, Ray, I 9 thought you were from Region I. Is that right?

10 MR. HARRIS: Yes.

MR. NOVAK: Or have we had a change that I didn't know about?

13 MR. HARRIS: Yes, Region I.

MR. NOVAK: I would like to add, and anyone else 14 from Region III, if you've got some kind of procedures that 15 16 you people do follow within the region in terms of discussing potentially reportable events between the 17 resident and the Regional Headquarters, that's the first 18 19 step. It does eventually -- and we certainly -- we do ask the regions if there's a question as to the reportability to 20 talk to NRR or AEOD. 21

22 So I'd like, Ed and Bruce, if you guys have any 23 specific comments, this might be a point to discuss it.

24 MR. JORGENSEN: I want to make one comment. The 25 Commission recognizes in certain cases; as a for instance,

pipe supports and restraints. We in Region III and most of the licensees in Region III have pursued interim operating criteria. That's one condition where you're outside your design basis where we were recognized because of the significance involved. In certain cases it might not be significant and we allow utilities to operate with the condition outside their design basis.

8 So certainly it's a circumstance or case-by-case 9 basis that we evaluate when we look at outside design basis. 10 \_f it happens to be a safety system at a plant, however, 11 typically it's reportable.

MR. DAVIS: I'd make a comment, too. You heard earlier that the events that we would take a special interest in following up include the really safety significant ones, but also those which are not understood. I understand. I think we can be sympathetic to the reluctance to call in an event that you don't understand yet, but it's mostly our business to be sure it's safe.

19 If the information isn't there to understand it 20 yet, how can we be sure it's safe? In the specific example 21 you gave, in the one hour that you get to try and make a 22 decision and an evaluation or the four hours that you get to 23 try and make an evaluation and a telephone call, I guess it 24 wouldn't be perfectly clear to me that if you're talking 25 about an unanalyzed condition, scmething you really haven't

had an opportunity to sit down and calculate out yet, how you know.

You don't understand it yet necessarily; how do 3 you know it's not significant? There may be cases where an 4 early seat-of-the-pants judgment will tell you, well, it's 5 outside the FSAR perhaps; we haven't analyzed it yet, but I 6 can clearly see it's trivial. But oftentimes I think it 7 would be difficult to say that right up front. Don't 8 understand it, it's not analyzed yet, but I don't want to 9 report it because I don't have the answers to the questions. 10 That's a tough one. 11

MR. NOVAK: Ed?

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MR. GREENMAN: Let me talk a little bit more 13 philosophy, particularly for Region III utilities. The 14 region doesn't make policy. Individuals don't make policy. 15 The rule exists. We've maintained all along that we do, in 16 fact, strive for uniformity. Bert Davis, myself and every 17 18 regional manager has emphasized that if you have a question, whether it's a simple reportability question, and you're not 19 satisfied with the answer that you get, to please contact 20 the region, contact the project section chief. 21

If you're unhappy with that answer, go to the branch chief. If you're unhappy with that, go to either Bill Forney or myself. And if you're unhappy with us, go to Bert Davis. We want to get uniformity. If we can't resolve the question, we'll do exactly what Eric talked about. We have frequent conversations to try to resolve it and try to get it back to you and also to try to get the information out to all regions.

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I agree with what Eric said. It's difficult to 5 zero in on one single case and say, well, this is reportable 6 or it's not reportable, without dwelling on the five percent 7 and without dwelling on your analysis. As Eric said, you 8 can come up with all sorts of hypotheses. You can have an 9 analysis, if you're a boiling water reactor, that says it's 10 okay to have a certain amount of foreign material in the 11 12 vessel. That may or may not be significant. It may be of a size that we're concerned in a BWR about it hanging up a jet 13 14 pump.

Again, we'd encourage you on a voluntary basis to let us know those things. The message I'd like to leave you with is don't let it just sit out there. Don't say, well, I'm going to report it because the resident tells me to, but contact any of us and we'll try to get you the right answer and using the best engineering judgment.

21 MR. CHAFFEE: I have one thing to add. In the 22 month I've been in the Events Assessment Branch, we have 23 seen probably half-a-dozen to a dozen cases where people 24 have made reports and then a couple days later they've 25 basically taken the report back. We don't have any problem

1 with that. It's not a black mark against anybody for making 2 a report that they decide that they later on decide didn't 3 need to be made.

For those that were made, I could tell when the initial report was made that it was sort of a judgment call. So even then it's helpful, even if it \*urns out to be not be a valid report, to convey the information to us. It stimulates us thinking about a particular item and sometimes we can, as a result of being aware of other things, see where it may have some generic implication.

MR. WEISS: I'd like to make two additional 11 12 points. One is we're sensitive to your concerns. If you 13 have specific issues that you'd like us to address, raise 14 them orally here or submit them on a piece of note paper or whatever, a card, and it's our intent to put out a NUREG --15 15 I believe that's still our planning -- that would be another supplement to 1022 to help further clarify the regulation on 17 18 specific points and achieve a degree of uniformity in 19 reporting.

Another point I'd like to make that I should have made in my talk was that we're sensitive to the abuse of reports. Specifically what I mean is the number of reports in themselves are meaningless. It's the significance of what's being said. What Fred Hebdon used to say many years ago was how many setpoint drifts equal the LOCA. Another

way of putting it, how many reactor water cleanup isolations are equal to a core melt.

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A plant that has 200 reactor water cleanup 3 isolations is not less safe than a plant that melts their 44 core. I mean, it goes without saying. There are so many 5 organizations that blindly count the number of reports, and 6 it's wrong. There are nuclear insurers, public interest 7 groups, even public rate commissions are getting into the 8 9 act and plugging the number of LERs into formulas. It's just not an accurate indication of plant safety. 10

11 You have to read the reports and know what they 12 mean and categorize them based upon their significance, not 13 just the numbers. So we're sensitive to that.

MR. NOVAK: Any other questions?

MR. SHARKEY: Tom Sharkey, Union Electric. You 15 16 mentioned the Supplement 3 to a NUREG and I just had some comments, just to get them into the record. First of all, 17 18 the current NUREG and its supplements focus on 50.73. We 19 would like to see more guidance on 50.72 in any supplement that's added. Along with that, we talked about ESF 20 actuations, or you did. We include as part of preplanned 21 22 actuations those HVAC ESF actuations that are manually 23 initiated to comply with tech specs. I don't know what your feelings are on that. The supplement could get into that 24 25 specific area.

1 I think you recognize that under (b)(1)(5) that 2 for a major loss of emergency notification system, that 3 should not be reported if you have a backup, especially if the licensee is not responsible, and we know that the staff 4 is aware of the problem. Then I noted in some meeting 5 minutes from the Region II workshop, there was a comment 6 made that on Mr. Weiss' list of things that would be nice to 7 be reported, but are not specifically mentioned in 50.72, 8 and there are a number of people at our plant that break 9 10 that out and look at the words given an event and try to fit the words to the event. 11

In the case where that doesn't occur, the rule is 12 13 silent on voluntary reports. If we could have some guidance 14 on when to make voluntary reports and specific examples, that would be helpful. There was a comment made in the 15 Region II meeting minutes that 50.9 could be used. Well, 16 17 that's a report to the Regional Administrator. It also does not, in most cases, get you an LER as would 50.72, 18 eventually get you an LER. 19

We could use a voluntary LER. Again, we have concerns about bean counting. We need some guidance in that area. Those are just some of my comments.

23 MR. NOVAK: Thank you. Question in the back? 24 MR. REPKA: Yes. My name is David Repka, with 25 Winston and Strawn. Two comments. My first is really a

followup, I think, to the previous discussion. I think the first question was very representative of what a lot of folks in the industry are experiencing. They have a rule, two rules really, 50.72 and .73, that are highly prescriptive. It's itemized as a number of different kinds of events and some very specific terms.

As I think Mr. Chaffee pointed out in his talk, a 7 lot of those terms are susceptible to different 8 interpretations and are often difficult to apply in real 9 specific circumstances. So I think on the one hand you have 10 industry out here reading those rules very carefully and 11 looking at whatever guidance exists and trying to apply them 12 13 in specific situations, and then, on the other hand, what I think we're hearing today is think more cosmically, think in 14 terms of significance to your plant, think in terms of 15 significance for other plants and generically. 16

17 It's just a fundamental disconnect. On the one 18 hand, a more prescriptive approach; on the other, one that's 19 much more judgmental and much more -- I'm sympathetic to 20 that approach, that you think, as reasonable engineers, and 21 try to arrive at something that's a reasonable result.

The problem is that's not really what the rule says and I just think maybe we're two ships passing in the night on that point.

MR. WEISS: Can I address that?

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MR. REPKA: Maybe a clean rewrite of the rule would be helpful.

3 MR. WEISS: I'd like to address the two ships in the night. When we're telling you to think cosmically, as 4 you put it, what we're really saying is think of the goal, 5 6 think of where you're trying to arrive at. Then, to use 7 your analogy, we put down specific markers on each side of the channel, as it were, with our examples in NUREG-1022 and 8 its supplements. So that as you're traversing towards your 9 10 goal, you have these specific signposts along the way.

But what we ask is if you're ever lost, don't lose sight of the goal. And the goal is to identify those things that Al Chaffee described this morning; the generic events analysis; to know when we as your regulatory agency need to notify all of the licensed plants of a potentially generic safety item or to respond to your plant in particular because of an event safety-significart.

18 So they're not contradictory. What we're saying 19 is keep in mind the goal and we'll help you along the way by 20 giving you specific markers in the channel. You tell us 21 what guestions you'd like to have answers specifically and 22 we'll try and include them in the supplement.

I should also comment that there is already an
effort underway under the BWR Owners' Group auspices to
develop a new scheme, some additional guidance. I believe

at least in concept we're receptive to that idea. We haven't seen the product yet, so it's a little bit hard to say whether we would accept or not.

But there are a number of efforts along the way to help you get additional guidance. But just keep in mind the goal and even if you don't have a specific marker in the channel, you'll probably get there. Call us when it doubt, and then, if you need three of four days to figure out the event wasn't reportable, call us back and say it wasn't reportable and that should take it off the bean count list.

MR. REPKA: I think that's helpful because I think a great deal of effort is spent on looking very closely at those standards and the relevant guidance, and keeping in mind the goal is always something I recommend that you think about in making a determination under a standard.

However, I guess the flipside of that is something 16 17 that after a good faith determination that it doesn't meet the standard, then you don't want to later end up in an 18 enforcement context because somebody can read the goals and 19 create, in a sense, a wider reporting kind of criterion. So 20 21 it seems like one of those inevitable debates that maybe it will just constantly arise under the rule the way it is. 22 But I appreciate where you're coming from. 23

24 My second point is really, I think, related to 25 this also. I think what I'm hearing and what I see in the

workshops and the presentations is really a fundamental merger of 50.72 and .73. I started with the assumption that bean count is a problem and that there are groups out there counting LERs and 50.72s and making something out of which they're really not.

6 But having said that, I also think that there's a 7 fundamental different purpose between .72 and .73: .72 was 8 something that requires immediate NRC involvement or 9 response, whereas .73 is something more susceptible to 10 longer-term reasoned analysis, the NRC can issue a trending 11 and other kinds of generic kinds of considerations.

12 But what I think I'm seeing is that .72s and .73s are really handled very such the same way. From what I 13 14 hear, it seems to force a lot of things into .72 that maybe 15 don't belong. So in terms of long-term reform, one of the suggestions I think I would have is to try to cross out 16 those things that really require a one-hour or a four-hour 17 18 report in which you call for an immediate response kind of 19 notification.

I noticed in the flowchart what happens at the NRC, that kind of screening is done for .72s and I would just make a comment that maybe all those things that are going into the generic box for longer term consideration really shouldn't have been 50.72s in the first place. I know they may fit the current criteria, but as you think

about maybe reforming the criteria, maybe a structured
approach that designates out those things to report
immediately, it keeps them separate from things that are
.73s. It might help the bean count drop.

Another comment along those lines is we hear that if the media or the public is concerned, the NRC wants to know. Well, that's fine and I think that's a valid concern, but 50.72 doesn't have that standard and there are other ways to notify the NRC. You can tell your resident inspector, a press conference that I would assume the resident inspector would probably know anyway.

12 So there are plenty of different ways of notifying 13 the NRC; voluntary LERs, etcetera; 50.9s. I don't think the 14 solution is to force them all into 50.72s because I think 15 that exacerbates the bean count problem. At any rate, I 16 draw that out for your --

MR. WEISS: I'd like to comment on that last point. 50.72 does require you to notify us of any event or situation related to the health and safety of the public or on-site personnel or protection of the environment for which a news release is planned or notification to other government agencies have been or will be made.

Then it gives an example. It says such an event may include an on-site fatality or an inadvertant release of radioactively contaminated materials. When I spoke to the

issue of notifying us when other agencies are notified, I
was specifically referring to that criterion. I was trying
to clarify that as to what we were looking for. A burned
out light on your cooling tower or a sea turtle on a
traveling screen isn't. But if you're holding press
conferences on steam generator tube leaks, we definitely
need to know about that.

8 MR. REPKA: I don't disagree with that. I think 9 that this -- if the public is concerned, state and local 10 agencies are concerned, the NRC should know and I'm not sure 11 that 50.72 is the proper avenue for all of those kinds of 12 things that would fall into that --

MR. WEISS: Well, it is because we may not have 13 14 the luxury of waiting 30 days before that reporter comes to 15 the Commissioners' assistant and says what about this plant melting. We didn't have the luxury the day that steam 16 generator tube leak occurred. People were hysterical and 17 were calling us about an event and we lost all credibility 18 with the locals because we were telling them we hadn't heard 19 of any such thing. Here the plant is melting in my front 20 21 yard and you don't know about it. What kind of regulatory agency are you? We don't have the luxury of waiting 30 days 22 23 to find out that the locals are upset.

24 MR. REPKA: There are a range of things that the 25 locals are upset about. An example, it's a serious concern,

and I think I'm thinking more when a public citizen decides that something is happening at the plant that may not be happening. That's a concern. It may not exist and, therefore, there may be no basis to report anything.

5 MR. NOVAK: I would like to continue this conversation. Let me just point out, and I think this 6 question has been brought up in different ways. For 7 example, I think it was in Atlanta where people were saying 8 could we at least wait till the day shift comes on to report 9 something. On the back shift, some tests might have 10 revealed that the plant was "outside of its design basis" 11 and it's been that way for ten years, and once the urgency 12 and the one-hour versus four-hour versus a one-day 13 reporting. 14

I think we are going to be looking at the 15 practicality of these kinds of reporting requirements. I 16 think what we're hearing is obviously there's a spectrum and 17 we all want to be sensitive to that spectrum of what needs 18 to be reported in a timely manner. So I think the point is 19 a good point and I think that's part of the reason we're 20 here for the workshop. But I would like to get a few more 21 questions out so that we get as much of a cross-section on 22 23 50.72s as we can.

24 We've only entertained two questions thus far.
25 Yes?

MS. GOODMAN: Lynne Goodman, Detroit Edison. I 1 have a guestion and a comment. Regarding the comment, 2 sometimes 50.9 can serve a better purpose for doing 3 voluntary calls. For example, we need to notify our county 4 whenever we pick up the red phone. So if there's something 5 that maybe we feel the NRC would like to know about that 6 doesn't meet the rule, it would be a lot easier for us to 7 have someone in another department, licensing or whatever, 8 pick up the phone and call the region, let the NRC know 9 about it, rather than picking up the red phone and having to 10 11 make a whole bunch of other notifications.

12 Second, a question or suggestion. I think the 13 criteria that needs the most amplification in the guidance 14 issue is the outside the design basis. I think that one, 15 partly based on cuestions we've heard already, gets very 16 misunderstood and very misused. I really think the failures 17 are more supposed to be considered under the system not 18 being able to do its safety function.

Outside of design basis is really looking at the plant, a plant outside of its design basis, not to the plant no longer can fulfill its design function.

MR. ROSS: I'd like to find out, as an example, what do you do, what does your company do. It's Saturday noon, you're starting a three-day weekend and General Electric calls up and said, oops, we had a plus instead of a

minus and your ECCS limits are wrong, we've had to 1 recalculate your linear heat generation rates. If you're 2 running the way you have been running, you'll exceed 2200 3 given design basis LOCA. 4 What do you do? With respect to the NRC, what is 5 your first step? 6 7 MS. GOODMAN: Well, the first step is to try to get a feel for what the problem is. 8 9 MR. ROSS: Yes. MS. GOODMAN: If it's a problem that we're going 10 11 to shut down our plant --MR. ROSS: The problem is that they goofed, made 12 the wrong sign. This is not hypothetical. I don't know 13 about GE or your plant, but vendors have been doing this for 14 15 some years. It's just a calculational error and it went 16 over 2200 if you keep running that way. 17 MS. GOODMAN: I think our first responsibility is 18 to decide whether or not we're running our plant safely; then decide what does this phone call mean; are you telling 19 us it's not safe to run our plant, are you telling us you 20 21 made an error that you don't know what the effect is, it's 22 actually not safe to run this plant. Then basically we'd be starting to shut down and calling the NRC. 23 It's a very -- type of situation, found an error 24

in our computer code, we don't know what it means, we want

to do some evaluations and figure out what does it mean.
There will be all sorts of spectrums as far as when an
engineering type problem comes up as far as we would jump on
tit right away and we know what it means or do we need some
time to evaluate it.

6 MR. ROSS: But is this the outside-the-design-7 basis example that you were talking about?

8 MS. GOODMAN: That was not the particular example, 9 but it would consider being in that situation and reportable 10 under that situation. If we're in a situation where we 11 can't safely shut down or safely operate the plant, that's 12 outside the design basis.

13 MR. ROSS: Okay. Thank you.

14 MR. NOVAK: We've had several comments regarding a 15 more workable definition of what constitutes outside the 16 design basis and on what timeframe need to be reported. 17 We've seen a lot with plants beginning reconstitution 18 reviews in the sense that they've identified things, and 19 certainly we want to encourage that kind of work.

20 So we're looking at how we can best accomplish 21 obtaining the information that we think we need, as well as 22 encouraging you to look hard at the design of your plant and 23 when you do identify something that is different than what 24 was in the safety analysis report, that it needs to be -- we 25 need to know about it. Not necessarily just for your plant

alone, but, again, as potentially a generic issue that needs
 to be disseminated within the industry.

We still can take a few more questions.

MR. PETERMAN: Kirk Peterman from Dresden. I have hopefully a relatively simple question on inadvertant criticality. We do local shutdown margins at the beginning of the cycle. These shutdown margins are supposed to be subcritical checks. However, we realize that the margin to criticality is slim and cocasionally you could get the critical.

11 It's something that we realize could happen 12 easily. We consider that anticipated, but the calculation 13 would show marginally we should not go critical. Should 14 that criticality be reported under an inadvertant 15 criticality?

MR. NOVAK: Any volunteers?

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MR. ROSENTHAL: As somebody who used to do 17 criticality calculations, the industry gets pretty good at 18 this point about predicting criticality. You expect to pull 19 20 to within just a few notches of predicted value. If you're way off, yes, and you didn't have a prompt excursion, but if 21 you're surprised because you're off and let's say the notch 22 23 is polled relative projected or critical boron concentration, there's no reason why this industry should be 24

25 off by one percent reactivity any longer.

So if you are surprised at the difference between what you got in your plant and the engineering analysis that made that prediction, then I think we'd want to hear about t.

5 MR. SHARKEY: Tom Sharkey, Union Electric. Along 6 with that, let's say that I get to the point where I 7 anticipated criticality and I'm way off, but I hadn't 8 reached criticality, so I back down, stop the shutdown, and 9 I recalculate. Is that in the same category or is this not 10 a reporting concern?

MR: ROSENTHAL: Well, yes. It's been reported. Do you discover that there's a basic flaw in the way you're doing the engineering calculations? Do you discover that there's a systematic problem in the quality assurance, that the error was made and that you're way off, you never reach criticality because your engineering groups weren't speaking to each other?

18 What was the underlying reason for the problem. 19 That's what has to be assessed almost on a case-by-case basis. Similarly, with the question on, well, gee, I'm off 20 by five pounds in my design basis, value of the pressure 21 allowed in a piece of pipe, was it a round-off error in a 22 23 calculation that you were re-reviewing under a design basis reconstitution effort, or did you find out that there's a 24 25 new scenario that nobody had thought of before, but it only

brings you to five psi greater than some other thing that
 you knew about.

Is there some system interaction that you have now discovered might take place that you hadn't anticipated before even though you're only five psi greater than that piping pressure? I mean, those things are going to affect whether it should be reported or not.

8 MR. NOVAK: If you had made that report -- since 9 I'm aware of exactly what you're talking about, having 10 occurred in another plant in Region V, that would have 11 stimulated me to ask the question we've had a lot of these 12 occurring in the past several years, is this something we 13 need to take a look at.

14 So if you make that kind of a report, you're going 15 to get that type of a review to try to decide if it's 16 something that's unique or does it have a generic 17 implication, maybe we need to focus on it a little bit more. 18 I don't know if the rule requires you to make it, but if you 19 make it, you may be helping us try to discover something 20 that has some generic implications.

21 MR. HARRIS: Ray Harris, `ennsylvania Power & 22 Light, again. The discussions I've heard talking about 50.9 23 use, first let me preface this by saying I concur; 50.9 is 24 not a substitute for 50.72 or 50.73. It does not 25 substitute. We have lowered our threshold for 50.9 based on

discussions with region and NRR and we are making a lot of 50.9 reports today.

3 Based on our belief that some of these things do not reach the level of 50.72 or 50.73, but that, in fact, 4 they do meet the goal, that cosmic goal of keeping NRC 5 informed of something that may have generic significance 6 somewhere else. We believe that's appropriate. We do in 7 some cases again report this as 50.72/50.73 as these design 8 9 basis reconstitution type things reach a better understanding. 10

I guess this is more a comment than a question. Because we do put all our 50.9 reports in writing, I think it alleviates some of the concerns you might have about 50.9 reports being made just to the region. We've made a decision internally to start sending chese things to AEOD because we're not sure they're getting there promptly.

Well, 50.9 obviously is a lower threshold than 50.72 and 50.73. Therefore, a lot of these things that are tough calls we are meeting the obligation of keeping you informed by using 50.9.

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MR. NOVAK: Question?

22 MR. GALLINA: Charles Gallina, Illinois Department 23 of Nuclear Safety. First, just a statement to calibrate my 24 question. An LER concerning inadvertant criticality to the 25 NRC and to the utility may mean one thing, but when the bean

counters start counting up their LERs and the public is told that a utility has experienced an inadvertant criticality, it means something else altogether. Basically, the bottom line of our threshold is 50.72, maybe a little lower, 50.9, but we stop there.

6 There have been recent efforts to adopt the 7 nuclear events scale on an international level, which I 8 personally believe a lot of the NRC's reporting requirements 9 could be integrated into it, and would take us below the 10 50.9 threshold all the way down to the "anomaly," maybe as 12 low as the burned out light in the cooling tower.

12 The MRC has decided not to cooperate, not to 13 integrate, not to use the international nuclear events 14 scale, and I was just going to ask what type . thinking 15 went on before that decision was made and do you feel that 16 had we done that, would it have given the public a more 17 realistic idea of what actually goes on in nuclear 18 operations?

MR. ROSS: The scale, if you what you meant, is sometimes called a severity scale. It's one that's being issued as a trial basis by the International Atomic Energy Agency. Recently, Mr. Jordan sent out an information package to all the licensees on this topic and it should have filtered down to many of you by now.

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It's not strictly, too, that we're not cooperating

because we have gone to several meetings and explored with people the various facets. It's certainly true we're not participating in the trial use, as are some other countries.

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We felt that the present four-tier system of 4 emergency notification from unusual event up to general 5 emergency and how deeply it's embedded into the utilities, 6 into the state and locals, into the other government 7 8 agencies, was a sufficient basis to handle the various classes of emergency events. And going to another scale 9 would mean having, at least for a long period of time, two 10 11 sets of scales.

12 The one-to-seven system that's in the severity 13 scale under the IAEA, it's real ; zero-to-seven because 14 we're seeing a lot of classifications from the countries 15 using it as a type zero, which is obviously less than one. 16 It would be -- it's more than the light bulb falling off the 17 cooling tower, but it's events below a Level 1.

As I recall, roughly speaking, one, two, three is the stuff that's on-site, and then you start, as you're making the transition into four, five, six and seven, increasing severity. I forget whether Chernobyl was a six or a seven. Do you remember, Eric?

MR. WEISS: It was a seven.

24 MR. ROSS: It was a seven. And I think TMI was a 25 five, tentatively. Mainly the reason that we didn't want to

switch over, we didn't want to upset what we thought was a deeply rooted system now where everybody understood event classification. Obviously, we're following it. We continue to go to meetings, exchange correspondence.

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As far as the decision process, this went up to 5 6 the Commission and the Commission fully understands the purposes I just gave you, so it is not a unilateral office decision. Did I get all the guestions? I didn't write down everything.

10 MR. GALLINA: Just one more followup question, 11 then. If we accept and keep the present system, is there 12 any way of adapting the system further down to include the equivalent of the one, two, three types of notification 13 14 levels or problem levels that that nuclear event scale does address? 15

16 In other words, go down through your general site, alert, unusual, your 50.72s, your 50.9s, and maybe create 17 another area where the public and the media can get more 18 involved and understand that simple problems do cour and 19 20 the first thing that the utility reports is not an inadvertant criticality. 21

22 In other words, if you don't want to confuse anybody, how about adapting the system that we have and 23 extend the bottom threshold to cover events that the media 24 25 and the public can understand. And then when the bean

counters stant counting them, the absurdity becomes obvious. That sort of takes a little bit of steam out of their impact.

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MR. ROSS: I understand your point. We were doing a little noodling. As a matter of fact, I think it was on 5 the back of a menu at night in Region I, about the relative 6 probabilities of the four scales that we have and the 7 relative probability that the site emergency is -- I don't 8 have much data -- it's about .1 per year. The alerts could 9 by any be eight or ten per year, but maybe with some changes 10 it might be less. But even so, there may be a decade or so 11 more likely, maybe two decades more likely. 12

13 The unusual events, we get a couple hundred a 14 year, something like that. The general emergency, there's 15 not too much experience. but there seems to be on the order 16 of one or two powers of ten between the scales. In other 17 words, the four event scales seem to be roughly separated by 18 about the same amount. So we don't have two crowded 19 together and then the other two crowded together.

The unusual events, the 200 or so a year, is there something more frequent, but less worrisome than those 200. I don't know what they would be, if that's your point. The criteria for an unusual event, maybe we have too many of them per year. I don't know. That's roughly one or two per plant per year.

Just as an example, last Saturday, three days ago, at Crystal River, there was unfortunately a fatality. A person fell in the reactor building and somewhere in the process was contaminated, was taken to the local hospital, whereupon he was pronounced dead. That's an unusual event. Should it be? I don't know. We can talk about it all day. I don't know --- certainly the NRC wants to know about it. Certainly there will be press attention.

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9 Depending on the press, you can imagine all sorts 10 of headl. as. But is that really a severity item? Is that 11 an item that could be called an emergency? In and of 12 itself, it's a really borderline case. Was that your point?

MR. GALLINA: Well, I think the point in that case 13 14 is what professional educated people would consider a 15 severity level or a significant event, and what is perceived by the general public as a significant event are two 16 17 different things. If educated regulators come up with a 18 system, it has to be able to be understood and perceived by the general public, or else the NRC or anybody else who is 19 20 involved in regulation or support loses their credibility.

When a person dies at a number power plant, we may see it as having absolutely nothing to do with reactor safety or reactor operations. But it is a radiation worker was killed at the Crystal River Nuclear Plant. That takes on a whole different meaning and importance to Mr. and Mrs.

Joe Smith who live in Miami, Florida.

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I think that we should have criteria that at least 2 we are alerted about everything, if it's on a voluntary 3 basis or not. I just think we stack our notification 4 criteria a little bit too high. It's all right for the NRC 5 and those educated regulators, operators, and people of 6 certain communities, but it does not get down to a level 7 where it really courts, and that's the level of the general 8 public understanding what's going on. 9

MR. ROSS: At the risk of prolonging it, let me finish it. I did discuss this very topic with some key regulators in Europe as to why they liked and wanted the severity scale from the IAEA, and their main desire in accepting it was to get proper attention from the media, not too much and not too little. Just like Goldilocks eating the oatmeal.

I hope we never do that. I think the four-tier 17 emergency system is to properly assist the utility, to 18 properly advise and inform the local and state people, the 19 other Federal agencies that we deal with, to cope with 20 whatever level the emergency is. If we pander to the media, 21 then I think we're making a gross mistake. Sure they've got 22 to be informed, but to let the media interest dictate 23 emergency classification, I think, would be a gross mistake 24 25 and I hope we never do it.

MR. NOVAK: Okay. We have a guestion.

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2 MR. MARROW: Mike Marrow from the D.C. Cook Plant. 3 A question about the design basis issue. Could I use tech specs to give me an indication of the significance being 4 5 outside of design basis? For example, post-accident 6 instrumentation tech spec says I can live without an 7 instrument for 30 days. Does that mean I -- could I -- does 8 that imply that I could say I really don't need to make a 9 one or a four-hour phone call if I've got 30 days by tech 10 specs? Can I use that as kind of a guidance for people on a 11 back shift to make those notification calls?

12 MR. ROSS: Do you have an answer? I don't have an 13 answer. Do you want to answer it, Novak?

14 MR. NOVAK: I considered that a good comment. 15 These are the kinds of things we want to know about. These 16 are good ideas. Our immediate reaction is we don't want to 17 be speaking out of both sides of our mouth. If we've thought long and hard about what needs to be reported, on 18 19 what timeframe, and what systems have to be operable, and 20 you know as well as I do that tech specs take you well over 21 a year to get through as part of the licensing process.

22 So we've done a lot of thinking about it. We 23 would tend to lean on that kind of judgment in terms of 24 making a decision as to whether or not it could fall under 25 it. But we need to have that opportunity to talk about it.

So I think you've got a good point there.

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Before we entertain one more question, I'd like to let Ed Greenman have a chance to just add a comment on this inadvertant priticality issue. Ed?

5 MR. GREENMAN. From the number of questions, I 6 want to make sure that I understand your question and I will 7 also give you a response.

The word "inadvertant criticality" and "premature 8 criticality" does not mean the same. There are those who 9 10 have tried to use them interchangeably. They are not interchangeable. If I understand the comment from Dresden 11 with respect to shutdown margin testing and the action that 12 13 resulted from shutdown testing or is anticipated to result from shutdown margin testing, if evaluated by reactor 14 15 engineering, if anticipated, if controlled, that is not an inadvertant criticality, it is not a premature criticality. 16

11 On the other hand, if that action, whatever it is, involves a reactor trip, unanticipated thing, then I believe 18 you're obligated to report. With respect to Callaway's 19 20 question and missing ECPs, if, in fact, it's a significant deviation, you may have a hot core, your reload analysis was 21 22 wrong, historically all Region III plants have reported that with a departure from, major departure from estimated 23 critical positions, and you've already taken the action to 24 take your plant back down to analyze yourself. 25

So we would anticipate a report to the Commission in that event. Does that answer the question, both sides?

MR. SHARKEY: Let's say I'm a shift supervisor in your case for Callaway and I call the gentleman on the emergency notification system and he's doing his checkoff and he says, oh, by the way, what paragraph are you reporting this under, and I say I don't know, let me call the day shift guy in licensing and find out.

9 Is it voluntary or what? I'm looking for some 10 help here.

MR. WEISS: Frankly, it's not important. Our goal 11 is to know about it. And if you don't know the paragraph 12 that it's reportable under, nobody is going to make an issue 13 14 out of that. I don't know if Ed Greenman agrees with me or not, but I'd bet my bottom dollar that you'll never ever 15 get a civil penalty or a cross word out of the region or 16 Headquarters if you don't know the paragraph that something 17 is reportable under and you report it. Right, Ed? 18

MR. GREENMAN: I will fully agree with that.
MR. NOVAK: I'm going to propose that we have one
more question and then we get back on our agenda. Go ahead.
MR. NALEPKA: Dave Nalepka, Wisconsin Public
Service. One of the questions and answers in the NUREG has
to do with reporting of ESF actuations, inadvertant ESF
actuations. The answer to that question says if a system is

not required to be operable by tech specs and it's been properly removed from service such that it cannot perform its function, it need not be reported.

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I guess I'd like to have you consider the situation of a utility that conservatively keeps a system in service below the requirements of tech specs and for some unknown reason has an inadvertant actuation, that utility is forced by the regulation to report it, where the utility that non-conservatively or is allowed by tech specs, takes it out of service below those requirements, would not have to report it.

12 I think some of the utilities are unfairly being 13 required to report it for taking conservative actions. I'd 14 like you to consider that in the supplement. Thanks.

MR. NOVAK: Thank you. I'm going to get us back on our agenda. The next discussion has to do with 50.73 and Jack Rosenthal is going to make that presentation.

18 MR. ROSENTHAL: We are well aware of what I call 19 external influences on the utilities which make one question 20 the need to report things that happen in your plant. And 21 that may well be true. We have to revise our -- we're 22 considering how we can revise 50.73, but we also need to 23 have a reporting system.

24 Everyone in this room clearly knows about Three 25 Mile Island and everyone probably knows about the Davis-

Besse precursor to Three Mile Island. But there was another event in June 1975 at Oconee which involved steam voiding in the candy canes following a reactor trip and it opened PORV, and the block valves were rapidly closed by the licensees --by the operators.

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6 Those values at one point were reopened and then 7 reclosed again because the operators didn't understand that 8 they had started to pull a bubble in the upper candy cane 9 and that the pressurizer level instruments weren't giving 10 them proper indication. Of course, we know about the 1979 11 TMI event, but there was another event at TMI involving 12 problems with their condensate polisher.

Now, fortunately, here there wasn't fuel in the 13 14 reactor. It was pre-op hot functional testing. But they ended up with a condensate polisher problem, resins all over 15 the place, lost their nuclear closed cooling water system. 16 17 When they lost that CCW system, they lost reactor coolant pumps and high head injection, and they ended up with a 18 steam bubble in the candy cane and erroneous pressurizer 19 level indications. 20

It took them several days until they finally pressurized the pressurizer with nitrogen, pushing cold water through the system back up and condensing the voids. I don't know that we would have avoided the Three Mile Island accident if we had known throughout the industry of

these two prior events.

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I am not saying that we're so smart that we would have recognized the implications, but it sure would have helped if that information was disseminated. So as we talk about how to change the reporting requirements and perhaps 5 make them less onerous, less burdensome, let's not forget 6 7 about why they're there.

That's the kind of information that drives the TMI 8 action plan of May 1980, which establishes an analysis and 9 dissemination of operating experience. That's Item 1(e)(6) 10 11 of the action plan. Every licensee here, I believe, is bound by that. We have embodied in the AEOD charter the 12 mission of collecting and disseminating operating 13 14 experience, the Rogovin committees, Kemeny committees have all recommended collecting and evaluating operating 15 experience, providing means of disseminating that 16 experience. 17

18 Before 1984, which is the current rule we're dealing with, reports were provided to us via tech specs, 19 20 Section 6, Reg Guide 1.16, LCO entries. We got a lot of LCO entries, setpoint drift, a lot of reporting noise. So the 21 current rule does set a higher threshold, but I think a 22 better threshold. 23

In 1980, we had an advanced notice of rulemaking 24 25 in which we proposed an integrated operational experience

reporting system. I think it's interesting to revisit that. That was to be a system which would get system level data, train level data, and component level data somehow reported. Well, what happened to that? On the component level, we went to NPRDS, which, as you know, is now managed by INPO, and that system has improved over the years. I know we're users of it and I trust you are.

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System level data really ended up in 50.73. So 8 9 that sets a high threshold of system failures. But notice in the shuffle here we lost train level data. All train 10 level is not the same, of not equal safety significance. 11 12 But in our consideration to change the rule, to get rid of 13 onerous and perhaps unneeded information, I submit that now 14 is a good time to also at least be thinking about what we do 15 want to collect and what form we might best collect that 16 information. So it goes both ways.

17 The LERS are a primary source of event data for 18 the NRC, for AEOD. We supplement that information with 19 NPRDS. Be aware that operational experience in the form of 20 LERS is broadly circulated within the NRC. INPO gets it, 21 the public gets it on request, contractors to us use that 22 information in the course of our studies, academicians have 23 asked us for that information.

So it's nationally used. It's also
 internationally used, although not directly as LERs. We

will send into the incident reporting system, the
international system, we tend to send them evaluated
products, INs, bulletins. generic letters, AITs, IITs,
rather than raw LERs. AEOD studies clearly go into that
system, which is a summary of many LERs. We believe that
that's more useful than a raw LER. But those LERs make up
the database for those studies.

We read every LER and we try to grade or classify 8 every LER in terms of what action we have to take. The 9 action may be, from an AEOD perspective, well, the region is 10 all on top of it and we perceive it as plant-specific, so 11 we'll let the region take care of it; or, my gosh, we've 12 just issued to INs this year on that very same topic and it 13 looks like we're getting this LER because the licensee was 14 looking at his plant, perhaps, but not necessarily spurred 15 on by that IN, and now he's finding the same problem, too; 16 well, we don't have to take any more action now because the 17 feedback process appears, in fact, to be working. 18

19 Then we find new issues that we choose to look at 20 it. In fact, we probably -- ten to 20 percent of the LERs 21 that we read get direct further followup action of some 22 sort, and the others go into a database. That database is 23 useful. We have a system called sequence coding and search 24 system. It's a causal and temporal database. I think it's 25 the best one that I know of. We seem to be able to find

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records that industry can't or INPO can't cither.

It's the one database that I know of that allows 2 you to ask questions like I want to know about aux feedwater 3 failure following the reactor trip, or I want to know about 4 5 a control room isolation leading to something else happening, or did HPCI go on first or after diesels, all the 6 key work systems. Sure you could search on give me all the 7 records with HPCI and trip, and you get a dump of them. 8 Maybe that -- rather than this causal and temporal system. 9

That's government property. You're helping pay 10 for it. You can get access to it, too. Just give us a 11 call. I have another bullet there called licensee 12 13 perspective, and I think it's really the wrong bullet. It probably is my perspective of your perspective. 14

15 That is that from my perspective, and I think we 16 understand some of the pressures that you're under, there's a drive to reduce reporting that doesn't meet the strict 17 letter of the moorting criteria. We're concerned because 18 19 we're worried about system interactions, about steam in candy canes, about intersystem LOCAs, about new and novel 20 sequences, and are worried that those external pressures 21 will drive down that reporting system, and that is not in 22 your interest and it's not in our interest. It's not in our 23 joint goals. 24

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So I, too, say let's not let what somebody in

Region I called causestrate drive our what I tend to call medieval scholasticism, drive our looking at do you have to report this event and not that event, but let's let our engineering judgment guide those veports.

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As you know, now there's guidance in NUREG-1022, Supplement 1. We clearly have to put out new guidance for 50.73 and I think that the point on 50.72 is well made. When that guidance is insufficient, and we do this all the time, your first step is your own resident inspector and the region for feedback.

If that doesn't work, case-by-case, AEOD and NRR 11 field questions. A lot of them are on the telephone and 12 13 verbal. From time to time, we issue written guidance to specific licensees. We're perfectly willing to do that. A 14 while ago we tried to evaluate LERs and, in fact, we did a 15 study from 1985 to the end of Fiscal Year 1987 where we were 16 17 looking at the quality of those LERs. We had a scale of one to ten, several fields. We were looking at did you have an 18 19 abstract and was the abstract representative of the LER, what did you report in the LER, etcetera. 20

What we saw over time was that in terms of LER quality, in terms of the facts, they were really pretty good. The majority of them were eight or nine on a scale of one to ten. So we're satisfied with the technical quality of those LERs. So I commend you for that.

We're now interested in -- we've always been interested, but I think we're more interested than ever in human factor aspects. I do know that in the LER Rule 50.73, Part B, where it describes how to report, given Part A says what to report, that we do ask for information on operator response, on cognitive error, on procedures, perceptions, etcetera.

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8 Let me just remind you it's in the current rule. 9 I think that that's an area where there is some weakness and 10 I would encourage you to report more in that area.

How do we use LERs? Our research group uses event reports in generic issue evaluation. For example, pump seals or diesel generator reliability. NRR, you've already heard discussion, generates ~eneric communications such as INS, bulletins and generic letters, often spurred by those LERS.

We have a large OE feedback program and we also 17 use them for performance indicators. Since we all got PCs 18 on our desks, it's fun to make up little drawings. So I'll 19 talk from the slides while you can look at the little 20 pictures. I wanted to talk about how we do a study, and 21 that is that we find an event, it's either a 50.72 or a 22 50.73 that gets us interested. We'll promptly search -- so 23 we've read that LER and we've decided that it warrants some 24 25 study.

The first thing that we'll do is hit our own PCs which connuct us up to a bridge and we'll do searches where there are like events of interest, where those events -- so is this an isolated case or is this a global case. Let me stop right here.

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6 The service water study which comes out of my 7 branch is based on a lot of data. So it's a data-driven 8 type study. On the other end of the spectrum, LaSalle power 9 oscill: ions, our branch led off on that issue. One event. 10 So it will either be the safety significance or the richness 11 of the data that drives us to study further.

12 One thing we'll do very early on is look at indices that we have of generic communications and say, gee, 13 14 did . already provide feedback on that issue and if we did provide feedback, can we tell from data whether things are 15 getting better or worse. We'll look at -- we'll use NPRDS. 16 17 We use the sequence coding and search system to pull out LERs we want. We try very hard to integrate our work with 18 INPO such that we're not duplicating SERs, SOERs, and other 19 databases; do plant visits; go to vendors; look at the 20 21 foreign event database; tall to people.

Let me give you an example of the importance of the foreign event database. In the LaSalle power oscillation, we had one event and we found no other domestic events, but we did find some foreign events. That tends to

be a database of higher threshold issues. We didn't find a lot, we just found a few more, but at least, in my mind, the decision to pursue that issue very much hinged on a was this a one-in-a-thousand reactor year thing or had there been others. And when we found other similar oscillations, we said, wait a minute, we really do have an issue here.

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7 So even though it's a small database, it's a very important database. Then depending on what we decide to do 8 9 with an issue, we may send it out for peer review, we may not. Engineering evaluations that lead to INs. We write, 10 11 receive a lot of management review. They're reviewed both 12 by AEOD and NRR. On the other hand, we just completed a 13 draft study on solenoid operated valve problems. That went out to peer review, to INFC, NUMARC, EPRI, ASCO, AVCO, lots 14 of licensees to get review comments. 15

And we briefed the ACRS once on that issue. I'm not sure how that issue will go, but if it goes in the form of a bulletin or a generic letter, which it may or may not, but if it does, then it will go through CRGR, and you heard yesterday's presentations. May I have the backup slide, please, the triangle? I have two backup slides.

This is a typical product. At the time we did the study, we had about 30,000 LERs in our database. Remember just a little bit earlier I said ten to 20 percent of those LERs we consider important enough to immediately pursue and

the rest go into a database, and you heard similar comment about 50.72. They are not forgotten. When we decided to do the service water study, we found about 1,000 events in that database which related to service water.

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Now, maybe it was a reactor trip and incidental to that reactor trip was a discussion of, oh, and, by the way, one of my two trains of service water didn't work, but all that had been captured in those databases. So what may have been a seemingly insignificant event at that time was properly stored and then ultimately retrieved.

The first thing that we found was that of the 11 1,000 events, it was spread over about 80 plants. Now, 12 that's a few years ago, that study, 1988 study, that was 13 almost every plant. We carved out 276 events that we 14 thought were more significant at 60 plants, broad industry 15 problem, and those are discussed at least in the appendices 16 of that report, and then there's 29 actual events starting 17 from the 30,000 that are described one-by-one in the report 18 19 as being representative and the ones that we thought the most significant 20

What happened to that? We wrote C-801 which is an AEOD case study in 1988, went out for peer review. We went through a peer review process, a reconciliation process, issued it in final form, ultimately went to CRGR. There had been parallel efforts in research on generic issue

resolution related to cooling water systems and between the RES efforts and the AEOD efforts, Generic Letter 89-13 was issued, and everybody in the room, I'm sure, has had to respond to that generic letter.

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So that's a typical data-driven study where it's 5 the preponderance of the data that drives the effort. The 6 7 next one on Rancho, just to give you the other end of the spectrum, it's good to talk about Rancho since they shut 8 down. They had an overpressure -- they oversped their 9 auxiliary feedwater system, steam-driven aux feedwater, and, 10 11 in fact, the governor had been modified and it used to spin two ways and then was modified till it only spun one way, 12 and had been mounted wrong so that the governor no longer 13 14 functioned.

15 We ended up writing a small engineering evaluation of that particular event in which the steam-driven auxiliary 16 17 feedwater turbine had oversped because we saw that the 18 resultant overpressurization of the piping, the discharge piping, could, in fact, represent a potential system failure 19 and we saw that there were some ways, operational ways of 20 typically opening and closing valves such that one train of 21 22 that -- single trains could be tested one at a time without 23 endangering the whole system.

An IN came out of that work, IN-9045. Just representative of products which are single-point or a few

number-driven and, of course, in this case you could see that there's an IN to alert industry to do something, in this case resulted in a generic letter. I can't make that universal rule because clearly LaSalle, very few events also resulted in requirements.

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6 Next slide, current issues. I think I've covered 7 the material. Let me just harp on just the point that we're 8 here to collectively share operating experience and to have 9 an operating experience feedback program, and that program 10 is embedded in safety. And as we look at ways to change 11 the rule, let's not forget what that goal is.

12 Next slide, current issues. We think that there 13 are missing reports that we ought to be getting or we find 14 out that -- you've heard a fair amount of that this morning. 15 I think that we understand the pressures on you between the 16 external to the NRC entities, as well as things like our own 17 performance indicator program.

We also recognize that there were reports of low 18 safety significance and clearly there are, and we'll be 19 discussing those this afternoon. The challenge is how to 20 21 get rid of the reports of low safety significance which cost us Federal dollars to collect, read, store, archive, 22 etcetera, and you, I think, more money to generate that 23 aren't being used, and yet to capture the TMI event that I 24 described to you at the beginning of my talk which did have 25

safety significance even though it was pre-op and no fuel in the core.

3 It's not a simple task. We clearly need an improved approach. I see two efforts as feasible. Near-4 term, it's easy for us to refine guidance as a NUREG 5 Supplement 3, Supplement 4, whatever, because that's well 6 within our doing. Longer-term effort going to rulemaking, 7 8 changing the rule, we're thinking about how to go about that. There is consideration all the way up to just a plain 9 10 total reassessment of the requirements as the long-term 11 approach.

Because of the time it takes to go to rulemaking, the impact of rulemaking, the impact on us, and even more important the impact upon you of changing rulemaking, I don't think that we should do this as a frivolous task, but rather be asking what kind of information do we need to suffery in 1995 to the year 2000, and that should be the goal of that reporting system.

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Thank you.

20 MR. NOVAK: Thank you, Jack. We're about ready to 21 take our lunch break. Can we get back in an hour and 22 fifteen minutes, or maybe even an hour? Let's start at 23 1:00. Thank you very much.

24 [Whereupon, at 11:50 a.m., the workshop was 25 recessed for lunch, to reconvene this same day at 1:00 p.m.]

## AFTERNOON SESSION

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## [1:05 p.m.]

3 MR. NOVAK: Let's have Jack Crooks, who is in the Trends and Patterns Branch of AEOD, give you a few kinds of 4 insights on what we've been seeing through 50.73 reporting, 5 and some of the short-term plans we have with regard t. 6 7 possible changes in the reporting requirements. Jack? 8 MR. CROOKS: As Tom said, what I'll do is try and 9 give you some background information that will aid in our 10 discussion later on what's been reported in the LERs in 11 1989, in a general quantitative sense, as well as under what

12 criteria things were coming in. I'll also then cover some 13 of the items that staff has considered in the past and that 14 we have under consideration now regarding rule changes to 15 event reporting, guidance, new guidance, a new guidance 16 document and things like that.

17 The information that I'm using, if you are 18 interested in more details, one AEOD Annual Report, NUREG-19 1272 contains more summary information, as well as detailed 20 information on what's been reported in 1989. What I'm using 21 is coming from the same data sources.

The information that will be shown, of course, covers events, as well as conditions that were reported. It represents a broad spectrum of the types of events and conditions. Individually, each report has to be assessed

1 for its safety significance and whether or not there's a generic concern.

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I've got some pie charts and tables. These things 3 4 do not represent, again, the results of any analyses. So I 5 think if we can go the first slide with the pie chart. This slide merely represents the distribution of LERs that were 6 received based on the various reporting criterion 50-73. A 7 few items worth noting are that two of these criteria 8 9 accounted for about 80 percent of what was reported.

They are the engineered safety features 10 11 stuations, 39 percent, and the items that were related to tachnical specifications. Those are completions of plant 12 13 shutdowns, operations prohibited by the tech specs. The reports related to preventing the fulfillment of a safety 14 function accounted for about ten persent. Reports related 15 to the plant being in a degraded condition or in an 16 unanalyzed condition or outside its design basis represented 17 18 about nine percent.

Reports on common mode failure covered about three 19 percent. Internal and external threats combined were less 20 21 than one percent. There were no LERs that addressed airborne or liquid releases that exceeded the reporting 22 criteria for 50.73. In 1989, there were about 2,375 LERs. 23 24 Now, I'm using numbers. We're trying to stay away from the use of numbers, but I think it's important in what we're 25

doing to give you some idea of the overall quantities in the areas we're looking at from a possible rule change standpoint.

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The next slide sho information on ESF actuation reporting by the system involved. The display is based on the percent of the total actuations reported in the LERs, not in the number of LERs. On average, there was about 1.7 actuations per LER, per ESF LER. Some additional points of interest was about half of these events occurred during operations. About 30 percent were occurring during testing. The remainder were predominantly during maintenance.

The overall trends in these directions have been 12 such that operational events are decreasing. Diesel starts 13 accounted for about seven percent, but, as has been 14 mentioned previously, we know this is an area where there's 15 inconsistent reporting due to some plants not having their 16 diesels classified as engineered safety features. The 17 original intent of the rule was to bring in emergency power 18 system starts. 19

The other thing I might point out is that the reactor water cleanup system isolations in BWRs and the control room emergency ventilation system isolation actuations are two areas where we focused some attention towards changing the criteria through a minor rule change. To give you a better feel in this area, in 1989,

the data for ESF reporting where there was not a reactor 1 protection system associated with the event, there were 2 about 609 LERs and about 1,358 actuations. Of these, 432 of 3 the LERs addressed single events, single system actuations. 4 Of these 325 wore invalid or unneeded, and by that I mean 5 that the measured parameter was not reached, the setpoint 6 wasn't reached. They were due to other causes, such as loss 7 of a power supply, personnel errors, some other reason. 8

9 I also have listed then for HVAC systems, the ones 10 that involved single system, there were 158 LERs, 132 of 11 which were unneeded. In the reactor water cleanup system, 12 there were 48 LERs, 34 of which fell in the unneeded 13 actuations category.

This slide shows a further cut of the single HVAC 14 system ESFs by area and by vendor, and it mainly is just to 15 show that the control room and control building -- give you 16 a feel for the control room and control building. Seventy-17 seven of these LERs were specifically associated with 18 control room vent system isolations. Again, 66 of these 19 were for reasons other than the measured parameter being 20 reached. These are the ones that we are again considering 21 for possible elimination through a minor rule change. 22

23 This slide just gives you a rough cut of a
24 breakdown of the technical specification violations being
25 reported, which are yeally things that are prohibited by the

tech specs. In a general sense, there have been about 1,000 of these LERs in 1989. About three-quarters came in under events that were related to exceeding the action statements in an LCO or some other operational limit. They have been cooling down too fast or something like that.

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Most of the other events had to do with not being 6 surveillance requirements, not conducting surveillance 7 8 tests. Now, reporting in this area, I think we all recognize there will be some effects from the technical 9 10 specification improvement program. Some of the things that are being done in that are surveillance testing that doesn't 11 12 belong in the tech specs is being removed and some of the 13 existing action statements are going to be changed. I guess some probably may be shortened, but others will be 14 lengthened. So there will be an impact on event reporting 15 16 as a result of the technical specification improvement 17 program.

At this point, I'd just like to mention some of 18 19 the discussion, and I think Jack mentioned this earlier, was focusing on there are a number of things that are being 20 reported that are individually of low safety significance. 21 22 Jack mentioned, he gave you examples of where collectively 23 we are collecting the information and these types of events are providing information for broad generic studies and the 24 25 operational experience database.

What we're trying to do is focus on how to draw the fine line that we would all like between what's reportable and what's not reportable. Some of the existing criteria, there is a fine line if you have a reactor trip from power, there's not much question that's reportable.

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6 In reality, some of the other criteria, as we've 7 talked about earlier, involve engineering judgment. So 8 there is a band, there is a gray area. What we will be 9 doing is trying to narrow that but through the issuance of 10 guidance, new guidance.

11 What I will do is now address some things that were done in the past. The first item has been mentioned 12 before and you're probably all familiar with it, but the 13 NUREG document, NUREG-1022 documents are the main source for 14 guidance. Those documents, plus the background for the rule 15 in the various associated Federal Register Notices are what 16 17 we are using for implementation purposes. NUREG-1022, the original document was issued in 1983. It provides the 18 19 background and the intent of the rulemaking system.

It also provides examples for how to interpret the reporting criteria. Supplement 1, as you are aware, was issued in 1984 after a series of workshops similar to this were conducted in the various regions where a number of specific questions were asked from the audience and specific answers were prepared and then provided as feedback for,

1 again, implementation under the rule.

2 NURSG-1022, Supplement 2 was issued in 1985 and that provided the results of a contractor's review of a 3 sizable sampling of the LERs that were received during the 4 first year of operation under Part 50.73. The focus of this 5 document was primarily on the adequacy of the content of the 6 7 LERs and it does contain some of the original shortcomings that were noted and recommendations for areas that required 8 9 improvement, and Jack presented a slide that showed we then 10 tracked that content for the next couple of years and 11 noticed sizable improvement.

12 The next thing we did was in the 1987-88 13 timeframe, Jack mentioned earlier that we did not have -- in 14 the rule change, we basically gave up train level, a fair 15 amount of train level information. At that time, there was 16 a considerable effort in the probablistic risk assessment 17 area. People needed train level information. In fact, they 18 used the pre-1984 information.

19 There was thought given and we had actually 20 proposed rulemaking to, again, gather train level 21 unavailability data on selected safety systems in a tabular 22 monthly form. Data that would have been collected included 23 the system, the subsystem components, the causes for 24 failure, that would have been corrective maintenance, 25 preventive maintenance, any actual downtime on the system,

as well as the corrective actions that would have been implemented to improve the availability where it was appropriate.

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Now, at the same time, we had under consideration 4 the reduction in the event reporting requirements, again 5 focusing on the engineered safety features area to where we 6 7 considered deleting the requirements for reporting when the system was not required to be operable. For example, 8 9 individual event reporting of unneeded actuations, particularly ventilation and isolation systems, would have 10 been eliminated. 11

We were anticipating a provision, though, to where 12 we would have captured "a high frequency" of these events. 13 In other words, I don't know what the numbers would have 14 been, but for given situations, if there was a high 15 16 frequency of unneeded ESF actuations, we would have asked 17 for a qualterly or a semi-annual report that would have focused atcention so people could have looked at the 18 aggregate significance of those events. 19

This proposal didn't really get out of the staff level for a number of reasons. This brings us to the current staff initiatives. They have been mentioned several times. We have under consideration deleting the unneeded reactor water cleanup system isolations and the control room vent system ESF actuations.

1 What this amounts to, if you look back at the 2 other slides. is probably in order of 100 to 150 LERs, which 3 is around five percent. Now, what we're doing is we're 4 looking at this from an administrative rule change, 5 something that we think we can do if it doesn't involve any 6 policy matters. In other words, if the Commission wasn't 7 intigately involved in that particular part of the original 8 rule, we think we can do it with a minor rule change and do 9 it in a matter of months as opposed to including it with a 10 longer-term or a major rule change which is going to lead us into at least a couple year effort. 11

12 The long-term -- I've identified a long-term 13 effort, and Jack fairly well covered that. What that would be is we plan to -- wall, short-term is issuance of 14 Supplement 3 to NUREG-1022 where I think we can incorporate 15 some of the things that people want incorporated in new 16 17 guidance. It may involve superseding Supplement 1 and 18 Supplement 2 to bring in the new perspective using under the existing rule. 19

Long-term is next. In that area, as I said, we really feel we need to set back, take a protracted look over what is it that we've had six years of operations under the existing rule, we've seen the effects of everyone focusing on existing -- on the operating experience, and over that five years have seen scram reduction programs and the

effects of those programs, concentrated efforts on reducing 1 system problems and ESFs, identifying other problems related 2 3 with system failures where there's generic feedback, and I think we're now seeing with the reduced number of LERs in 4 total -- like is you look at the information, the number of 5 plants has increased by 30 percent, the total numbers of 6 7 LERs from the 1985 timeframe are down about in the range of about 3,000 to 2,400. 8

9 So they're also down, and the combined effect is 10 that I think the industry has been responsive and we've all 11 learned from operating experience and implemented things 12 that needed to be implemented to correct the problems.

I think that's all I had to say.

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14 MR. NOVAK: Thank you, Jack. We want to get into 15 guestions on 50.73, and if you have anything that's still 16 left over from 50.72, place bring it up. I think what 17 we've tried to do is give you a background of what we tried 18 to do and what we do do with the information that is 19 provided to us under 50.73, what our experience over the 20 last five or six years is showing us in terms of unneeded 21 reporting, and what we can do about it.

Those are our near-term plans. We hope that with regard to these minor changes, being the two that Jack mentioned, they could be accomplished within this year, a matter of months, we hope. So I'd like to open up questions

on any subject regarding 50.73. Just grab the microphone,
 please.

MR. BAUER: Scott Bauer from Portland General 3 4 Electric Company, Trojan Nuclear Plant. And, yes, I realize I'm in the wrong region. I'd like to just make three brief 5 comments. One is I really applaud the efforts of the NRC to 6 work cooperatively to clarify .eportability. I think the 7 base rule is very good. I think if you could just make some 8 clarifications, we all would be happy with what we have to 9 10 do.

11 The second comment is -- I don't know whether this 12 is a question or a comment, but when regional inspectors 13 want to dite somebody for not reporting something that they 14 felt should be reported, do they typically come to AEOD and 15 consult the expert, so to speak, on the matter or just kind 16 of go off on their own? You can may hold off on answering 17 that.

18 MR. NOVAK: Why don't we get your whole question 19 out.

20 MR. BAUEP: The school part of the question is 21 really just drawing from that, but I'd just like to put two 22 things on the record as things that we would like to see 23 considered if a supplement is to be issued, and they both 24 have to do with ESF actuations. One is if you have a non-25 ESF signal that actuates an ESF component, is that

reportable? The second one is if an ESF signal is
 generated, but no equipment actuates because the equipment
 is already in its actuated state or in the safety position,
 that reportable?

5 We have had a lot of problems with spikes on perms, radiation monitors, electric spikes, and we're trying 6 7 to figure cut the root cause of the problem, but they either actuate containment ventilation isolation or send a signal, 8 but if the values are already closed -- we report it if they 9 10 shut the valves and we're not sure what to do if they don't shut the valves. We've been reporting them anyway, but I 11 12 just wanted clarification.

13 MR. NOVAK: Let me ask Ed Greenman or anyone else 14 from the region if they wanted to first answer the question 15 about reporting.

MR. GREENMAN: Of course, there isn't any such thing as a typical region-based inspector anymore than there a typical plant. I would say that by and large, r orting violations, and they're relatively small number in this region, would not rise to a threshold where we would have a discussion with AEOD.

What generally happens if there is a situation that involves a reporting requirement or something that we believe should have been reported, that will be surfaced with the inspectors, immediate management, and up to the

branch chief level in the region to sign out that report.
If it's clearly a contested type issue, it will probably
surface up to my leval and we may, in fact, have some
dialogue between divisions in the region to determine
reportability and, very occasionally, with ALOD.

6 MR. NOVAK: 1'll second that. Occasionally we are 7 called and we get us and the people in NRR that are involved, but it pretty much follows th. path that Ed is 8 9 talking about. Now, we, at the same time, look at the 10 inspection reports where we call out items to where there has been at least they've cited people r violation. We 11 will nex at that and we have a collection of that 12 information and we're kind of using it also in this 13 14 supplement, areas where there appears to be a need for more 15 quidance.

MR. CROOKS: Some of the things get into somewhat the original policy area, too. That's usually a call to us or we'll end up -- a few times we've ended up with written guidance.

20 MR. NOVAK: Then we had a couple of questions on 21 whether or not if you had a non-safety grade signal 22 initiated, an engineered safety feature, is that reportable. 23 I think that was the thrust of the first question.

MR. CROOKS: Yes, Tom. And I think we've talked. That's come up several times and it will be addressed in the

guidance.

2	MS. ARNOLD: Tracy Arnold, Illinois Power. I have
3	two comments and two questions. My first comment is I'm a
4	member of the BWR Owners' Gr up which is currently working
5	on a guidance LER rule wit PWRs and BWRs both involved, and
6	our goal is to bring consistency to reporting which a lot of
7	1395 indicated that there isn't any, and when we were
8	first meeting, we realized there wasn't, and we know plants
9	on the east coast, not our region, that report well, that
10	don't report entry in a tech spec 303 if they get out of it
11	within the hour allowable prior to shutdown, which is pretty
12	shocking to us, it was anyway, because we're pretty
13	conservative.

Then safety relief values that are reported under all different criteria, 50.73, 50.9 or special reports. It seems kind of shocking that you guys didn't recognize earlier that there was inconsistency in reporting or taken any action to bring it into consistency. That's one.

19 Two -- well, it was just different. Well, I'll 20 skip to questions. I have specific questions on .57(d)(3) 21 as compared to .57(d)(2). When we determine something is 22 reportable under 50.73, but not reportable under a 50.72 23 criteria like a tech spec violation, and further evaluation 24 reveals it was reportable under a 50.72 call-in criteria, 25 but it's just prior to us initiating the 50.73 report, do we

1 still have to call it in under 50.72?

MR. NOVAK: I wish I had the lawyer here.

MR. WEISS: At the risk of sticking out my neck, in effect, that I may be reversed later, it sounds to me like what you're asking is you've submitted an LER and now you've discovered that this thing was also reportable under 50.72, but you didn't realize that at first.

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MS. ARNOLD: Right.

9 MR. WEISS: So the NRC has the LER in hand and now 10 you're asking whether you're going to make a red phone call. 11 Just as a common sense thing, I would say no. I'd say we 12 got the document, what do we need the written report for. 13 But I don't know. Maybe there are some keener minds here 14 than --

MR. CROOKS: What I was going to say is the 15 gentleman earlier today was talking about the tie between 16 50.72 and 50.73. It's simply that in 1984 the two rules 17 were run together and the criteria, in many cases, are the 18 19 sare bacause what was envisioned was the telephone notification and then the 30-day report. So where the 20 criteria are the same -- for example, you find a -- it was 21 discussed earlier -- a condition that's outside the design 22 basis of the plant. You'd make a 50.72 call and send in a 23 30-day report. 24

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Now, that's an area where many times what's

happening is what you're describing. We'll get the LER and 1 2 there never is -- there wasn't a 50.72 report. Some of that 3 comes from -- we've had discussions where the engineering people think that, well, if it's an engineering problem, 4 it's not event-related, and nothing in particular happened 5 at the plant, that, therefore, throws it outside of the 6 7 50.72 or 50.73. We will try and address that in the guidance, too. 8

9 MS. ARNOLD: And the next thing that I'd like to see addressed in the guidance, and I don't know if you will, 10 11 but we made a 50.73 report of outside design basis, which I didn't agree with, but we made a report and subsequent 12 analysis showed that it wasn't really reportable at all. So 13 14 we changed our report, our LER, to make it a voluntary LER. Now, I don't know if that was the right approach. Could we 15 16 have just withdrawn the whole thing?

17 MR. NOVAK: Yes. We appreciate the voluntary LER, 18 but you could have -- the rules permit you to withdraw it if 19 you conclude that it is not a reportable item.

20 MR. WEISS: I kind of regret that we're getting 21 into the bean counting questions. It seems to me we've get 22 to attank the problem fundamentally, both the industry and 23 the LRC, and get away from looking upon these things as 24 negative beans in the bean count. One quick comment on the 25 previous question. That is if between time zero and 30 days

you discover that you've got a reportable item under 50.72,
 make the call then, because you haven't submitted the LER,
 and just tell us.

MS. ARNOLD: But you say we're supposed to get away from Lean counting, but you said earlier that if you call something in under 50.72 and later determine it's not reportable, call and get it 'f your bean count.

8 MR. WEISS: That's your option. That's a tool you 9 can use to minimize the impact of those entities that make 10 the mistake of thinking that numbers are important, when 11 it's not numbers, but the safety significance of the thing 12 that's being reported that is important.

13 If you can use that, fine, go ahead and use it. 14 But it's not for our benefit, it's for yours. I don't like 15 it and you don't like it, but some people count these things 16 blindly. What we insist upon is that you tell us about 17 those things that have safety significance so that we can do 18 our job.

MR. CHAFFEE: Also, when you tell us that you've decided that something is not reportable for some reason, that provides an input to the people that are reviewing it as further followup as to how we should react to it. First you told us it was outside your design basis, and now you've looked at it, your not, for example, then -- the more you talk to us through these things, the better the reaction.

1 MS. ARNOLD: I'll guite hogging up the mike after this, but I remember what my other comment was. The Owners' 2 Group, for the gentleman from D.C. Cook, when we're putting 3 together design basis of a plant or we're using as a basis 4 for determining if you're outside design basis of the plant, 5 the Chapter 15 analysis for accidents and if you don't -- if 6 you meet your accident analysis, you're not outside the 7 design basis of the plant. 8

9 MR. NOVAK: Is that a comment or a question? 10 MS. ARNOLD: That's a comment, for now. We're 11 working with the NRC --

12MR. NOVAK: Yes. I was just going to --13MS. ARNOLD: That's our guidance.

14 MR. NOVAK: -- mention that we have met with the 15 representatives from the BWR Owners' Group before the 16 workshop started and we're also getting input from others.

MR. ROSENTHAL: Let me just get to the consistency issue. I think it depends on -- and the safety valve issue, all at one time -- in part, depends where you're sitting in the NRC. We are getting about one report per plant per year of safety valve deficiencies, not necessarily failures. That's safety valves on the steam line, on the pressurizer,

23 failing on a boiler, etcetera.

2424There aren't that many companies that make safety25valves. In the report which we're about to issue, we have a

histogram, we don't name plants, but showing the
distribution, and it was clear some plants had reported no
safety valve failures. Other plants had reported 20 LERs,
and it was the same valve. There was no reason to believe
that one plant had some magical maintenance practice that we
didn't know about.

From my perspective, we came to the conclusion that, number one, the reporting rate was very high, that the times when it wouldn't perform its tech spec safety function were too high, and that we needed action to fix it, and, if anything, that the reporting was low relative to the actual situation. I stopped there. But, no, we're not so naive as not to recognize that is inconsistent to your reporting.

But the fact that some plants weren't reporting, I knew they had to have same problem, really wasn't a driving force for me. Then you get to something like the performance indicator program where we are looking at trips and diesel starts and HPCI injections, etcetera. That's a program in which, effectively, you do lay out one plant against another.

Well, that stuff is set at a high enough threshold, I hope, that we do capture all of them. That's the sort of thing where we would worry more about consistency.

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MR. NOVAK: I think you've got a good point, and I

think in our guidance document, and we hope with industry support that we would all more or less report things to the same level. I think it's unfair for plants to be compared at different levels. We see that and I think that's part of the reason that industry, I think, is concerned, because there seems to be a dissimilarity.

7 Those things we have recommized and there's just a 8 priority that we have to given certain kinds of deficiencies 9 in reporting. When we do see them, we do talk to the 10 regions about it and they may sit down and talk to you. We 11 don't usually in AEOD sit down with the licensee directly 12 We will work through the regions because they are the people 13 that you deal with on that issue.

Why don't we ast some more questions out.

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15 MR. SHARKEY: Two comments. Tom Sharkey from Union Electric. Please consider these two comments for 16 17 addition to Supplement 3, if there is one, to the NUREG. Mr. Jordan and I had a discussion maybe four years ago, a 18 case where we inadvertantly shut a common discharge valve to 19 both safety injection trains. The phone call and an LER, 20 21 the paragraph would be the one that lists A, B, C, D, in the event or condition alone could have prevented. 22

And if you look below that in the rule, there is a Paragraph 7, any event where a single cause or condition caused at least one independent train or channel to become

inoperable. On the LER form, I asked you when did we mark that box, and you said that this paragraph is a subset of the Paragraph 5, and in a specific case like this where one component took out both trains, mark both Paragraph 5 and 7. The only time you mark seven is if you had previously marked five.

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7 I don't believe the industry knows of our 8 discussion and I just wanted to get that as a possible look 9 into clarification. The other comment was on reporting 10 failure to satisfy tech spec 6.12 on radiological protection 11 posting. We need some more clarification on that. The 12 NUREG, Supplement 1, Item 2.9 currently has words to the effect that if it's an administrative requirement and les 13 14 not involve plant operations, it's not reportable.

15 If I fail to post properly or lock a door properly 16 for a high rad area, that in itself, we believe, is not 17 reportable. If, however, a person, unauthorized or 18 authorized, enters because of that failure, received exposure, etcetera, that that would be something that would 19 be reportable. And I think we're not the only plant that 20 21 has a problem with this particular tech spec violation. 22 That's all I have to say.

MR. NOVAK: 'Hank you. Other questions? Yes?
 MR. PROBST: Jim Probst. I'm with Iowa Electric
 and I'm a member of the BWR Owners' Group Committee. I have

specifically been working on ESF actuations. First, I just have a general comment. I think it's become clear in the meeting and I think you folks recognize that some of the rules and regulations out there aren't exceedingly clear on what is reportable and isn't.

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In fact, I'm confident I could come up with 6 specific questions in areas, give you as much information as 7 you want, and if I polled you all individually, I'd come up 8 with varying answers. What I'd request is when you come up 9 with this Supplement 3 or your new regulations, that you put 10 those to the same test. If you don't know of enough rough 11 questions to ask, I'm sure NUMARC or the BWR Owners' Group 12 would be happy to make some up. 15

But the real point of it is if you've got a tough question and if your new regulation still gives six yes and six no, then we're going to be back here again in two or three years with the same problems. So I'd request you put it to that standard.

In specific, on the ESF actuations, in the BWR Owners' Group we did this. We made up some very difficult questions, tough calls people have had to make, asked a number of utilities, and on the tough questions, most of them split right down the middle, 5 50. Fifty re, fifty weren't. We decided at that point what we really needed to do for ESF actuations was define the terms. People were saying actuation, what does it mean. We assumed that if we could define them, then we could take those definitions and answer all of these questions and come up with the same answer every time. And we believe we have done that in our draft document which will be shown to you sometime in the future.

but, in particular, we hit one problem I'd ask you 7 to address in Supplement 3. I don't particularly like to 8 read something right out of your regulation to you, but I 9 think I will. We looked for a definitio. of actuation, 10 11 looked a lot of places. The only one we found was in 1022, the original, Page 13, it defines actuation, it says 12 "actuatic of multi-channel ESF actuation systems is defined 13 as actuation of enough channels to complete the minimum 14 actuation logic; i.e., activation of sufficient channels to 15 cause activation of the ESF actuation system." 16

17 In other words, it says actuation is an actuation. 18 I'd request that when you're doing the next supplement that 19 actuation be defined a little clearer, trying to avoid use 20 of words like actuation and activation in the definition. 21 It's an obvious point.

Thanks.

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23 MR. NOVAK: Thank you. Other questions? Yes? 24 MS. GOODMAN: Lynne Goodman, Detroit Edison. I 25 have a suggestion that might be able to balance our desire

1 not to have more beans to count and your desire to get more volunteer report. That would be if maybe we'd use the same 2 form, but not call them LERs. Call them something else. 3 Either have them not numbered, have a different numbering 4 5 scheme such as what we have with security LERs, so that we could still be sending you the information, but not have to 6 7 treat them in our count of LERs to our counties, regulators 8 and whatever.

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## MR. NOVAK: Thank you. Question?

MS. ARNOLD: Tracy Arnold, Illinois Power. Mr. Rosenthal specifically. When you look at other similar events, what do you look at versus what are we supposed to look at when we report to you and how far back are we supposed to go? For us, it's easy, we haven't been licensed that long, but for other plants -- when we're writing our 50.73 reports, what do we include for other similar events?

MR. CROOKS: I think that in Supplement 1 there is 17 18 an intent to provide some guidance on that. I think, again, 19 that's an area where you use some judgment. I would go back -- I mean, if you go back a couple of years and if it's 20 21 something that's a very high frequency type thing, I don't 22 know that you need to go bac': a couple of years. What we're primarily looking for is that; is this something that 23 continues to recur, and then you focus on the corrective 24 25 action.

We're all aware of situations where things do keep occurring and the corrective actions keep changing. Sometimes we find that the corrective action is the same and it's not really addressing the root cause of the problem. So I think originally that's why that was in there. People were saying look at the problem and how recurrent is it. I think you use an element of engineering judgment.

8 I'm not aware that any of the regions have pushed 9 that particular issue to where they've gone back and 10 somebody said, well, gee, you had 25 of these and you only 11 said you had 20 of them or something like that. It's the 12 reasonable man approach, that if -- you're even going to get 13 into in the judgment, what is the event, what's the 14 significance of the event.

15 MR. ROSENTHAL: Why don't I say that's fair game, and I'll be fairly -- and the Court Reporter is going. We 16 21 don't use that in our analysis and the reason that we don't use it is that I have this gigantic computer database and 18 PCs on everybody's desks, and that's stuff that didn't exist 19 in 1984. So when we're interested in an event, we poll the 20 system and we dump the related events that you've generated, 21 plus the whole industry's related events, if we're doing the 22 search correctly, for the purposes of doing an engineering 23 24 study.

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So at least from my -- and remember I'm just one

of many users and we don't really use it. Now, Ed, from the regional standpoint? Again, you can post those same databases.

MR. GREENMAN: Right. And we don't count specific numbers. We look far enough to see that you have -- to see if there's any generic implication. We're certainly interested if you're saying what is similar. If you had a widget fail in System X and you haven't had any other widgets fail in that system, we certainly would expect you to tell us that you did have that widget fail in System Y.

11 MR. HARRIS: Ray Harris, PP&L. It seems then that 12 you could just take that out of the rule and any revisions 13 you come up with, if you don't want it, clarify it so you 14 make clear what you really do want.

15 MR. NOVAK: Other questions?

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MR. SHARKEY: I might be a little conservative here. That's a trigger for us to go back and look at it in our corrective action program. That triggers us to say, hey, wait a minute, has this happened five years ago. So I would say that we're going to count, say maybe there is some value to us, the licensee, not the database or whatever.

MR. NOVAK: Good point. Other questions?
 MR. HEGRAT: I'm Henry Hegrat. I work for CCI at
 the Perry Plant. It became pretty clear during the earlier

discussions on 50.72 that the people involved in receiving 50.72 notifications would like to see an expansion, and that expansion would be somewhat downward with respect to the number and the types of -- upward with the number, downward with the threshold of types of events reported under 50.72.

Those that were identified were large spills, inadvertant criticality, small water hammers, etcetera, the list --

MR. WEISS: No, I disagree. We're not looking --9 I prefaced my remarks by saying we get 2,400 50.72s in a 10 year and out of those, maybe six a year go unreported. I'm 11 not looking for an expansion. My thesis was that when we 12 wrote 50.72, we expected that the existing criteria, those 13 14 already in place, would have captured those events. I'm prepared to give you some specific examples and discuss the 15 16 reporting criteria, but, for example, how can you say that you have an overpressurization of a suction of RCSI piping, 17 the NRC launches an AIT, and that's not a degradation of 18 19 your primary system safety boundary.

20 MR. HEGRAT: If I can interrupt you, I wasn't 21 trying to say that you were trying to expand the criteria. 22 What I'm saying is that you did establish the fact that, 23 from your viewpoint, there were events that were not being 24 reported that should have been and are captured under the 25 existing rules. Is that correct?

MR. WEISS: Yes, but I wouldn't say that that's an
 expansion of the rule.

MR. HEGRAT: Expansion of what's being reported, not the rule. I didn't mean to imply that. My real guestion is does that same philosophy or that same desire exist with 50.73? Is there a feeling with the staff that 50.73 reports also are not being captured to the same extent as .72 with the criteria that are now given in the rules?

9 MR. CROOKS: My response would be yes because 10 they're closely tied together with the same criteria, with 11 the exception of common mode failure. I think the criteria 12 in 50.72 and 50.73 are almost the same.

MR. NOVAK: I think where Jack is saying, too, I think part of the whole concept of looking at 50.72 and .73 in this workshop is to stimulate again what we are really trying to learn from operating experience. Jack Rosenthal, you might just want to take a few minutes ---

MR. ROSENTHAL: I was just thinking that there was 9 -- you know, the exceptions stick in your head. It was in 20 Region II, a guy had a spill of his spent fuel storage pool, 21 and water runs down into the cable chases and the cable 22 spreading room and drips ontr. cabinets in his control room, 23 and it only got reported because they decided to make a 24 press release.

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I said, wait a minute, is this right. Then

there's another, also Region II, as a matter of fact -- it's nice to cite Region II examples in Region III -- in which diesel problems weren't being reported because it was an older plant in which the FSAR did not specifically identify diesels as an engineered safety feature.

6 Well, doesn't that plant manager think those 7 diesels are there for safety? That, to me, was a word engineering game. So those examples stick in your head. I 8 think that Eric's point is right, that maybe we're clearly 9 10 going to diminish some stuff that we mutually don't feel is needed, and that there's probably specific plants and 11 specific issues, a few dozen a year or less that aren't 12 13 getting reported that I feel ought to be.

MR. HEGRAT: Just to amplify the effects from the 14 non-reporting, are these issues, in your opinion, also not 15 being fed through the other communications chain? I'm 16 trying to establish whether or not the information is not 17 18 getting to the people who really need to look at it and to analyze it and whether that's the problem, or the mechanism 19 which has been established, and that's the 50.72 20 notification, and the LER report. Is it a matter of use of 21 that vehicle to get this information or is that information 22 23 actually not getting to the departments that have to analyze it, either through the residents or the daily reports or the 24 other devices that were discussed before? That's the extent 25

1 of the question.

2 MR. GREENMAN: From a regional perspective in that 3 broad category, I think it's a fair assessment to say that, by and large, we, NRC, stumble on it by one means or 4 another. Sitting in on a meeting or in walking throughout 5 the plant or participating in a conference call between the 6 utilities. It is not something that the utilities make a 7 conscious act to notify the region, notify the resident by 8 9 any of these other mechanisms. Like he has to speak directly to outside agencies. 10

11 MR. GREEN: I know you had this to get industry 12 viewpoints, but I want to give you one from the staff, too. 13 I'm Mark Green. I'm with the Engineering Branch in Region 14 III. I have some specific familiarity with some of the 15 issues that Henry might have been talking about. First off, 16 I'm not sure you know what goes unreported.

17 In Region III --

18 MR. NOVAK: He only knows what he doesn't know. 19 [Laughter.]

20 MR. GREEN: In Region III alone in the last two-21 and-a-half years, I guess I'd like to rattle off a few 22 examples of things that either went unreported under 50.72 23 or were incompletely or not properly reported under 50.72. 24 For your benefit, Henry, I think the real concern under 25 50.72 is the promptness of reporting so that the promptness

of response can get there.

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50.73 generally takes care of ensuring that 2 everybody eventually knows. 50.72 is what makes it happen 3 quickly. But the issues that I had in mind involved 4 containment overheating and resultant cable damage; core 5 power oscillations; large movements of water to the wrong 6 places, like 30 and 40,000 gallons worth: significant cracks 7 in the reactor vessel head; multiple small bore pipe cracks 8 or leaks; potential water hammers where supports have been 9 pulled from walls; and, cff-gas releases for which the state 10 or other entities are made aware and the NRC isn't. 11

So I guess I would like to see both the BWR 12 Owners' Group and I know there's lots of folks here from 13 those type of industry organizations, or NUMARC or whatever, 14 as well as our panel members and our people that are looking 15 at long-term things, look at expansion of either the rules, 16 if that's the right thing, or the supplements to the NUREG 17 to provide guidance in areas that are -- I think all these 18 19 areas, you could make a legitimate case, are not required to 20 be reported.

In the same vein, they're all areas of obvious regulatory interest. We were greatly interated in each and every one of those. Those have all occurred in Region III plants and it's all been within the last two-and-a-ha f years. So I'd like to see either the guidance or the rules

expanded to envelope those kinds of things.

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MR. NOVAK: Thank you. We want to entertain some more questions. Let me mention one thing, and it will be the only little speech I have today. One of the things we do in .EOD is we monitor operating experience through what we call the accident sequence precursor program. You may have heard about it. It's been around for a decade. It was developed out of Oak Ridge under a research contract.

9 But what it does, and if you forget about the 10 absolute numbers of the probability of core damage, it kind 11 of ranks the events that we see across the country in terms 12 of safety significance. Now, what I think I was surprised about is what it's telling us. For example, over the last 13 two years, in each of the last two years, if you take a 14 15 number like five out of the top seven significant events or four out of the top seven were caused due to common mode 16 failure. 17

I think if you've been in this business long enough, you kind of wante' to downplay the likelihood of common mode failure as something that would get you into trouble. But operating experience is telling us that's just what's happening; that the events that we see today that are most significant are a result of common mode failure.

I think that you have to know. So that's the job that we have, to provide this operating experience back to

you so that you can recognize this, and it does kind of perhaps recalibrate you to what today's experience is telling us. We just are in the process, as Jack Rosenthal mentioned, of completing a study on solenoid operated valves. If we weren't worried about common mode failure, we would have killed this or stopped this study several years ago.

8 But because of the potential for common mode 9 failure, cross trains in different systems, we said we 10 better look at it. So I think in looking at what we are 11 getting and not getting, I think it's important to recognize 12 what is it telling us; are we using the lessons from 13 operating experience; and that's the point that we're 14 getting at.

15 I think we see some practical applications of 16 operating experience to improve the next ten years of 17 operation in every plant in the country.

18 New questions?

MR. CROOKS: Tom, one thing. I don't know that we really answered this question regarding whether or not the mechanism was important. All I would say is that the preferred mechanism is the 50.73-50.73 system because that is set up to give the broadest review. You notify the resident, you notify the region, you notify the project manager.

1 On some of the events that Eric was talking about, 2 they just escaped the system. The 50.73 report is what 3 trips the other levers from the industry-wide feedback 4 standpoint, many times not only just from us, but from your 5 own systems and through INPO.

6 MR. HONMA: George Honma from Toledo Edison. I'm 7 aware that NRC issues notices, bulletins and generic letters 8 to identify Part 21s, but is there a means for NRC to merely 9 notify the licensees of any Part 21 issues?

MR. ROSENTHAL: That's the most typical thing 10 that, in fact, happens. You get a Part 21 and you've spoken 11 to the vendor and you realize that there's four people 12 involved, and you assure yourself, either by communicating 13 14 directly or assure yourself that the vendor has communicated 15 with those four people, it's a narrow issue, and you stop. So what you're describing is the most common way that things 16 17 have been, if I understood you.

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MR. HONMA: Yes.

MR. ROSENTHAL: That is, in fact, the most common way that things are handled, and we typically don't write INs and bulletins on those.

22 MR. HONMA: However, I think the way the system 23 works is the manufacturer probably notifies the NRC first. 24 Is there a way to assure that that information is passed 25 back to the licensees immediately, other than through the

## manufacturer?

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2 MR. ROSENTHAL: Other than through the --3 MR. HONMA: Manufacturer that provided the 4 product. Like, is there a way that --

5 MR. WEISS: We've done that, Jack. I remember when there were some bad squib valves around the industry 6 and then that night we called all the regional offices, 7 project managers, and through the projects division in each 8 of the regions, all of the affected licensees were known, 9 and then we proceeded to write an information notice just to 10 paper things up. But in a matter of hours we had everybody 11 notified. 12

13 MR. CHAFFEE: This is Al Chaffee. My understanding from the Part 21 system is that normally the 14 person who submits the Part 21 takes on responsibility to 15 16 notify these people that may have the same problem. As people have been saying, if it turns out that we have a 17 particular Part 21 that is extremely significant, then the 18 agency may take on the effort of very quickly making sure 19 20 that everybody is aware of it.

One of the things I believes that happens in Carl Berlinger's branch is they check the Part 21 to see if the report itself says that the person providing the report has notified the people that would be interested. My belief is that in most cases they've done that. Many times when we

get the Part 21, it's almost after they've already gone
 through the proce s of telling other people.

MR. HONMA: However, there's some materials that a licensee may get through secondhand through another utility that may not show up as a list. Is there like a listing that's provided by NRC that could be periodically issued to all licensees identify Part 21 notified for the year or month?

9 MR. NOVAK: It's a good point. We'll look at it.
10 MR. CROOKS: We'll look at it.

11 MR. NOVAK: Thank you. Question?

MR. KRAUSE: Chuck Krause, Wisconsin Electric. Having had Part 21 just brought up here sort of tickled my memory. It seems to me about two years ago the NRC was proposing a change to the Part 21 rule which, in essence, would have, I guess, rejieved 10 CFR Part 50 licensees from reporting under Part 21 given that we already have criteria in 50.72 and .73.

19 I wonder if you perhaps could update us on what's20 happened with that proposed rule change.

21 MR. NOVAK: You know how to hurt a guy, don't you. 22 I didn't mean to cut anyone off short. I would like to get 23 as many questions on the record as we can. So if we get the 24 essence of your question, even if we don't give you a 25 complete answer, we'd move ahead.

Jack, in 30 seconds ---

MR. ROSENTHAL: In 30 seconds, we're in the final throws of rulemaking and that revised rule will make it very, very clear that if you have a deficiency that's been freported by Part 21, 50.55(e) or .57(e)(3), then you have fulfilled your requirements and you need not do duplicate reporting.

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## MR. NOVAK: Question?

MR. DILLICH: My name is Jack Dillich from Toledo 9 10 Edison. I'd like to reiterate what was brought up previously about Section 6 or the administrative tech specs. 11 I think that's one area that we can really stand to improve 12 in. From the operations section, I find myself on the other 13 side of an argument a lot of times with the licensing people 14 in that the software type of tech specs that I call them are 15 15 not guite as clearcut as the rest of the tech specs.

You'll have programmatic type tech specs in Section 6 associated wich Committees, how often they meet, the maximum amount of hours worked by key personnel, that type of thing. It becomes very difficult then to sift out what is actually a violation of a tech spec and what has to be reported as an LER.

You get into situations, I like to call them nonevents. They're really not events, they're just conditions, and we at Davis-Besse, in general, we usually end up going

with the consensus. If the consensus of opinion feels that we need to report this, we normally report conservatively. A couple of examples would be missing an hourly fire watch by two minutes. That was an LER at Davis-Sesse. Hours worked, if someone -- we have a program to make sure that hours worked is not exceeded, whether it be for a seven-day period or a 48-hour period.

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8 In one particular case, if one guy out of many, 9 many hours, many, many years, happens to work 73 hours in a 10 consecutive seven-day period, that's an LER. These are 11 examples, in my opinion, that we could probably save a lot 12 of paperwork and a lot of time by reporting events and not 13 these types of conditions.

In that particular case, my contention is Section 6 tech specs makes you have a program to do compensatory fire watches, makes you have a program, for instance, to make sure you track hours worked by key personnel. Those programs are in place, but these are individual exceptions to that program. In my opinion, they're not reportable.

If that could be clarified, perhaps we could cut down on the unnecessary reports that are submitted. And I would agree with Mr. Weiss, not on everything, but I agree with his contention that I don't think there are that many conditions or events out there that go unreported. I know -I can't speak for all the different utilities, but at

Davis-Besse, I think we report to excess in some cases. We 1 certainly don't report -- we don't miss that many, in my 3 opinion.

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MR. JOVAK: Thank you. Other guestions?

MR. PUTNAM: Ken Putnam, Iowa Electric. With 5 regard to ESF actuations, on any of your studies of cleanup 6 and some of the other high frequency isolations, unnecessary 7 isolations, do you see any evidence that frequent challenges 8 to ESFs did, indeed, lead to degraded performance when 9 called upon to actuate for real, which would seem to be --10 11 everybody seemed to think that's not what we want, we don't 12 want to have them failing when they really come in. Was 13 there any correlation there?

14 MR. ROSENTHAL: The only example I can think of is diesels, where we clearly recognize that all these diesel 15 16 starts were, in fact, damage in the diesels. I don't think we have any -- I do not know of any study that says 17 actuations or RWCU is damaging the isolation capability of 18 19 the RWCU. Reactor trip breakers, we were doing so much testing of big trip breakers that I think we were damaging 20 them. So you have to look at those devices for which the 21 22 design life is just a few hundred cycles, and then compare 23 that to what's going on.

24 MR. PUTNAM: And related to that a little bit, I quess, there seemed to be some agreement up here that a 25

certain group of ESF actuations had negligible safety significance. Yet, there is extremely high pressure for any time one of these events occurs that is defined as reportable, that we have to take For a sort of corrective actions to preclude recurrence of ... at event. Now, maybe 5 that's just our own perception and not yours. 6

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But for ESF actuations, if they, indeed, have very 7 little safety significance, I'd suggest that perhaps some of 8 the corrective -- it's very easy to fall into a trap in 9 taking corrective actions where you're risking reducing the 10 reliability of the system. Clearly that's not our intent 11 when we're taking them, but given the fact that what you're 12 talking about is unplanned actuations of engineered safety 13 14 features and you're out there trying to come up with ways to reduce the likelihood that they're going to be asked to 15 work, it's very delicate and easy to get yourself into a box 16 where you've actually reduced the likelihood of them working 17 on a valid demand. 18

So in terms of bean counting and all, well, don't 19 worry about the bean count, that's all well and good, but if 20 the system and the reporting requirements are set up to 21 drive you towards taking actions that are undesirable, then 22 we should be worried about that kind of reporting 23 requirement. 24

I guess along those lines, I'd like to know what

you guys' response would be to an LER that said this event
 occurred, this is why it has very little safety
 significance, and this is why we're taking no corrective
 actions to preclude recurrence.

5 MR. NOVAK: Good point. Do we have any other 6 questions? Yes, please.

7 MR. KIRK: My name is Mike Kirk from NUMARC. I'd 8 like to make a couple of general comments, if I may. 9 Earlier on Jack talked about a couple of initiatives that 10 the NRC is taking regarding reporting requirements, and I 11 think later on this afternoon we're going to hear some other 12 things regarding security reporting, and these are all 13 initiatives for which the NRC should be applauded.

As in most things, much of this concern, I think, about reporting is tied into the efficient utilizatic of resources. I don't think this is something that has been articulated as such in the meeting today, but I don't think there's anybody here that would disagree with that statement.

20 Reporting, whether it's under 50.72 or 50.73, is 21 very manpower-intensive. There was an informal poll, I 22 believe it was at the Region II workshop, where it was 23 indicated that a preparation of a "simple LER," one for 24 which the chain of events is understood, the causes known, 25 and has a minimal safety significance, takes a minimum of

1 two man weeks to prepare.

2	More involved LERs may take six to eight man weeks
3	or even more, and this would be exclusive of any subsequent
4	supplements. This obviously is a significant load on
5	operations, licensing and engineering manpower resources.
6	The elimination of reporting requirements such as we've
7	heard about, like the more non-significant ones, the non-
8	significant control room HVAC and reactor water cleanup
9	isolation actuations, will certainly go a long way to reduce
10	this manpower burden.

We would urge the NRC to keep this burden in mind when you consider any further modifications to the existing reporting system. Thank you.

MR. NOVAK: Thank you. Other questions? 14 15 MR. NALEPKA: Dave Nalepka, Wisconsin Public Service. I guess one consideration that I would like the 16 17 group to take a look at when evaluating Supplement 3 is, again, the definition of actuation. One specific example to 18 19 consider would be if a ventilation system has a partial actuation, that one damper within that ventilation system 20 actuates for some reason or other, is that considered an 21 22 inadvertant actuation of an ESF system?

MR. NOVAK: Thank you. Other questions?
[No response.]
MR. NOVAK: Well, we've had a good showing of

1 questions. We'll wait a few more minutes.

2	MS. ARNOLD: We were recently wrestling with
з	reportability of a given event, which we determined was not
4	reportable. It was kind of connected to I'm trying not
5	to be real specific here and hang ourselves, but it was kind
6	of connected to the transmitter bullatin. So we were trying
7	to decide if it was reportable under 50.73 and we determined
8	it wasn't. But my management kept asking, well, isn't it
9	like Part 21. If the NRC has adequate information, why do
10	we have to tell them again. Though it's not in 50.7273,
11	if we've responded to the generic letter, if we had
12	determined it was reportable, why should we report it again?
13	MR. NOVAK: I don't know if we got the full intent
14	of the question.
15	MR. CHAFFEE: Correct me if I'm wrong. What
16	you're saying is if you've told the NRC through responding
17	to the generic letter, do you need to tell them again
18	through writing an LER.
19	MS ARNOLD: Right.
20	MR. CHAFFEE: That's the question.
21	MR. NOVAK: Would you mind providing an answer?
22	[Laughter.]
23	MR. CHAFFEE: If it's reportable, you report it.
24	MR. CROOKS: What I would say is if it's another
25	event and it is reportable, you've determined it isn't

reportable, and it is reportable, then I think you would send in and make the notifications. If there are other circumstances -- why don't we just go from there. What you're alluding to, there certainly are a number of things in the database for problems that are known and are continuing to happen and people are focusing on.

7 MR. PETERMAN: I'd like to address that just a 8 second. What we have done in the past, if the event is 9 similar enough, we would handle it with a supplement to the 10 original report.

MR. CROOKS: Okay, but don't go too far with that 11 one. There is some guidance, if they're within 30 days and 12 all that kind of thing, fine. We have looked at that. And 13 that, by the way, is not -- I think I looked at that and I 14 found that there were two or three events that had five or 15 16 six supplements at the most, and four or five of those were really new events. They did have some different information 17 in them. So there was a little bit of gamesmanship in that. 18

But in most cases, the supplements are providing new additional information. That was the intent of the supplements.

22 MR. HARRIS: Ray Harris, PP&L. If you 23 collectively reach an opinion that certain things don't need 24 to be reported, like reactor water cleanup isolations that 25 are inadvertant and are not related to a need for isolation

in the way of a leak, or HVAC, it seems to me you'd be free to issue an exemption and not wait two or three years for rulemaking and just stop it. Why not do that?

MR. NOVAK: Well, if we thought we had to wait two to three years to do just what we've suggested, we would take a different action. We think that it's very possible that those kinds of changes could be entertained under what we call minor rulemaking.

9 MR. HARRIS: Two years ago I heard an NRC 10 individual say that you were thinking about doing that.

11 MR. NOVAK: We have also looked at the exemption option and that still is open. You've got a good point, 12 though. I'm not minimizing the fact that we promised more 13 than we can deliver sometimes in terms of changes in the 14 15 rule. But we've got the operating experience now, we've got the reg impact study, we've got pretty much a directive from 16 17 our agency to move forward in this area, to do what we can 18 and do it quickly.

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Other questions? Yes?

MS. GOODMAN: Lynne Goodman, Detroit Edison. Another thing that would be helpful in the guidance that's going to be coming out, if you could address guidance -- the condition many of us have in our license regarding items that aren't otherwise covered by tech spec reporting requirements, there a violation of a license condition, they

1 still get reported under an LER.

Since that uses the LER form, it follows 50.73, 2 even though the criteria of 50.73 isn't met. Some 3 additional guidance on that as far as what kind of detailed 4 items are considered to be reportable under that criteria 5 would help. An example of that might be we're all required 6 to have, or many of us, fire protection programs. If you're 7 an hour late on doing the fire drill, does that make it a 8 violation of your license, and so an LER? Some of those 9 types of questions have come up over time. 10

MR. NOVAK: Thank you. Other questions? Yes, go
 ahead.

13 MR. PROBST: Jim Probst, Iowa Electric. Will the 14 utilities be given the opportunity to comment on the new 15 NUREG supplement before it goes out so that we can see that 16 all these questions we are asking are being taken care of so 17 we don't have to go through this again in a couple years?

18 MR. NOVAK: We had that question asked of us, I 19 think it was at the Atlanta meeting. I sort of answered it 20 by saying yes, but also as part of the response, I think Ed 21 Jordan mentioned that we don't want to delay this thing. In 22 other words, we'd like to be able to move forward.

If we send something out and ask for peer review comments, we're sending it out to the world; not just to you, but to anyone else that wants to comment on the

guidance document. And then, in the sense, we lose a certain amount of control over how guickly we can respond. 2 So it's a compromise. If we think we've got the essence of the things that are on the table for clarification or 5 possible change, I think you would want us to go forward with it. 6

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In other words, I think we're looking to improve 7 the system. We'll never make it perfect. So I think that 8 would be my response today on reflection. If we can get the 9 essence of what needs to be done, let's go about doing it. 10

MR. PROBST: Will you be using, say, the BWR 11 Owners' Group and some of the other utilities in an informal 12 13 way to get some -- it just seems like we're doing this -these meetings, you're going to go away and come back with a 14 completed document and we'll have to live with it. 15

MR. NOVAK: We'll take that under consideration. 16 We've had at least one meeting with the BWR Owners' Group. 17 We're not against those kinds of meetings, but we do want to 18 19 try to move this thing forward. After while, we'd like to see it where it sort of says, okay, we've gone far enough, 20 21 let's try to wrap this thing up.

Other questions? Yes?

23 MR. PENDERGAST: I'm Joe Pendergast from Detroit Edison. When we were talking about exemptions to reporting 24 25 requirements, I was wondering if there were ever any issued

1 to date. I've talked to several plants and nobody seems to know of any.

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MR. NOVAK: Let me give you a quick answer. If we 3 had someone from General Counsel here, Marty would give you 4 a very direct answer. The logic that the lawyers always 5 come is if you want an exemption, if it's plant-specific, 6 fine. If the issue is generic, you go to rulemaking. In 7 other words, they don't like to grant generic exemptions 8 because that's not the purpose of the exemption. The 9 purpose of the exemption is that you, as a specific 10 individual, the utility, have a specific problem or some 11 12 situation that the rule was not intended to cover or it treats you unfairly and you come in and ask for an 13 exemption, that's a legitimate use of the exemption process. 14

All boilers have reactor water cleanup systems. 15 16 For us to grant an exemption that says you don't have to report reactor water cleanup systems, it could be done, but 17 18 the lawyers are saying that's not the process that was 19 intended to accomplish that. If you want to change that, get it out of the rule. It's simple enough. 20

So I think that's the kind of thing that we see 21 when we look at exemptions. Other questions? 22

[No response.]

MR. NOVAK: Why don't we do the following? Let's 24 take about a five-minute break and then we're going to start 25

up with safeguards. Thank you.

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[Brief recess.]

MR. NOVAK: Before we started, I want Ed Greenman 3 4 to respond to suppose I decide there's no corrective action 5 required.

[Laughter.]

MR. NOVAK: You can't -- Bert Davis will be here 2 tomorrow talking to it. 8

9 MR. GREENMAN: I debated deciding it myself, but I decided that would be out of character for me. So I'm honor 10 bound to respond to that. It's obvious that there's a lot 11 12 of frustration just upon the amount of time we've spent talking about reactor water cleanup system isolations, and I 13 14 think it's especially appropriate since we have out-of-15 region guests from other plants in the different regions.

If any utility says in an LER that we don't plan 16 17 to take corrective action, I guess, first of all, I would find that refreshing since normally what I hear is that 18 19 you're going to revise procedures and do some training. 20

[Laughter.]

21 MR. GREENMAN: That would obviate some of the 22 discussion that we might usually have about whether or not 23 you were capable of coming up with an engineering fix to a system that you and we normally would expect to operate 24 25 properly. But seriously. We would look at any evaluation that you sent in that made common sense and had a safety
 payoff. I think that's the bottom line.

I'm aware in Region III that people are capable of 3 designing themselves around what happens to be a real 4 5 problem with RWCU. That's what, from a regional perspective that I would expect. What kind of safety 6 payoff? I think you, your plant management, and corporate 7 management have to ask yourselves the question, even on 8 9 those types of isolations that neither you nor we see have a significant safety impact, what kind of a distraction 10 11 responding to those types of events over and over again has to do on your operating staff and what it diverts their 12 13 energies and other more important things they must be able 14 to do.

So we entertain any proposals that you might want to send in. Thank you.

MR. NOVAK: Thank you, Ed. What we'd like to do 17 now is move over into the safequards area. We've asked two 18 19 additional staff people to join us on the panel. To my far 20 left is Joan Higdon, who is in the Domestic Safeguards Branch of NMSS. Then to her right is Nancy Ervin, who is in 21 the Safeguards Branch of NRR. Nancy is going to be our 22 first speaker, and she is the NRR professional responsible 23 for evaluating and developing NRC policy in the safeguards 24 event reporting area. 25

So we'll just move right into that area. Nancy? 1 2 MS. ERVIN: I'm going to discuss our regulation that deals with reporting of safeguards events. For the 3 benefit of those who aren't in safeguards, I'll give a brief 4 5 description and history of the regulation. Then I will be 6 discussing some activities that we have going to revise our guidance on reporting of events. It's in an effort to 7 eliminate unnecessary reporting. Also, we're revising it to 8 9 better clarify our reporting requirements.

10 10 CFR 73.71 requires licensees to report 11 significant safeguards events to the NRC Operations Center 12 within one hour after the discovery of each event. Although 13 the rule covers fuel facilities, transportation of S&M and 14 some non-power reactors, I'm going to limit my discussions 15 to the power reactors because of the audience that's 16 present.

Significant events are those that threaten nuclear 17 activities and have the potential to endanger the health and 18 19 safety of the public. These events include acts, attempts 20 or threats to do significant physical damage to a power 21 reactor, including the interruption of normal operations through tampering. Significant events can also include 22 23 safeguard system failures if the failure is uncompensated, if it hasn't been compensated, and if it could allow 24 :5 undetected or unauthorized access into a protected or vital

area.

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The rule also requires licensees to record certain less significant safeguards events in a log for quarterly transmittal to the NRC. These events include safeguard system failures that are compensated and that do not immediately endanger the health and safety of the public.

7 73.71 was originally published in 1973. A major 8 revision to the rule was published on June 9, 1987 and it 9 was effective October 8, 1987. The purpose of the revision 10 was to clarify 10 orting requirements, eliminate unnecessary 11 reporting, and improve NRC's data analysis system. Reg 12 Guide 5.62, entitled Reporting of Safeguards Events, was 13 revised in November 1987 to clarify the rule revisions.

14 NUREG-1304, same title, was published in February 15 1988 to address questions discussed at a September 14, 1987 16 workshop on the revised rule. Prompt notification of 17 significant events is very important. We analyze these 18 events for their immediate impact on the safe operation of 19 the plants and the health and safety of the public.

20 Some of the events may warrant NRC oversight, 21 which can include activation of the NRC Information 22 Assessment Team or the NRC Response Center. In some cases, 23 we may also need to notify other agencies, such as the 24 Federal Bureau of Investigation if sabotage is involved, or 25 the Bureau of Alcohol, Tobacco and Firearms if explosives

are involved.

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2 If the event affects other licensees or agencies, 3 we may issue an immediate generic communication. More long-4 term feedback would be rule or guidance revisions, as 5 appropriate. An example of this is a generic letter that 6 we've recently developed in an effort to reduce unnecessary 7 prompt reporting that I'll be discussing shortly.

8 The loggable or less significant events that we 9 receive each quarter are reviewed to determine if generic 10 safeguards system effectiveness problems exist or are 11 developing. Our formal long-term analysis is conducted by 12 NMSS and results are forwarded to the licensees. Ms. Higdon 13 will be discussing this analysis shortly.

We issue generic communications and initiate rule 24 15 or guidance revisions when necessary based on review of these event logs. A recent example of a generic information 16 -- a generic communication is Information Notice 90-13 17 18 entitled Importance of Review and Analysis of Safeguards Event Logs. This information was issued to remind licensees 19 of the benefits of meaningful reviews and analysis of event 20 logs and reports required by 73.71. 21

It was also issued to remind licensees of the importance of initiating prompt, effective corrective measures to prevent recurrence of the identified problems. The information notice was generated because of a 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, to get to the root of the problems.

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5 About a year ago, we initiated a revision to Reg Guide 5.62 and NUREG-1304 to incorporate lessons learned 6 from two years experience with implementation of the revised 7 8 73.71 rule. The revision is based on our evaluation of the safety significance of all events reported and the immediate 9 actions taken by the licensees and by the NRC. The proposed 10 revision incorporates appropriate parts of NUREG-1304 into 11 12 Reg Guide 5.62 and will result in additional reduced 13 reporting, primarily in the area of one-hour reports and 14 fitness-for-duty events.

15 It also will provide further clarification of the 16 reporting requirements, which was our intent when we revised 17 the reg guide before. The revision also addresses improvements necessary for event log analyses programs. We 18 intend to issue the revised reg guide for public comment by 19 the end of this year. This may be optimistic because the 20 reg guide has to go through extensive inhouse concurrence, 21 22 and that includes going through CRGR before we even put it 23 out for public comment.

24 We have also developed a generic letter that, when 25 published, will eliminate unnecessary prompt reporting of

certain safeguards events. The generic letter also provides further clarification of our published guidance for some events. It will reduce unnecessary reporting to the NRC Operations Center and reduce the reporting burden on licensees.

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6 The generic letter represents an immediate 7 revision to our current published policy, and is responsive 8 to concerns raised in the impact survey. It should be 9 published in the near future. It's in CRGR right now for 10 backfit considerations.

We intend the generic letter to be guidance only. When it's published, there is no written response that will be required and any actions taken by licensees in response to it will be strictly voluntary. The generic letter maybe modified in the final revision to Reg Guide 5.62, but that wouldn't be for at least a year. Again, this is because of the lengthy process involved in revising the reg guide.

This is why we went with the generic letter, because we knew it was going to take too long and we wanted to get something out to provide some relief from these unnecessary reports that are coming in.

The policy changes that I'm going to discuss will not be effective until the generic letter is published, and that's because it's pre-decisional until it gets through CRGR and it actually is published. Until that time, you

should continue to follow the published guidance. If you have site-specific concerns, you can contact me, your license reviewer, or your region. We didn't put a handout on the generic letter, and, again, it was because it was pre-decisional.

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Before I talk about the specific events that are 6 7 listed in the generic letter, I'll go through some of the 8 more generic policy in the letter. Our current published 9 policies suggest that licensees report safeguards system 10 failures to the Ops Center within one hour of discovery if they're not properly compensated within ten minutes by a 11 12 licensee employee, contractor, or vendor, or within the time prescribed in the licensee's approved security plan. 13

14 This is already stated in Reg Guide 5.62. We've 15 revised our policy on this to allow logging the event even 16 if it takes longer than ten minute to comp it, if extenuating circumstances prevent the timely compensation, 17 and this is provided all other aspects of proper 18 19 compensation as currently described in Reg Guide 5.62 and 20 NUREG-1304 are met; also, provided there was no malevolent 21 intent, nothing adverse resulted from the delay, and that 22 the licensee takes appropriate measures to ensure a more 23 timely response or other necessary action in the future.

An example of this type of event is when an individual inadvertantly fails to notify security of a

safequards event in a timely manner. This is what typically
causes the delay in the ten-minute window for your
compensation of the event. When you do log an event and
it's one that you could not comp it within ten minutes, you
should note the cause of the delay in the log entry, why you
couldn't comp it within ten minutes.

7 Another policy change deals with fitness-for-duty 8 events. Significant fitness-for-duty events are now 9 reportable under 10 CFR 26.73 and not under 73.71. Fitness-10 for-duty performance data must be submitted under the provisions of 26.71(d). In those rare cases where an event 11 12 with safeguards significance was caused by a fitness-for-13 duty event, the fitness-for-duty aspect should be reported 14 to NRC in accordance with Part 26 and the safeguards aspects 15 in accordance with 73.71.

When a telephonic report is required by both rules, the licensee need only make one call to the Operations Center, if it's made within one hour, which is the requirement for the safeguards events. That's your choice. If you want to make separate reports, that's fine, but if you do want to make one, it would have to be within the one hour of discovery of the safeguards degradation.

In either case, a tten report of the safeguards aspects must be submitted with 30 days as required by 10 CFR 73.71. Now I will discuss the events listed in the

generic letter that can be logged instead of being reported
 to NRC within one hour of discovery.

These events have been coming into the Ops Center 3 during the past three years. You can log them, if you want 4 to, once the generic letter is published. These events can 5 be logged if they're properly compensated in accordance with 6 the guidance provided in Reg Guide 5.62 and NUREG-1304, and 7 8 the areas of the generic letter that we just discussed. When there are factors that could change the reportability 9 of specific events, I will discuss them with that particular 10 11 event.

12 The first one is a design flaw or vulnerability in 13 a protected or vital area safeguards barrier. If the flaw 14 or degradation existed for more than ten minutes -- in our 15 guidance that's already out, this was a one-hour report. 16 Now if it's properly compensated and nothing adverse is 17 discovered, now you can log the event.

18 The next example is a failed compensatory measure, 19 such as an inattentive or sleeping security guard, or 20 equipment that fails after being successfully established as 21 an effective compensatory measure for a degraded security 22 system. If security personnel are ineffective because of alcohol or drugs, the security degradation is reportable 23 24 under 73.71, and the licensee should include the positive 25 results of the for cause test in the data submitted to NRC

under 26.71(d).

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The next example is discovery of contraband inside 2 the PA that is not a significant threat. For example, such 3 a condition could be the discovery of a few bullets or a 4 weapon that was inadvertantly left unattended by the 5 security force. If contraband is found in a vehicle located 6 in a parking lot outside of the PA, the event does not have 7 to be reported or logged as long as there is no threat or 8 9 attempted threat associated wit's it.

10 The next example is compromise, including loss or 11 theft of safeguards information that could not significantly 12 assist an individual in gaining unauthorized or undetected 13 access to a facility or in an act of radiological sabotage 14 or theft of S&M.

The next example is loss of all AC power supply to 15 16 security system or loss of all computer systems provided adequate compensatory measures can be maintained until the 17 systems are restored. If a pover loss or computer failure 18 could not enable the unauthorized or undetected access, no 19 20 report or log entry is required. For example, a computer failure would not require reporting if it's negated by an 21 22 automatic switchover to a functioning backup computer 23 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. The lat group of loggable failures deal with partial failures of an otherwise satisfactory access authorization or access control program.

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5 The first example is a vendor who has been cleared 6 and authorized to receive a badge permitting unescorted 7 access to protected and vital areas who inadvertantly enters 8 the PA through a vehicle gate before being searched and 9 before being issued a badge. The licensee discovers the 10 event, searches the individual, issues a badge and takes 11 corrective action to prevent recurrence.

Again, with all of these, it's based on proper comp measures and that nothing adverse happens. If something is discovered that constitutes a threat or it endangers the health and safety, then from the time it's discovered, your one-hour clock starts for reporting it to the Center.

If search equipment fails and the licensee does 18 19 not detect the failure, thereby allowing unsearched 20 individuals to enter the protected area, you can log the event. If licensee -- and, again, if nothing adverse 21 happens from the event. If the licensee discovers search 22 23 equipment failure before anyone goes through unsearched and immediately uses other equipment with the same capabilities, 24 25 such as a hand-held or another detector that is functioning,

1 no report or log entry is requirad.

2 The next example is an individual who is required 3 to have an escort for a particular area who inadvertantly 4 becomes separated from his or her escort, but the escort or 5 an ther person authorized unescorted access recognizes the 6 situation and corrects it. If an individual separates from 7 his or her escort to use a restroom which has limited means of egress and the escort remains nearby with full view of 8 9 the egress area, no report or log entry is required.

10 If an employee of a licensee or contractor or 11 licensee contractor enters the VA improperly without 12 realizing that the card reader is processing a preceding employee's card or the employee walks in behind another 13 14 employee without using a card, tailgating, the event can be 15 logged, even if the employee was not authorized access to any vital area, if the improper entry was inadvertant and 16 17 without malevolent intent.

18 If an individual enters a vital area to which he 19 or she is authorized unescorted access by inadvertantly 20 using an access control medium, key card or badge, intended for another individual who is also authorized access to the 21 22 area, this can be logged. If an individual is authorized only PA access and is incorrectly issued a badge granting 23 24 vital area access, but does not enter vital areas or does 25 not enter vital areas with malevolent intent, the event can

be logged.

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2	Further, if an individual is issued an incorrect
3	badge, but cannot reasonably use it because for example,
4	if he or she would need to know a four-digit or five-digit
5	PIN ' order to get into the protected area and they had
6	been
7	area, they can't key anything in because they don't know the
8	code, then you would not have to report this, you would not
9	have to log it because it's not reasonable to assume that
10	they could have compromised the system, unless there's
11	intent. If intent comes into it, that's different. But if
12	it's just someone that's been given a wrong badge, then no
13	report or log entry on this particular one.

14 The next example is improper control to include loss or off-site removal of access control media, including 15 picture badges, key, key cards or access control computer 16 codes that could be used to gain unauthorized or undetected 17 access. Proper compensation includes preventing successful 18 use of the medium and initiation of measures to determine of 19 20 the medium was used during the period it was lost or off-21 site.

If the licensee determines that it was used during this period, you should report the event to the NRC from one hour from when you discovered that the medium was used. If the licensee determines that the medium could not have been

used to gain unauthorized or undetected access, you do not have to report or log the event. Situations of this type could include the following; if the authorized individual 3 only momentarily takes a badge outside of the PA and the event is immediately discovered and corrected by return of 5 6 the badge before compromise could occur; if a badge or key is only momentarily misplaced and the event is discovered 7 8 and corrected before anyone could reasonably use the device for entry; or, if a badge is automatically deleted from the 9 10 system when taken off-site, a new badge with a different access code is issued to the individual involved upon 11 reentry, and the previous code is not used in another br.dge. 12

Those are examples of events that would not be 13 14 reportable and you would not have to log them. Card reader failure that causes vital area doors to unlock in the open 15 position or to lock in the closed position, but with no 16 17 functioning door alarm can be logged. If card reader 18 failure causes VA doors to lock in the closed position and 19 the door alarm functions properly no report or log entry is required. 20

The last example of a loggable event is incomplete preemployment screening records, to include falsification of a minor nature or inadequate administration control or evaluation of psychological tests. Unescorted access of the individual should be cancelled or suspended until the

identified anomaly is corrected. If the licensee determines that unescorted access would have been denied based on developed information, a one-hour report is required after discovery of the new information. This is currently stated in 5.62 and 1304.

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Those are the examples of events that, although they have been coming in with one hour, can be logged once this generic letter issues. Now Joan Higdon will address the safeguards analysis system that NMSS does for us.

MS. HIGDON: Good afternoon. I am Joan Higdon, MS. HIGDON: Good afternoon. I am Joan Higdon, Manager of the Logs Analysis Program. T'd like to take a few minutes right now, give you some i background information on the program, our purpose and goal and objective. The Division of Safeguards and Transportation has responsibility of conducting and implementing the logs programs.

Activities associated with this effort are the review and analysis of reported events in the guarterly logs and the feedback to NRC and the licensees of analysis findings and statistical data. The goal of this program is to serve both audiences. The logs is one mechanism to be used for improving safeguards system performance.

23 Emerging from this program are a number of cases 24 where the event logs and feedback data were the bases for a 25 root cause analysis and resulted in improved equipment

operation or reduced human error. Additional staff resources have been dedicated to this program at this time, which will enable us to perform a technical analysis of the event data and the results provided as a companion report or on an ad hoc basis on various topics as a companion to the guarterly log report.

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7 Each quarter, review and analysis is performed for each quarterly log submittal. Reported events are 8 9 categorized based on the root cause of the event. We are 10 focusing on specific components that fail, type of human 11 error or environmental factors that impact on this system. 12 The results of this review are distributed to each reporting 13 licensee and appropriate NRC staff. Copies are distributed at the corporate level on an as-requested basis. 14

For anyone who is not on our mailing list and would like to be added, please see me after the meeting. The facilities are listed by random code number and we have done that for two reasons. One is so the report would not be safeguards information and the other is that we did not want to reveal the statistics being reported from each facility by name.

The quarterly report presents statistical data from events reported and with regional and industry averages. These numbers, whether they are event totals or average, are to be used as a point of reference only for the

licensee and NRC staff. These numbers are not the norm or standards of performance for any facility, event category or any reporting order.

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These numbers should be evaluated along with an understanding of a facility's design, equipment, population, on-site and other circumstances that impact on reporting for that particular guarter. Although numbers are useful in trend analysis, we find they vary substantially from facility to facility as a result of site-specific characteristics and other factors that impact on reporting.

11 Therefore, emphasis is being placed on identifying and evaluating the root cause of unusual trends and reported 12 events. There is much value in the analysis program for 13 14 maintaining effective safeguards. The use of the event logs 15 and feedback reports are designed to be a positive approach for improving system performance. The trending of events 16 from quarter to guarter will focus inspection resources to 17 18 specific areas that merit closer examination.

Emphasis is placed not just on the event numbers, but what that number is comprised of, what events went into that number, what circumstances affecting reporting. NRC feedback to industry will give the licensees an opportunity to evaluate equipment 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.

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9 The event data should be reviewed again in 10 conjunction with the previous quarter's data. We do not 11 want to focus on one quarter. We want to focus on a 12 facility's reporting trend and events reported from quarter 13 to quarter. As mentioned earlier, there are cases where the 14 logs and feedback report highlighted, indeed, for certain 15 changes at a facility.

16 The analysis findings have resulted in 17 modifications to equipment or security procedures which 18 improved the reliability of reduced human error. These 19 findings are provided to industry since it may have 20 application at other facilities. We're hoping that the 21 feedback report will be used as a medium to exchange 22 information across industry, to share information of 23 analysis findings, or where changes have improved a 24 facility's operation.

Some of these are mentioned very specifically in

your handout, but just on a side note some of the information that I've had in talking with the licensees and how they've been using the logs, it's very interesting to see some of the changes that have come cut of your analysis, and a lot of them do not involve a lot of additional costs.

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6 There was one facility that -- they noticed that 7 their card readers that were located in very high traffic 8 areas did not have the reliability of others. Upon further 9 investigation, it was an insertion type, they found that the 10 tab on the inside was interfering with the card being lined 11 up with the sensor to read the code. They removed the tab 12 and they said it increased reliability significantly.

Another facility noticed that their rate of badges taken out of the protected area increased on Fridays than any other days. What they had done is, on Fridays, they have over a loud speaker and at different times, to people leaving the area, a reminder to turn their badge in.

So some of these are very simple changes and I've noticed that there is really no medium at all to exchange this information. We're hoping to start that through our quarterly feedback report. We want to include in our report not just numbers, but some worthwhile information.

23 Another facility found out by installing a strobe 24 light that comes on when you exit a security door and stays 25 on until the person has shut the door and it's secured, they

found their rate of unsecured door events went down. That strobe light served as a reminder to the individual exiting that door was not shut and secure.

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As mentioned earlier, we have provided additional resources to the program. We want to have a technical review of the data by our technical staff. We want to review it for different topics. If any of the licensees have suggestions on anything that they would like to see in our analysis, please let us know. We're open to any suggestions.

11 Right now, facilities are being compared on an 12 equal basis. We have a contractor working with us to change our computer program and we want to normalize the data so 13 14 when we give feedback to the licensees, when we present data 15 for like CCTB events or unsecured doors, that we are 16 comparing like facilities. So over time, the guarterly report will be revamped to group facilities that have like 17 18 characteristics and hopefully that will take on more meaning 19 with the event numbers.

Finally, our staff is very sensitive to industry's concerns and need with regard to this program. We appreciate the opportunity to talk with you and to have your input at the Orlando meeting. This information received was very useful in our effort to improve the program and we want to benefit from our experiences so NRC and industry can take

a positive ar proach for improving their facility's
 operation.

I think now we can take questions from the group. MR. NOVAK: Thank you, Joan. Any question right now? Why don't we start with anything doing with safeguards.

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7 MR. SAUNDERS: My name is Barry Saunders and I'm with Commonwealth Edison's nuclear security, and this is for 8 Ms. Ervin. One of the things that you indicated was that 9 logging -- you can log events if extenua' ng circumstances 10 11 require measures to take longer than ten minutes. How much 12 longer than ten minutes? I mean, it's going to get down to is 15 minutes too long, is a half-hour too long, how much is 13 14 acceptable?

MS. ERVIN: We were going to allow for licensees 15 for reasonable judgment with that. If you'd like a more 16 specific window, we can consider that. The generic letter 17 18 isn't out yet. But we had in mind that if a licensee would take appropriate measures immediately within ten minutes 19 20 after finding out of the event, and there may be some cases where even after you've been notified of an event, even if 21 the notification was timely, that there is something that 22 causes a slight delay, but it's not something that, again, 23 24 endangers the health and safety of the public or the safe 25 operation of the plant.

We were going to leave the window open to reasonable judgment. We would not expect it to take days or weeks or hours, in some cases, and that would be very eventspecific. To be able to sit here and give you different timeframes for different types of situations, you'd get into a lot of variables.

7 MR. SAUNDERS: I think for guidance purposes, so 8 we don't get into those various situations, there should be 9 maybe some guidance on what is reasonable, because 10 reasonable to you versus me versus Region III versus Region 11 IV or V could be varied tremendously and we might be still 12 in that same bag of what is reasonable. So I would 13 appreciate consideration for that.

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MS. ERVIN: Okay.

MR. SAUNDERS: Secondly, you talked about barrier degradations, if found within ten minutes, could be logged. Does that apply to longstanding barrier degradations?

18 MS. ERVIN: Yes, it does.

MR. SAUNDERS: That may have existed for years and once you find them and comp within ten minutes, that would be a loggable only.

MS. ERVIN: Yes. But, again, this is based on your investigation and your determination that nothing adverse happened as a result of it.

MR. SAUNDERS: Right.

MS. ERVIN: And that the safe operation of the
 plant is not jeopardized.

3 MR. SAUNDERS: Thank you. Contraband. The 4 definition of contraband, if I'm not mistaken, and maybe you 5 just alluded to this, is firearms, explosives, and 6 incendiaries. You mentioned bullets. Bullets doesn't necessary fall under firearms, explosives or incendiaries. 7 Is that a new interpretation to include in contraband or is 8 that just an accepted -- included in firearms, incendiaries 9 or explosives? 10

MS. ERVIN: Well, bullets are part of fircarms. If the person's got the bullets in the weapon, that's where it becomes more dangerous.

MR. SAUNDERS: That may be more difficult if you look at more applications of finding a bullet on an ingress search versus a firearm on an ingress search. I don't know if that's possible. I'll just throw that out for --

MS. ERVIN: So what you're really getting at is if someone detects a bullet during an entrance search, should you have to log it? Is that what your question is getting toward?

22 MR. SAUNDERS: I guess my question is -- well. 23 Let's leave that one for a second and go on to the next part 24 of contraband. If you find contraband during the ingress 25 search process, is that still a one-hour?

1 MS. ERVIN: By our current guidance, that is a 2 one-hour and that is not something -- one-hour -- that's a loggable event. That's by the current guidance that's 3 4 already out. If you find something during the search and 5 there is no malevolent intent and you determine that, by the 6 current guidance that's out, you could log that. You do not 7 have to call that in within one hour. But it is loggable. 8 MR. SAUNDERS: During the loss of all -- you said 9 AC power to the security system. What happens if you have 10 DC power that instantaneously switches over? 11 MS. ERVIN: It would be the same concept. 12 MR. SAUNDERS: Okay. Same concept. Good. 13 MS. ERVIN: These are just examples and they're 14 not --15 MR. SAUNDERS: I realize that. 16 MS. ERVIN: -- all encompassing. MR. SAUNDERS: These conjure up all sorts cf 17 questions and what if's and possibilities with regards to 18 how we would be reviewed and evaluated against to those 19 20 comments. Getting back to the bullet, you're considering bullets to be contraband then. 21 22 M3. ERVIN: Bullets do fall under contraband. 23 MR. SAUNDERS: Okay. Even in the definition -- I 24 quess --25 MS. ERVIN: They do explode and they do go with a

gun.

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MR. SAUNDERS: I understand that, but I'm not so 2 sure that everyone looks at bullets as contraband. 3 4 MS. ERVIN: Are bullets something that licensees 5 allow to come in their sites? MR. SAUNDERS: No, no. That's a prohibited item 6 that we wouldn't allow on-site. 7 MS. ERVIN: So that's contraband that you don't 8 9 allow on-site. MR. SAUNDERS: No. It's prohibited items which we 10 wouldn't allow on-site, which would not require a one-hour 11 call prior to this time. If you look at firearms, 12 13 explosives and incendiaries as being what's contraband and 14 would require a one-hour, bullets may fall out of that category. But if you're saying now that bullets by 15 themselves could be contraband and that would require a one-16 17 hour, then --MS. ERVIN: No. We're not saying it requires a 18 one-hour. We're saying that if a single bullet is found 19 somewhere and there doesn't appear to be any threat to the 20 plant that you could log the event if you determine there is 21 no threat. 22

MR. SAUNDERS: Fine. Thank you very much.
MS. ERVIN: You're welcome.
MR. NOVAK: Other questions?

MS. ERVIN: By the way, these are reports that have come in within one hour, and that includes finding a bullet somewhere in a protected area. So this is why we wanted to address that specific example, because we felt if it did not represent a threat, then you should not have to call it in within one hour. You could log it.

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7 MR. BROWNELL: Jim Brownell, Illinois Power.
8 We're one of the ones that did call it in, so we thank you
9 for that. A couple things. By issuing this generic letter,
10 are we essentially changing the rule?

11 MS. ERVIN: Not the rule. What we're doing is we are revising our position in previous guidance that's been 12 13 put out, but the changes do not change the rule and they 14 don't change the intent of the rule. After we had 15 experienced -- we had been under the new rule for about two 16 years, we started analyzing all of the events that had been 17 coming into the Operations Center under the one-hour 18 reporting criteria.

We also took a look at some of the events that had been coming in as log items. We took into consideration comments, concerns that had been expressed by licensees during this two-year timeframe. This evaluation took us about a year. We're going on three years now since we first had the revision to 73.71. So after analyzing all these events, we determined that we needed to revise our policy,

our guidance.

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It was not that the intent of the rule was being revised, but we found that where the rule wanted significant events coming into the Center, some of the things that we had thought were significant and should be reported, in 5 fact, were not. So this is why you're seeing this policy 6 7 revision.

MR. PULEC: Rick Pulec, Wisconsin Public Service. 8 I don't have a good handle on definitions of safeguards 9 information, but generally I've been under the impression 10 that if it can significantly assist an individual, then it 11 is safeguards information; otherwise, it isn't. That's 12 probably a misconception, but could you clarify to me what 13 the difference is between the new guidance that you're 14 15 saying if it can't significantly assist an individual, what 16 does that mean?

17 MS. ERVIN: Well, we said compromise of information that could significantly assist. In the 18 guidance that's currently out, if safeguards information 19 that could significantly assist somebody was compromised, it 20 was a one-hour report. What we're saying now is that if you 21 determine that this information could possibly help someone 22 in evaluating or determining whether or not this was a path 23 to get into the site or --24

MR. PULEC: Maybe the question would be what type

1 of safeguards information cannot significantly assist or 2 compromise. That's the differentiation, I guess. I just 3 don't understand it, but maybe you could clarify that 4 difference. Where is that threshold at?

5 MS. ERVIN: Let me give you an example. We had a 6 licensee call us not too long ago. There were some 7 blueprints that were out and they contained safeguards 8 information. They were rolled up and they were in a pile 9 with some other blueprints that were not safeguards 10 information. These were left unattended overnight. They 11 were left out in the open.

12 The next day, the licensee found them. The 13 building was controlled. They had a guard there to control 14 access, but they had an uncleared cleaning person that came 15 through. The licensee didn't know whether they had to 16 report this type of an event within one hour or if they 17 could log it. The information that was in these rolls and rolls of blueprints was very voluminous. It was a lot of 18 19 information and the licensee couldn't really make a 20 determination on the spot.

It is hard to determine sometimes if the information would significantly assist. I see what you're getting at, but if it wouldn't significantly assist, you don't think it should even be safeguards information.

MR. PULEC: I don't understand --

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MS. ERVIN: But there is a difference between 2 information that if you gather it here, here, here and here and put it all together, then it would significantly assist, 3 or if information is -- if you've got a lot of information that it may or may not. It might be a plan that by 73.21 5 you're allowed to classify safeguards in the total. A plan 6 can be a security plan. The whole plan can be classified 7 safeguards.

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9 Now, clearly, every page in that security plan is not safeguards information. But it is safeguards 10 11 information under the rule. When that rile was developed, this was for the convenience of industry, as well as NRC, 12 because it's so hard to separate every little bit of 13 safeguards information. You'd have to stamp and control 14 15 each page. That would have been an unreasonable burden.

So the NRC said, okay, we'll allow you to just 16 17 stamp the whole document safeguards and protect the whole 18 thing safeguards. This goes for procedures that are developed. They have allowed you to mark a document in 19 total safeguards or a manual in total even if all of it is 20 not. So sometimes parts of it are found and it's marked 21 safeguards, but they're not sure. They have to look at it 22 and determine. 23

This is where your safeguards significantly would 24 assist or does not. Some of it is, in fact, not even 25

safeguards.

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2 MR. PULEC: Certainly that's understandable if 3 it's misclassified.

MS. ERVIN: Well, it's not misclassified.
MR. PULEC: Classified for convenience, that's
understandable. But I still don't understand what real
safeguards could be, and I guess the only answer I've gotten
is the composite. A composite package of safeguards,
different facility features.

MS. ERVIN: That's an example. I could -- if you'd like, I could get back to you when I get back to the office. We have been working -- our office has been working on some of these problems that licensees have had in evaluating the significance of safeguards information. So if you'd like, I could get back in touch with you.

This is something when the reg guide comes out that maybe 's ought to address in more detail. But I don't think you're going to have 100 percent clear answer because of the 73.71 rule allowing you to mark entire documents when there's things in there that are not safeguards information.

21 MR. BROWNELL: Jim Brownell, Illinois Power, 22 a. n. Has any consideration been given to low much time is 23 involved with preparing logs? I know at our site we have 24 one person dedicated fulltime. That's all he does is fill 25 out the log. Is that considered in the unnecessary burden

1 thing and by this new guidance we're adding more things to 2 the log?

3 MS. ERVIN: When the new guidance -- by that, you
4 mean the reg guide revisions.

5 MR. BROWNELL: Well, what you're proposing; the 6 generic letters and all that stuff you're saying. These 7 things are going to have to be reported, they should be 8 logged.

9 MS. ERVIN: Well, you may be adding an event or two or however many events to your log, but, yes, we did do 10 11 a regulatory -- we did a cost analysis on it and you save a 12 substantial amount of money because when you report an event 13 into the Center, a one-hour report, for that single event, 14 you have to file a complete written report within 30 days. 15 Now the tradeoff is all you have to do is log it in your 16 log. There's a substantial savings associated with the 17 reduction of these events from one hour to a logged event. 18 MR. BROWNELL: Side question. Have we seen a 19 significant increase in the number of items logged in a 20 guarter?

MS. HIGDON: No. There's been a decrease.
MR. BROWNELL: That's interesting.
MS. ERVIN: And there should be a further
decrease, too, when the generic letter comes out and after
we get the reg guide published, because in the generic

1 letter we're already pro ding examples of events that have 2 been coming in in the logs that you don't have to log. When 3 the reg guide goes out for comment, we're going to be 4 getting your input as far as any events that you feel we 5 haven't covered in the generic letter or in the reg guide 6 that should not have -- that you should not have to log.

MS. HIGDON: Let me qualify that. Are you talking
 about from any particular region or industry-wide?

9 MR. BROWNELL: Well, I'm interested in industry 10 versus region.

MS. HIGDON: Industry-wide. Basically, what I have seen is there have been a decrease in the number of events being reported from the logs, especially from the very first reporting quarter. A lot of that is attributed to fine tuning and a better understanding of events to be reported in the quarterly logs.

17 MR. BROWNELL: Is that regions other than this18 one?

19 MS. HIGDON: Yes, sir.

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20 MR. BROWNELL: What about this region?

MS. HIGDON: There has been an increase in events being reported from the last two quarters as a result of changing reporting practices from six of your facilities, which I know you're aware of.

MR. BROWNELL: That's what I thought.

MS. HIGDON: But I will say this. What they are undergoing right now is what I've seen industry-wide from the very beginning of this reporting quarter. There is kind of a settling down period. 4

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MR. BROWNELL: I'll follow that up. As a result 5 of your analysis then, are you trying to feed back to the 6 7 regions that they may have been getting inaccurate guidance?

MS. HIGDON: No, sir. It's just a better 8 understanding of events to be reported. I will say this, 9 that there's always been a requirement to have a lot. With 10 11 the revised requirements that went into effect in October c? 1987, it's the first time that these logs were to be 12 submitted to Headquarters for review and analysis. 13

MS. ERVIN: Do you have a concern about guidance 14 15 that needs to be more clearly defined? If you do, we can address it. 16

17 MR. BROWNELL: I dug myself a hole now. I guess 18 it's more of a gut feeling than anything else. I think that since the new rule has come out, or in 1987, at least at my 19 site, we went from an average of 30 or 40 events being 20 21 logged each quarter to 250-260 each quarter. I think that's 22 mainly because we've been -- I don't want to use the word ratcheted. We've been asked to include things in our log 23 that we didn't do before and [ don't think it's because of 24 25 what you people are doing, I con't know how we got into it,

1 but that's where I'm headed.

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2 MS. HIGDON: What facility are you from? Do you 3 mind?

> MR. BROWNELL: I work at Illinois Power, Clinton. MS. HIGDON: Yes.

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6 MS. ERVIN: If you do have a concern that you may 7 be -- that someone might be asking you to log things that we 8 don't ask to be logged in our guidance, then I would recommend that you touch base either with your region or you 9 10 can call -- if you have a policy question, I get a lot of calls from licensees all the time with regard to the policy, 11 and I'll be happy to discuss the intent of the policy with 12 13 you. But your region should be the person that you contact 14 if you're concerned that the guidance that you're getting 15 might be more than what is intended.

16 MR. GREENMAN: Jim Creed is the contact and he's 17 here today.

18 MR. NOVAK: I have a question. Is there any chance -- and I was just trying to understand the log. Is 19 it comparable to NPRDS? Maybe you can help me from the 20 21 floor. In other words, can you learn about how well your equipment is operating through the log compared to other 22 people using the same kind of equipment? Is there some 23 feedback process that the log provides comparable to what 24 25 you can get out of NPRDS if you're interested in looking at some equipment performance?

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MS. ERVIN: I can generally say that, yes, the log does provide you a measure to look at your systems from one 3 guarter to the next and to also compare them with industry norms. I understood from Joan that they are getting a lot 5 more specific and they're going to include, like, 6 environmental causes, different types of equipment that fail 7 8 because of different types of reasons. So I don't know about this other system that you'r talking about. I don't 9 know much information it provides you. 10

But from Joan's briefing, this one does allow you to trend if the equipment is functioning and if it's caused by environmental conditions versus mechanical problems. Is that correct, Joan?

MS. BIGDON: Yes. The feedback we're giving is not just -- we've established categories and subcategories to capture the type of events being reported in the guarterly logs, and they're not to be construed as guidance. You still have to refer to the guidance document and the NUREG. But they are designed to capture all the events being reported in the logs.

Like the parameter system, we have broken it down to show those alarms that come in for E fields versus microwave systems versus other systems. For badge events, it shows lost badges, badges taken out of the protected

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area, those that are out of control within a protected area. For access control and authorization, we'll be breaking those down to show tailgating events and those where a badge is incorrectly issued and other access procedures.

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5 For hardware equipment, for door events, we're breaking that down to show that where there is a problem 6 7 with the balance magnetic switch versus another component on 8 the door. So we're further refining the categories to give 9 you as much definitive information as possible. There are a 10 number of licensees out there that are using the logs and 11 the quarterly feedback report to do their own trending, and 12 there is a document included in the report that shows for 13 each facility the events reported and each category and 14 subcategory back to January of 1988.

15 So you can see, when you get your feedback report, 16 you can see for your facility a number of events reported 17 since January of 1988 for CCTVs, door hardware, unsecured 18 doors. This is why I say we don't want to emphasize just 19 looking at one quarter's data, but you want to look at your 20 history and trend of reporting to show where there have been 21 increases and decreases, and to see what has changed and 22 why.

23 MS. ERVIN: Does this compare to the system that 24 you're talking about, Tom?

MR. NOVAK: I think so.

1 MS. ERVIN: Does that answer your question? 2 MR. NOVAK: I think so. 3 MS. ERVIN: Would you like a copy of our guarterly feedback report? 4 枋 MR. NOVAK: I think so. 6 [Laughter.] 7 MS. HIGDON: We'll add you to our mailing list. 8 MR. NOVAK: Just one other guostion. I don't know 9 if you gave a schedule for the generic letter and the 10 revision to the reg guide. 11 MS. ERVIN: I mentioned that we hope that the 12 generic letter comes out soon. It is in CRGR for review 13 right now for backfit considerations. The reg guide we hope 14 to publish within the next year for public comment. Before

15 it goes out for public comment, it also goes through CRGR 16 for backfit review. So hopefully generic letter soon, and 17 hopefully on the reg guide within a year out for public 18 comment.

MR. NOVAK: Does that mean you can operate, one, under the generic letter in the interim until the reg guide is revised?

MS. ERVIN: This is correct. As I mentioned in my briefing, that's strictly voluntary. If a licensee for some reason chooses to continue to call in the one-hour reports, that is your option. This generic letter is strictly

voluntary.

2	MR. NOVAK: Thank you.
3	MS. HIGDON: Could I ask the gentleman from
4	Clinton, do you receive directly the quarterly feedback
5	report?
6	MR. BROWNELL: No.
7	MS. HIGDON: Have you see a copy of it?
8	MR. BROWNELL: Yes.
9	MS. HIGDON: Okry. Do you want to be added to our
10	mailing list?
11	MR. BROWNELL: I think I asked to be added a
12	couple times.
13	MS. HIGDON: Are you receiving it yet?
14	MR. BROWNELL: No.
15	MS. HIGDON: Okay. Well, why don't you
16	MR. BROWNELL: I'll be happy to give you my
17	address again.
18	MR. NOVAK: J think I interrupted someone was
19	going to get up to the speaker. Go ahead.
20	MR. NALEPKA: I just had one question. Dave
21	Nalepka, Wisconsin Public Service. In regard to SALP
23	2 reports, do these guarterly logs and reportable events, are
2:	3 those considered in the evaluation for SALP ratings?
2	MS. ERVIN: No. This was a concern that was
2	5 expressed in the regulatory impact survey and if you're

talking about whether or not your number of events can go against you just strictly by the number, no. This cannot -it should not be happening. Again, if you're concerned that it is happening, then you should talk to Region III and get it resolved.

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6 MR. GREENMAN: As a voting member of the SALP 7 Board representing projects, you're absolutely right. The 8 numbers game and how many numbers, that is not part of the 9 SALP process. What you're doing with loggable events, what 10 they mean and how you react to them and how you respond, 11 that's fair game for the SALP analysis.

12 MS. ERVIN: And that would include, like, remember 13 I mentioned that we put the information notice out because 14 we were concerned because some licensees were, in fact, not. 15 analyzing their problems. We didn't limit them to the logs. 16 That's one tool. You have many tools. You've got your 17 incident records, whatever. You've got your daily logs. 18 You've got your maintenance records. But our concern was 19 that some licensees were not analyzing their problems. They 20 weren't trying to find the root cause and they weren't 21 taking the proper corrective measures to correct the problem and to ensure that it didn't repeat itself. 22

We did, in fact, state the log as one effective tool that you could use to do this, but the problem was it wasn't being done.

MR. NOVAK: Other questions?

[No response.]

1

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MR. NOVAK: We're at a point -- I don't want to drag the meeting on, but if there are any areas that you still have a question, this is the time we were going to put them on the record, or if there way a comment that you wanted to leave, we can do that now.

375

Also, if, in fact, you've got something and you just want to give it to me as a written question, we will take it and it will be included when we develop the guidance document. Seeing no more questions, I would say I think this meeting has come to an end. It's been, I think, a very beneficial meeting.

We expected these things to go a little downhill.
I'm surprised. I think Region III -- we've had a very
active meeting today and, again, I thank you very much for
your participation.

18 [Whereupon, at 3:30 p.m., the workshop was 19 concluded.]

()

20

21

22

23

24

## 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 III Workshop

DOCKET NUMBER:

PLACE OF PROCEEDING: Rosemont, Illinois

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.

Official Feporter Ann Riley & Associates, Ltd.

WINSTON & STRAWN 1015 90

## LEGAL ASPECTS OF BACKFITTING --THE EXPERIENCE WITH IMPLEMENTATION OF SECTION 50.109

NICHOLAS S. REYNOLDS DANIEL F. STENGER

## (FORMERLY BISHOP, COOK, PURCELL & REYNOLDS)

## COUNSEL TO NUCLEAR UTILITY BACKFITTING AND REFORM GROUP

NRC REGIONAL WORKSHOPS ON BACKFITTING

1990



## PURPOSE OF SECTION 50.109

- \* TO RESTORE STABILITY AND PREDICTABILITY TO THE REGULATORY PROCESS
- \* 1981 SENIOR NRC MANAGEMENT SURVEY:

"NOTWITHSTANDING THE COMPETENCE AND GOOD INTENTIONS OF THE STAFF ... THE PACE AND NATURE OF REGULATORY ACTIONS HAVE CREATED A POTENTIAL SAFETY PROBLEM OF UNKNOWN DIMENSIONS."

NUREG - 0839 at 1.

\* UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT AFFIRMED RULE IN JULY 1989



# GENERIC BACKFIT PROCESS

## MAJOR GENERIC COMMUNICATIONS OCTOBER 1988 - SEPTEMBER 15, 1990

	NQ	RESPONSE BURDEN (PERSON-HOURS PER PLANT)	50.109 ANALYSIS
GENERIC LETTERS	18	13,000-17,000	6
BULLETINS	_7	7,500-17,000	Q
TOTAL	25	20,500-34,000	6

WHY REGULATORY/BACKFITTING ANALYSES NOT DONE

\* MANY GENERIC COMMUNICATIONS ISSUED AS "INFORMATION REQUESTS" UNDER 10 C.F.R. § 50.54(F)

EXAMPLES:

- GENERIC LETTER 89-07 (VEHICULAR BOMBS)
- \* GENERIC LETTER 89-19 (SG AND VESSEL OVERFILL)
- \* PROPOSED IPEEE GENERIC LETTER -- COST OF \$1M AND 6 PERSON-YEARS
- IN MANY CASES, "INFORMATION REQUESTS" CALL FOR (1) MAJOR NEW PROGRAMS OR (2) EXTENSIVE ANALYSES AGAINST NEW CRITERIA

ISSUE OF SECTION 50.54(F) VERSUS 50.109
 IS BEING ADDRESSED BY OGC



CRGR DECISION ON USI A-46 (SEISMIC QUALIFICATION):

"UNDER THE PROPOSED RESOLUTION THE ADEQUACY OF THE DESIGN OF A LICENSEE'S FACILITY WOULD BE JUDGED AGAINST SIGNIFICANTLY DIFFERENT CRITERIA THAN WERE USED BY THE STAFF IN LICENSING THE FACILITY INITIALLY ... THESE WERE CLEARLY THE TYPE OF CIRCUMSTANCES CONTEMPLATED BY THE COMMISSION IN APPROVING THE BACKFIT RULE. SECONDLY, THE TIME AND EXPENSE INVOLVED (IN PERFORMING THE ANALYSES) IS CLEARLY GREATER THAN THE 'INFORMATION REQUEST' CONTEMPLATED BY THE COMMISSION IN APPROVING SECTION 50.54(F)."

CRGR, OCTOBER 1986





\* MANY GENERIC COMMUNICATIONS ISSUED UNDER "COMPLIANCE" EXCEPTION TO THE BACKFITTING RULE, SECTION 50.109(A)(4)(I)

- EXAMPLES:
  - GENERIC LETTER 89-04 (INSERVICE TESTING)
  - GENERIC LETTER 89-13 (SERVICE WATER SYSTEMS)

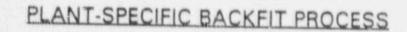
- COMMISSION EXPLAINED IN 1985 RULE:

"THE COMPLIANCE EXCEPTION IS INTENDED TO ADDRESS SITUATIONS WHERE THE LICENSEE HAS FAILED TO MEET KNOWN AND ESTABLISHED STANDARDS OF THE COMMISSION . . . NEW OR MODIFIED INTERPRETATIONS OF WHAT CONSTITUTES COMPL! ANCE WOULD NOT FALL WITHIN THE EXCEPTION."

- SCOPE OF "COMPLIANCE" EXCEPTION:

- 1. MUST HAVE EXPLICIT REQUIREMENT
- 2. REINTERPRETATIONS ARE BACKFITS





PLANT-SPECIFIC BACKFITTING APPEALS OCTOBER 1985 - PRESENT

NUMBER OF FORMAL	GRANTED/ RESOLVED	DENIED	PENDING
20	10	7	3

## ROOM FOR IMPROVEMENT

## 1. IDENTIFICATION OF BACKFITS

- \* SOURCES OF POTENTIAL PLANT-SPECIFIC BACKFITS:
  - INSPECTION REPORTS, NOV'S, SER'S

## \* STAFF RESPONSIBILITY

1

"THE NRC STAFF SHALL BE RESPONSIBLE FOR IDENTIFYING PROPOSED PLANT-SPECIFIC BACKFITS .... THE STAFF AT ALL LEVELS WILL EVALUATE ANY PROPOSED PLANT-SPECIFIC POSITION WITH RESPECT TO WHETHER OR NOT THE POSITION QUALIFIES AS A PROPOSED BACKFIT....."

## MANUAL CHAPTER 0514

2. BACKFITTING APPEAL PROCESS

1

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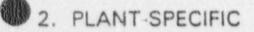
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- " "BACKFIT" IS NOT A BAD WORD
  - USE OF SECTION 50.109 IS CONSISTENT WITH SAFETY-FIRST PHILOSOPHY

\* INFORMAL USE OF RULE -- I.E., IN DISCUSSIONS WITH THE STAFF DURING INSPECTIONS OR TECHNICAL MEETINGS -- PROMOTES EFFICIENCY

## SUGGESTIONS FOR IMPROVEMENT

- 1. NRC SHOULD CONTINUE EFFORTS TO IMPROVE GENERIC COMMUNICATIONS PROCESS
  - \* MAKE DRAFTS AVAILABLE FOR COMMENT
  - \* TAKE HARD LOOK AT 50.54(F) AND COMPLIANCE ISSUES



- \* IMPROVE PROCESS FOR NRC IDENTIFICATION OF BACKFIT POSITIONS
- FOCUS ON RESOLVING ISSUES INFORMALLY

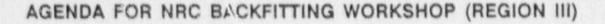


	NRC BACKFITTING WORKSHOP	•
	October 15, 1990 REGISTRATION	
Name	Affiliation	Address
1. Clehns J Frank	CLEXCLAND ELECTRIC JUMMMATING (b.	RERY, OH.
2. Watter Rain	32 24 64 64	
3. ISRYAN LAWZAU	Anterican Electric Rower	Columbus Oh
4. Denny Poss	USNEC	Work BC
5. Hubber Minier	WEARC, REG ID	CAEN ELLYN, 11
6. JOE SIPER	Illinois Power Co	Clinton IL
7. For Jutnam	Iowa Electric	Dunne Arnel Ex Conter
8. FOBUT W. Sishor	NUMARC	1776 Est ST N'ES RUCE RECENCING
9. Tom Malanowsky	WEPCO	231 W. Mich. Hilamaton OI
10. 89 6 HCS5 2	月 JUN	Clen Ellun 32
11. Frank Spangenberg	Illinois Tower	1 3
12. Rick Pullec 0	11	CREEN BAY WIT
13. Gheve Braver	AEP	1 Riverside Plaza Col. of 42216
14. PATTY DAY	NUS CORPORATION	2650 McCormick DR. CLEARWATER FL 34619
15. I KARA ARMOLD	L	P.O. Box 678 Cluton I 6120
16. JAN STENDER	WINSTON & STRAWN	WASHINGTON, D.C.
11. Richard Kurd	USNEC	clon Ellin IL
1	PACIFIC GAS & ELECTRIC	333 MARKET SF, GA 94106

0 715 Roseoolt R& Clan Ellyn, IL. 20177 2275 HALFIND RANMOCH 1776 I ST. NW, WASH, DC Betherde MD Betherde MD JA + SAM Address ByRow NRC BACKFITTING WORKSHOP October 15, 1990 REGISTRATION NRC 4/Q TENECH NRC RIT TENEEA Affiliation NUMARC USARC NUS NRC 25. GEOFFREY C WRIGHT 26. Orec H. BERLINGER 22. Mike Aurock 23. GENE KURTE 19. WAYNE KREPP 20. MICHAEL KIRK 24. J. HEUTEMES Name 27. 29. 30. 35. 33. 36. 28. 32. 31. 34.

2650 M Corner Dr. Cleanafel H. 5469 71760 Columbia River Havy Roinier OR 97048 2650 Mª CORMICK DR. CLEARMADER FL 34617 799 ROOSEVELTRU, GLENEUTA, IL 6037 300 MADISON AVE, TOLETO OH 43522 1035 00002 7 Add. STFLD, 16 62704 Dresday, RRP/ Herris IL 60450 99720 Quod Cities Nucley Statin 7501 Mine R. WASHINGTON D.C. 20595 799 Remercit Rd, Glar Ely, I Box 620, FULTON, MO 65251 payasher No Mankor valle PA. 200 2" St x Odd Papels 7 4 52706 US 31 Userty, Charleway, Mi. 55 6. MONEDE Chings Ill WWhith UC 20533 Address NRC BACKFITTING WORKSHOP Union Electric - Callemon PORTAND GENERIAL SLETTEIL October 15, 1990 REGISTRATION CPC - Big Park Paint Councywoolk adiscy US NRC NRR SARGENT & LUNDY US NZC RIL Affiliation USNAC/ RILL Nestrie 40W2 USNAC/NRR エーの町につ TOLEDO EDISCH US NRC NUS CORP. CECS KIUS CECO TUNS 12. Armend Mascianton: 0 1. Kink W. Peterman 13. Davik Perkey 18. Togan Lanksbury PAUL Bessetto 10. MARC 7 HUBER T.P. Sharkey 8. KON DitiALLA R. J. GDEBBERT 9. TOM TELLA NIKE PRENCE Lob Mexander 16. KICHARD BARREN 11. Darrell Taylor 15. Scott BAUER STERIU Sminh 17. Day Gibson 14. PETER JORDAN Name 

799 Roozevelt Rd. Glen Ellyn, Il 60137 1900 OPUS REAC, WITCHO BOUR, D 1400 EPUS PLAKE SUTE SOO DAWATASSANEIL. 1400 OPUS PLACE, SUITE 300 DOUNTED GROWE, IL 414 Nicellet Mall, MPUS, MN, 55401 M.S. A-433 Washington D.C. 20545 710/ Wise. Ave, Kellussule, 10. 20 217 6400 N. Dixie AWY Newley, MI. 48110 6400 N Directiony the space All you SO W WOURDE ST CHICAGO IL Address 90.24 NRC RACKFITTING WORKSHOP Commencia / Edicis October 15, 1990 REGISTRATION Commenter EDISEN COMMENTINE FOISON SARGENT & LUNDY DETROTEDISON CONRONINEMTH EDISON Dept. of Energy Utroit Edison THURD-LP Affiliation NRC-RIL NRC Nsp 20. K.S. Duorakowski 28. GIRIJA SHUKLA 25. Tom Parker Chegen . 22. Frank Hawkins 23. JOHN GOUVAS ROBERTLEZON Tsa T. Yin M. Hylcocle 19. Lynne Books 21. GA DEVENDER V. ERUZU Name 35. 36. 33. 27



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Time Topic

Presentation/Discussion

- 9:00am Opening Remarks Moderator's Comments Welcome/Introductions Opening Remarks
- 9:30 NRC Process for Backfit Review Review of NRC Internal Process Summary of NUREG-1409 "Backfitting Guidelines"
- 10:15 Break (15 min)
- 10:30 Legal Aspects of Backfitting NRC Perspectives of Issues Industry Perspectives of Issues
- 11:00 Bulletins and Generic Letters Discussion of process for development and review of bulletins and generic letters with illustrative examples
- 12:00 Lunch (1 hr)
- 1:00pm Utility Perspectives and Processes Discussion of utility views on current backfit issues, including the need for improvement in the current process to identify, evaluate and prioritize safety issues for backfit
- 2:00 IPE/IPEE (Severe Accident) Discussion of closure status, and use of methodologies for evaluation and integration of backfit issues
- 2:30 Regulatory and Backfit Analyses Discussion of planned improvements to NRC internal guidance
- 3:00 Break (15 min)

Conran (AEOD) Paperiello, RIII Ross (AEOD)

Ross (AEOD)

Mainton (OGC) Bishop (NUMARC) Stenger (NUBARG)

Berlinger (NRR)

Illinois Power Authority, Spangenberg

Ross (AEOD)

Heltemes (RES)

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3:45	Backfit Appeal Process Discussion of experience to date (plant-specific and generic appeals)	Ross
4:00	NRC Panel Discussion and Wrapup Discussion of followup questions and comments on any/all agenda topics	Discussion by NRC Panel
5:00	Adjourn Workshop	







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10

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### NRC PROGRAM AND ACTIVITIES ON

### BACKFITTING

Denwood F. Ross

Deputy Director

Office for Analysis and Evaluation

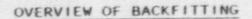
of Operational Data

NRC/Industry Backfitting Workshop

October 15, 1990

Ramada Hotel O'Hare, Rosemont, IL





- 0 Background
- 0 Backfit Rule
- 0 NRC's Program and Process
  - Plant-specific applications

.

- Generic applications
- 0 Perceptions of Licensees
- 0 Recent Initiatives
- 0 Future Staff Activities





#### BACKGROUND

- 0 Backfitting is the decision process by which the NRC decides whether to impose new requirements on nuclear power licensees.
- 0 Backfits are expected to occur and are an inherent part of the regulatory process.
- 0 Backfits are imposed only after a formal, systematic review to assure that changes are justified and suitably defined.
  - Necessary for public health and safety, common defense and security
  - Ensure compliance with rules and commitments
    - Cost-justified substantial safety improvement
- 0 Backfit process is imposed on the NRC to provide for order, discipline and predictability and optimal utilization of staff and licensee resources.







#### BACKGROUND

- 0 There are two different types of backfitting.
  - Plant-specific backfits are applicable to one facility only.
    - -- Proposed backfits are handled in accordance with a specific staff procedure (Manual Chapter 0514).
    - Generic backfits are applicable to more than one facility.
      - -- Proposed backfits undergo review by the Committee to Review Generic Requirements (CRGR), which makes recommendations to the Executive Director for Operations (EDO).
- 0 These backfits will be discussed separately because of the difference in the way they are reviewed and imposed.

### AECD RESPONSIBILITIES IN MONITORING OF PLANT-SPECIFIC BACKFITS

- 0 Director of AEOD assigned oversight of plant-specific backfit process.
- 0 Assure adequacy of regional and office backfitting procedures.
- 0 Conduct training on plant-specific backfitting for staff and industry.
- 0 Inform licensees of NRC program and procedures (e.g., Manual Chapter 0514).
- 0 Conduct annual assessment of office and regional programs for implementation of NRC program controls.
  - Reviews all staff or industry identified plant-specific backfits.
  - Review office procedures and selected records of inspection reports, notices of violation, confirmatory action letters, and licensing actions.
    - Interview regional and office staff on understanding of the program.
    - Obtain industry feedback on the backfitting process.

#### BACKFIT RULE

#### 0 Backfit Definition

- Modification of or addition to
  - (a) systems, structures, components or design of a facility; or
  - (b) the design approval or manufacturing license for a facility; or
  - (c) the procedures or organization required to design, construct or operate a facility
- Which may result from
  - (a) a new or amended provision in Commission rules; or
  - (b) imposition of a regulatory staff position that is either new or different from a previously applicable staff position
  - Imposed after
  - (a) issuance of a construction permit<sup>x</sup>
  - (b) six months before docketing of the operating license application\*\*
  - (c) issuance of the operating license
  - (d) issuance of the design approval for standard plants<sup>22XX</sup>
- CP issued after 10/21/85
- \*\* CP issued before 10/21/85
- XXX Some certificates and permits are subject to more stringent rules

#### BACKFIT RULE

- 0 Revised backfit rule (10 CFR 50.109) has been in place since 1985.
  - Provides specific guidance for backfits.
  - Provides for management control and accountability.
- 0 1985 rule was vacated by U.S. courts in 1987.

0

- Not clear that costs could not be considered in establishing or enforcing adequate protection of the public health and safety.
- Clarified rule was issued in 1988 upheld by court.
  - Backfitting shall always be required if necessary for adequate protection.
  - Costs not considered when backfitting is necessary to ensure adequate protection or when Commission defines or redefines adequate protection standard or to ensure compliance with Commission rules or licensee commitments.
- 0 Applies to generic and plant-specific actions.
- 0 Regulation is based on the fact that each mlant, as initially licensed, meets a then-acceptable level of safety -- an adequate protection standard.







#### BACKFIT RULE

- 0 Applies only to power reactors.
- 0 Applies only to positions or requirements imposed on licenses.
  - Not actions which are optional or voluntary.
- 0 Applies to all mandatory changes.
  - Reductions of requirements have been troublesome.
- 0 Does not apply to requirements imposed by laws passed by Congress.
- 0 All backfits require a documented justification.
- 0 No cost benefit analysis required for the following:
  - For compliance with license, rules or written licensee commitments.
  - To ensure adequate protection.
  - When defining or redefining what constitutes adequate protection.
- 0 Has been applied since effective date of rule (October 21, 1985).
- 0 Does not apply to requests for information.

### REQUESTS FOR INFORMATION

0 Commission may require licensee statement under oath or affirmation (10 CFR 50.54(f)).

0 Purpose: to determine

.

- Modification of license
- Suspension of license
- Revocation of license

0 Requests for information are not a backfit, but do impose a burden on licensees.

- 0 Covered by a rule (10 CFR 50.54f) and use involves an analysis and justification of the burden to be imposed.
- 0 Justification for request includes:
  - Definition of burden to be imposed
  - Potential safety significance of information

0 Review by CRGR required (if generic).







### PRINCIPLES OF PLANT-SPECIFIC BACKFIT MANAGEMENT

- Responsibility and accountability for management controls starts at highest levels in the NRC.
- Plant-specific backfits result from events, revisions or inspections which uncover deficiencies in specific plant design or operation.
- 3. NRC trains staff at all levels in the principles of plant-specific backfit management.
- Procedures have been in place since 1985. NRC Manual Chapter 0514 applies. Each operating office has approved procedures
- ARC conducts an annual essessment, and reports to Congress each year on backfits imposed during that year.
- There is a centralized, agency-wide record system that documents each plant-specific backfit in process, for each plant, and is used to monitor status.







### NRC MANUAL CHAPTER 0514

MC-0514 covers these activities:

- 0 Responsibilities and Authorities
- 0 Identifying Backfits
- 0 Preparing Regulatory (Backfit) Analyses
- 0 Preparing Documented Evaluations
- 0 Appeal Processes
- 0 Implementing Backfits
- 0 Recordkeeping and Reporting
- 0 Exceptions to the Process
- 0 Definitions of Backfit
- 0 Guidance for Making Backfit Determinations





#### PLANT-SPECIFIC BACKFITS

- 1. NRC staff members, at all levels, are responsible to identify proposed backfits.
- NRC staff completes a regulatory (backfit) analysis or documented evaluation before communicating backfit to licensee.
- 3. Licensees have a right to claim:
  - That an action is a backfit
- 4. Licensees have the right to appeal:
  - To reverse a denial of licensee claim of backfit
  - That an adequate protection or compliance exception does not meet the criteria
  - To modify or withdraw a staff proposed backfit
  - Normal levels of appeal are Region/NRR, EDO
- 5. Appeals are resolved through meetings and are resolved, if necessary, by EDO.

# 0



#### GENERIC BACKFITTING

#### CRGR Process

- 0 Objective is to eliminate unnecessary burdens on licensees, reduce exposure of workers to radiation in implementing requirements, and conserve NRC resources - while ensuring public health and protection.
- 0 Provides single agency-wide point of review for all generic correspondence requiring power reactor licensee action.
- 0 Committee is composed of six members -
  - Chairman Director, AEOD (Ed Jordan)
  - Member Deputy Director, NRR (Frank Miraglia)
  - Member Division Director, RES (Brian Sheron)
  - Member Deputy Director, NMSS (Guy Arlotto)
  - Member Deputy Assistant General Counsel, OGC (Janice Moore)
  - Member Regional Office Division Director (Luis Reyes)

#### GENERIC BACKFITTING

#### CRGR Process

0

0 Members appointed uy EDO (General Counsel concurs for OGC member).

0 Members are individual contributors, and not office representatives.

0 Committee was established in November 1981.

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0 Charter established scope, responsibilities and authorities of Committee.

0 Charter established under Commission authority and review.

#### TYP'S OF DOCUMENTS TO BE CONSIDERED BY CRGR

- 0 The types of documents to be considered by the CRGR include the following:
  - Staff papers proposing the adoption of rules or policy statements affecting power reactors.
  - 2. Staff papers proposing new or revised rules including Advanced Notices.
  - Proposed new or revised regulatory guides, Standard Review Plan (SRP) sections, and branch technical positions
  - Proposed generic letters, neiltiplant orders, show cause orders, and generic information requests under 50.54(f).
  - 5. Proposed bulletins.
  - New or revised Standard Technical Specifications.
  - Any correspondence to licensees which may reflect or interpret new generic NRC staff positions.







#### CRGR REVIEWS

- 0 Focus is on Justification:
  - Need for requirement does it enhance safety?
  - If not required for adequate protection or compliance, does it provide a substantial improvement in safety and is the cost justified?
- 0 No prior review is necessary for items involving emergency action.
- 0 Urgent matters are considered within two days.
- 0 Routine items are usually considered within 2 to 4 weeks.
- 0 Meetings are held at scheduled two-week intervals.
  - Agendas and background material provided sufficiently in advance to allow detailed review.
- 0 Items are carefully reviewed on the basis of oral discussion and written justification.







#### CRGR REVIEWS

- 0 Meetings are closed.
- 0 Committee recommends approval, revision, or disapproval of office proposals to EDO through formal meeting minutes.
- 0 Committee can request additional information from staff or industry prior to making recommendations.
- 0 A written response is requested from cognizant office to report agreement or disagreement with CRGR recommendations.
- 0 Cognizant office can disagree with CRGR recommendations, and refer issue to EDO.
- 0 CRGR staff maintains records and prepares minutes (AEOD responsibility).
- 0 When action is completed, review packages, presentations and meeting minutes are placed in Public Document Room.





0 Review packages include the following information:

- Proposed generic requirement
- Supporting document justifying need
- Proposed method and schedule of implementation
- Regulatory (backfit) analysis or documented evaluation
- Category of reactors to which the requirement applies
- Safety goal considerations

#### EXAMPLES OF TYPICAL CRGR RECOMMENDATIONS OR COMMENTS

#### 0 Against taking proposed action

- Proposed revision to Reg Guide 1.33 on QA (not justified)
- Proposed endorsement of ASME Subsection IWE on inspection of steel containments (not justified)
- 0 Narrowing proposed action
  - Bulletin 90-01 on Rosemount Transmitters (narrow actions to specific models)
  - Bulletin 90-02 on Channel Box Bow (narrow actions to re-used channel boxes)
- 0 Strengthening Proposed Actions
  - Bulletin 89-03 on Shutdown Margin (add training)
  - Proposed final rule on dry storage (add testing)

#### 0 General

- Proposed NURFG 1385 on Implementation of Fitness for Duty Rule (remove all hints of new requirements)
- Proposal to drop CRGR review of routine endorsements of ASME Code in
   10 CFR 50.55(a)(g) (CRGR review should continue)







#### EXAMPLES OF BACKFITTING CONSIDERATIONS

(For Items with Favorable CRGR Recommendations)

ACTION	ISSUE	BACKFITTING BASIS
Proposed rule change (50.61) on criteria for pressurized thermal shock considerations	New data on reactor vessel embrittlement	Adequate protection exception (at some future time)
Bulletin 89-03 on shutdown margin in spent fuel pool (PWR's)	Use of higher enriched fuel requires additional measures to ensure shutdown margin	Adequate protection exception
Generic letter 89-10 on testing of motor operated valves (MOV's)	Capability of MOV's under design basis accident conditions	Compliance exception
Generic letter 89-13 on service water systems	Capability of service water systems for design basis conditions	Compliance exception





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(For Items With Favorable CRGR Recommendations)

AC TON	ISSUE	BACKFITTING BASIS
Proposed rule change (App. E, 50.72) on Emergency Response	Enhanced data transmittal to NRC during emergencies	Cost justified enhancement
Pata System (ERDS) Generic letter 90-06 on PORV block valve reliability and low	Enhanced procedural require- ments for some plants	Cost justified enhancement
temperature overpressure protection		
Proposed rule (Part 54) on license renewal	Standards and procedures for license renewal	Not backfitting (prospective action)
Revised regulatory guides 1.35 and 1.35.1 on inservice inspection of ungrouted tendons	Improvements in inservice inspection program	Not backfitting (voluntary)

#### PERCEPTION OF LICE SEES

- 0 The number and overall burden of recent generic communications is of concern to many licensees.
- 0 The consideration of cost and schedule impacts are often thought to be inadequate.
- 0 The basis for issuing requirements involving backfits is often not clear to licensees.
- 0 Licensees believe that use of the backfit rule is not encouraged.
- 0 Some licensees fear retaliation if a back/it claim is filed.
- 0 The appeal process for backfit claims is of concern since it may not be independent, i.e., involves the same individuals that imposed the requirement.
- 0 Many licensees believe that both the NRC staff and licensees could benefit from additional training on backfitting.

#### FUTURE STAFF ACTIVITIES

0 Hold periodic workshops with industry.

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- 0 Conduct periodic workshops with NRC staff.
- 0 Examine ways to better consider cumulative impact of new requirements.
- U Consider need for changes to CRGR Charter.
- 0 Consider need for revisions to 50.109.







#### NRC PROGRAM AND ACTIVITIES ON

#### BACKFITTING

Denwood F. Ross

Deputy Director

Office for Analysis and Evaluation

of Gperational Data

NRC/Industry Backfitting Workshop

October 15, 1990

Ramada Hotel O'Hare, Rosemont, 11.





- 0 Background
- 0 Backfit Rule
- 0 NRC's Program and Process
  - Plant-specific applications
  - Generic applications
- 0 Perceptions of Licensees
- 0 Recent Initiatives
- 0 Future Staff Activities



#### BACKGROUND

- 0 Backfitting is the decision process by which the NRC decides whether to impose new requirements on nuclear power licensees.
- 0 Backfits are expected to occur and are an inherent part of the regulatory process.
- 0 Backfits are imposed only after a formal, systematic review to assure that changes are justified and suitably defined.
  - Necessary for public health and safety, common defense and security
  - Ensure compliance with rules and commitments

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- Cost-justified substantial safety improvement
- 0 Backfit process is imposed on the NRC to provide for order, discipline and predictability and optimal utilization of staff and licensee resources.







0 There are two different types of backfitting.

Plant-specific backfits are applicable to one facility only.

 Proposed backfits are handled in accordance with a specific staff procedure (Manual Chapter 0514).

Generic backfits are applicable to more than one facility.

 Proposed backfits undergo review by the Committee to Review Generic Requirements (CRGR), which makes recommendations to the Executive Director for Operations (EDO).

0 These backfits will be discussed separately because of the difference in the way they are reviewed and imposed.

## AEOD RESPONSIBILITIES IN MONITORING OF PLANT-SPECIFIC BACKFITS

- 0 Director of AEOD assigned oversig't of plant-specific backfit process.
- 0 Assure adequacy of regional and office backfitting procedures.
- 0 Conduct training on plant-specific backfitting for staff and industry.
- 0 Inform licensees of NRC program and procedures (e.g., Manual Chapter 0514).
- 0 Conduct annual assessment of office and regional programs for implementation of NRC program controls.
  - Reviews all staff or industry identified plant-specific backfits.
  - Review office procedures and selected records of inspection reports, notices of violation, confirmatory action letters, and licensing actions.
  - Interview regional and office staff on understanding of the program.
  - Obtain industry feedback on the backfitting process.

#### BACKFIT RULE

#### 0 Backfit Definition

- Modification of or addition to
  - (a) systems, structures, components or design of a facility; or
  - (b) the design approval or manufacturing license for a facility; or
  - (c) the procedures or organization required to design, construct or operate a facility
- Which may result from
  - (a) a new or amended provision in Commission rules; or
  - (b) imposition of a regulatory staff position that is either new or different

from a previously applicable staff position

Imposed after

- (a) issuance of a construction permit<sup>x</sup>
- (b) six months before docketing of the operating license application<sup>22</sup>
- (c) issuance of the operating license
- (d) issuance of the design approval for standard plants"\*\*

\* CP issued after 10/21/85

HX CP issued before 10/21/85

XXX Some certificates and permits are subject to more stringent rules

#### BACKFIT RULE

- 0 Revised backfit rule (10 CFR 50.109) has been in place since 1985.
  - Provides specific guidance for backfits.
  - Provides for management control and accountability.
- 0 1985 rule was vacated by U.S. courts in 1987.
  - Not clear that costs could not be considered in establishing or enforcing adequate protection of the public health and safety.
- 0 Clarified rule was issued in 1988 upheld by court.
  - Backfitting shall always be required if necessary for adequate protection.
  - Costs not considered when backfitting is necessary to ensure adequate protection or when Commission defines or redefines adequate protection standard or to ensure compliance with Commission rules or licensee commitments.
- 0 Applies to generic and plant-specific actions.
- 0 Regulation is based on the fact that each plant, as initially licensed, meets a then-acceptable level of safety -- an adequate protection standard.



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#### BACKFIT RULE

- 0 Applies only to power reactors.
- 0 Applies only to positions or requirements imposed on licenses.
  - Not actions which are optional or voluntary.
- 0 Applies to all mandatory changes.
  - Reductions of requirements have been troublesome.
- 0 Does not apply to requirements imposed by laws passed by Congress.
- 0 All backfits require a documented justification.
- 0 No cost benefit analysis required for the following:
  - For compliance with license, rules or written licensee commitments.
  - To ensure adequate protection.
  - When defining or redefining what constitutes adequate protection.
- 0 Has been applied since effective date of rule (October 21, 1985).

0 Does not apply to requests for information.

#### REQUESTS FOR INFORMATION

0 Commission may require licensee statement under oath or affirmation (10 CFR 50.54(f)).

0 Purpose: to determine

- Modification of license
- Suspension of license
- Revocation of license

0 Requests for information are not a backfit, but do impose a burden on licensees.

- 0 Covered by a rule (10 CFR 50.54f) and use involves an analysis and justification of the burden to be imposed.
- 0 Justification for request includes:
  - Definition of burden to be imposed
  - Potential safety significance of information

0 Review by CRGR required (if generic).





#### PRINCIPLES OF PLANT-SPECIFIC BACKFIT MANAGEMENT

- Responsibility and accountability for management controls starts at highest levels in the NRC.
- Plant-specific backfits result from events, revisions or inspections which uncover deficiencies in specific plant design or operation.
- 3. NRC trains staff at ali levels in the principles of plant-specific backfit management.
- Procedures have been in place since 1985. NRC Manual Chapter 0514 applies. Each operating office has approved procedures.
- NRC conducts an annual assessment, and reports to Congress each year on backfits imposed during that year.
- There is a centralized, agency-wide record system that documents each plant-specific backfit in process, for each plant, and is used to monitor status.







#### NRC MANUAL CHAPTER 0514

MC-0514 covers these activities:

- 0 Responsibilities and Authorities
- 0 Identifying Backfits
- 0 Preparing Regulatory (Backfit) Analyses
- 0 Preparing Documented Evaluations
- 0 Appeal Processes
- 0 Implementing Backfits
- 0 Recordkeeping and Reporting
- 0 Exceptions to the Process
- 0 Definitions of Backfit
- 0 Guidance for Making Backfit Determinations







#### PLANT-SPECIFIC BACKFITS

- 1. NRC staff members, at all levels, are responsible to identify proposed backfits.
- NRC staff completes a regulatory (backfit) analysis or documented evaluation before communicating backfit to licensee.
- 3. Licensees have a right to claim:
  - That an action is a backfit
- 4. Licensees have the right to appeal:
  - To reverse a denial of licensee claim of backfit
  - That an adequate protection or compliance exception does not meet the criteria
  - To modify or withdraw a staff proposed backfit
  - Normal levels of appeal are Region/NRR, EDO
- 5. Appeals are resolved through meetings and are resolved, if necessary, by EDO.





#### GENERIC BACKFITTING

#### CRGR Process

- 0 Objective is to eliminate unnecessary burdens on licensees, reduce exposure of workers to radiation in implementing requirements, and conserve NRC resources - while ensuring public health and protection.
- 0 Provides single agency-wide point of review for all generic correspondence requiring power reactor licensee action.
- 0 Committee is compose 7 six members -
  - Chairman Director, AEOD (Ed Jordan)
  - Member Deputy Director, NRR (Frank Miragiia)
  - Member Division Director, RES (Brian Sheron)
  - Member Deputy Director, NMSS (Guy Arlotto)
  - Member Deputy Assistant General Counsel, OGC (Janice Moore)
  - Member Regional Office Division Director (Luis Reyes)



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#### GENERIC BACKFITTING

#### CRGR Process

0 Members appointed by EDO (General Counsel concurs for OGC member).

0 Members are individual contributors, and not office representatives.

0 Committee was establined in November 1981.

0 Charter established scope, responsibilities and authorities of Committee.

0 Charter established under Commission authority and review.

#### TYPES OF DOCUMENTS TO BE CONSIDERED BY CRGR

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- The types of documents to be considered by the CRGR include the following:
  - Staff papers proposing the adoption of rules or policy statements affecting power reactors.
  - 2. Staff papers proposing new or revised rules including Advanced Notices.
  - Proposed new or revised regulatory guides, Standard Review Plan (SRP) sections, and branch technical positions.
  - Proposed generic letters, multiplant orders, show cause orders, and generic information requests under 50.54(f).
  - 5. Proposed bulletins.

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- 6. New or revised Standard Technical Specifications.
- Any correspondence to licenseer which may reflect or interpret new generic.
   NRC staff positions.

- 0 Focus is on Justification:
  - Need for requirement does it enhance safety?
  - If not required for adequate protection or compliance, does it provide a substantial improvement in safety and is the cost justified?
- 0 No prior review is necessary for items involving emergency action.
- 0 Urgent matters are considered within two days.
- 0 Routine items are usually considered within 2 to 4 weeks.
- 0 Meetings are held at scheduled two-week intervals.
  - Agendas and background material provided sufficiently in advance to allow detailed review.
- 0 Items are carefully reviewed on the basis of oral discussion and written justification.

- U Meetings are closed.
- 0 Committee recommends approval, revision, or disapproval of office proposals to EDO through formal meeting minutes.
- 0 Committee can request additional information from staff or industry prior to making recommendations.
- 0 A written response is requested from cognizant office to report agreement or disagreement with CRGR recommendations.
- 0 Cognizant office can disagree with CRGR recommendations, and refer issue to EDO.
- 0 CRGR staff maintains records and prepares minutes (AEOD responsibility).
- 0 When action is completed, review packages, presentations and meeting minutes are placed in Public Document Room.

Review packages include the following information:

Proposed generic requirement

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- Supporting document justifying need
- Proposed method and schedule of implementation
- Regulatory (backfit) analysis or documented evaluation
- Category of reactors to which the requirement applies
- Safety goal considerations

#### EXAMPLES OF TYPICAL CRGR RECOMMENDATIONS OR COMMENTS

- 0 Against tiking proposed action
  - Proposed revision to Reg Guide 1.33 on QA (not justified)
  - Proposed endorsement of ASME Subsection IWE on inspection of steel containments (not justified)
- 0 Narrowing proposed action
  - Builetin 90-01 on Rosemount Transmitters (narrow actions to specific models)
  - Bulletin 90-02 on Channel Box Bow (narrow actions to re-used channel boxes)
- 0 Strengthening Proposed Actions
  - Bulletin 89-03 on Shutdown Margin (add training)
  - Proposed final rule on dry storage (add testing)
- 0 General
  - Proposed NUREG 1385 on Implementation of Fitness for Duty Rule (remove all hints of new .equirements)
  - Proposal to drop CRGR review of routine endorsements of ASME Code in
     10 CFR 50.55(a)(g) (CRGR review should continue)







#### EXAMPLES OF BACKFITTING CONSIDERATIONS

(For Items With Favorable CRGR Recommendations)

ACTION	ISSUE	BACKFITTING BASIS
Proposed rule change (50.61) on criteria for pressurized	New data on reactor vessel	Adequate protection exception (at some
thermal shock considerations		future time)
Bulletin 89-03 on shutdown margin in spent fuel pool (PWR's)	Use of higher enriched fuel requires additional measures to ensure shutdown margin	Adequate protection exception
Generic letter 89-10 on testing of motor operated valves (MOV's)	Capability of MOV's under design basis accident conditions	Compliance exception
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(For items With Favorable CRGR Recommendations)

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50.72) on Emergency Response	NRC during emergencies	enhancement
Data System (ERDS)		
Generic letter 90-06 on PORV block	Enhanced proce gral require-	Cost justified
valve reliability and low	ments for some plants	enhancement
temperature overpressure		
protection		
Proposed rule (Part 54) on license	Standards and procedures for	Not backfitting
renewal	license renewal	(prospective action)
Revised regulatory guides 1.35 and	Improvements in inservice	Not backfitting
1.35.1 on inservice inspection	inspection program	(voluntary)
of ungrouted tendons		

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#### FERCEPTION OF LICENSEES

- 0 The number and overall burden of recent generic communications is of concern to many licensees.
- 0 The consideration of cost and schedule impacts are often thought to be inadequate.
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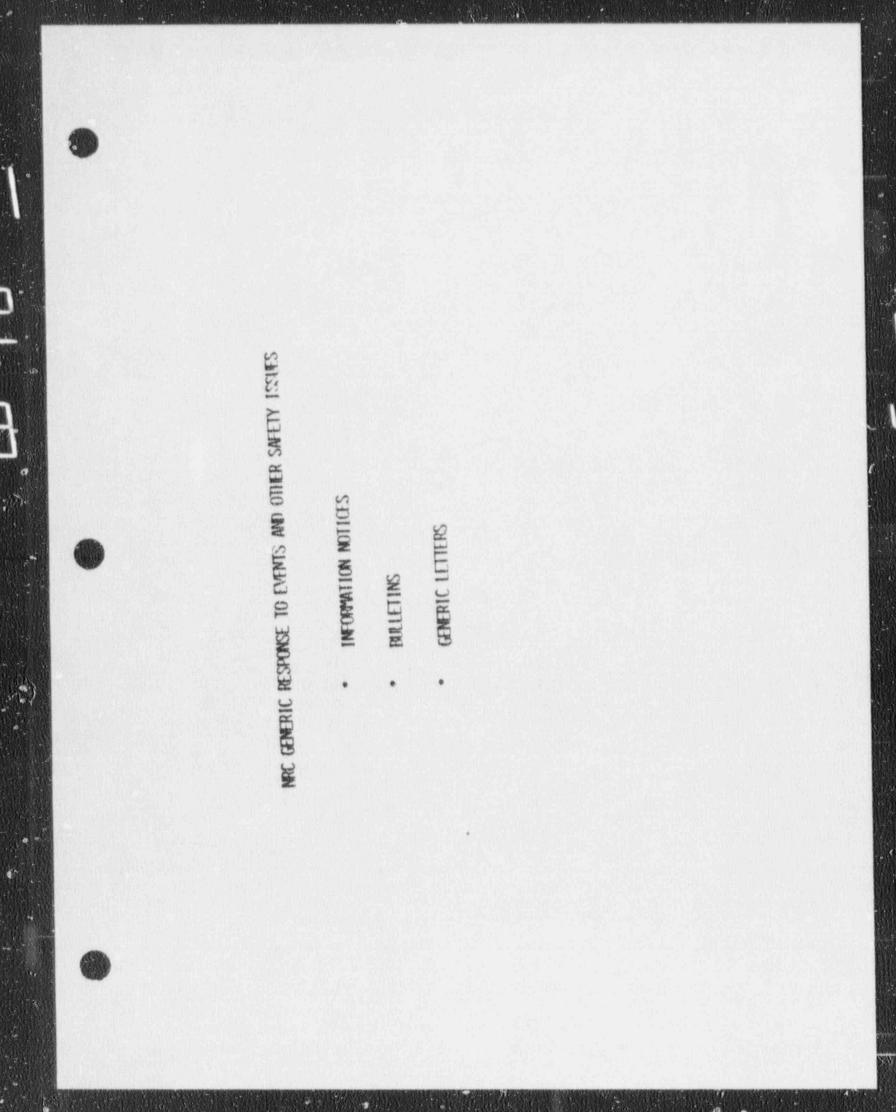
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#### FUTURE STAFF ACTIVITIES

- 0 Hold periodic workshops with industry.
- 0 Conduct periodic workshops with NRC staff.
- 0 Examine ways to better consider cumulative impact of new requirements.
- 0 Consider need for changes to CRGR Charter.
- 0 Consider need for revisions to 50.109.







NUTIFY UTILITIES OF PROBLEMS THAT COMP AFFECT THEIR PLANTS

MAY RELINEATE CORRECTIVE ACTIONS TAKEN BY ONE OR MARE UTILITIES

TO NUT PRESCRIBE ANY SPECIFIC ACTIONS

DO NOT REQUIRE RESTRICE

ON NOT COMMEY ANY CHAMES TO STAFF POSITIONS

# BILLETINS

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PEQLEST ACTIONS IN RESPONSE TO AN EVANT OR PARTIEM OR SEVERAL PELATED EVENTS AND PPOBLERS

MAY REGREST UTILITIES TO DETERMINE ANYROPRIATE PROPOSED COPPECTIVE ACTIONS WITHIN GENERAL GUIDELINES AND SUPPLIT PROPOSED ACTIONS FOR NEC APPROVAL MAY CONTAIN SPECIFIC CONSECTIVE ACTIONS AND ASK UTILITIES TO CONFIRM TO THE NHC THAT THE ACTIONS HAVE BEEN OR WILL BE TAKEN

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PEQUIRE MPITTEN RESPONSE

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REGLEST ACTIONS IN RESPONSE TO PROCRAMMITIC PROBLEMS OR ISSUES

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WRITTEN RESTRICE GENEPALLY REGULAD

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AS WELL AS IN FLEE OIL AND LINE OIL SYSTEMS APPARENTLY CAUGED BY VIBRATTON MHICH CAN REMERP IN OPPHICAN NOTICE DESCRIBING FAILURES IN A SING OF INSTRUMENTATION AND CONTROL ALL SYSTEMS EMERGENCY DIESEL GENERATORS INVERTIGE

INFORMATION NUTICE ISSUED AS A RESULT OF SEVERAL RELATED FVENTS AND PROPUEDS

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# INFORMATION NUTICE 89-15

INFORMATION NOTICE DESCRIBING APPAPENT DECOUPLING OF A REACTOR COOLANT PUMP SIMPT AND IMPELLER AT THE CRYSTAL RIVER UNIT 3 PLANT IN JANUARY 1989.

INFORMATION NOTICE ISSUED AS A RESULT OF ONE SPECIFIC EVENT. OTHER INFORMATION NOTICES HAD BEEN ISSUED DISCUSSING PREVIOUS REACTOR COOLANT PUMP SHAFT FAILUPES.

### INFORMATION NOTICE 89-20

INFORMATION NOTICE DESCRIBING WELD FAILURES IN PRIMARY LOOP RECIRCULATION PUMPS OF BYRON-JACKSON DESIGN EXPERIENCED BY OWNERS OF BOILING WATER PEACTORS IM A FOREIGN COUNTRY.

INFORMATION NOTICE ISSUED AS A RESULT OF SEVERAL RELATED PROULEMS OCCURRING IN A FOREIGN COUNTRY.



### INFORMATION NOTICE 89-21

INFORMATION NOTICE DESCRIBING VENDOR PRACTICES IN WHICH CHANGES TO MOLDED CASE CIRCUIT BREAKER TIME-CURRENT CHARACTERISTIC CURVES PERTAINING TO PARTICULAR BREAKER TYPES WERE MADE WITHOUT CHANGING THE PART NUMBER OF THE BREAKERS AND WITHKAIT ANY SPECIFIC NOTIFICATION TO THE CUSTOMERS.

INFORMATION NOTICE ISSUED AS A RESULT OF FINDINGS FROM NRC INSPECTIONS OF EQUIPMENT VENDORS.





INFORMATION NOTICE DESCRIBING PROPLEMS WITH THE CERTIFICATION OF BOLTS, MITS, AND STUDS FURNISHED BY HARDWARE SPECIALTY COMPANY, INCORPORATED OF LONG ISLAND CITY, NEW YOPK.

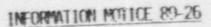
INFORMATION NOTICE ISSUED AS A RESULT OF FINDINGS FROM NRC INSPECTIONS AT THE WATEPFORD SITE AND HARDWARE SPECIALTY COMPANY.



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INFORMATION NOTICE DESCRIBING FROBLEMS FOUND BY UTILITIES WITH PERFORMING ACTIONS REQUESTED BY NRC IN A GENERIC LETTER ENTITLED "INSTRUMENT AIR SUPPLY SYSTEM PROBLEMS AFFECTING SAFETY-RELATED EQUIPMENT."

INFORMATION NOTICE ISSUED AS A RESULT OF SEVERAL RELATED PROPLEMS. CONSIDERAPLE DETAILS FOR THE INFORMATION NOTICE PROVIDED BY REGIONAL OFFICES.





INCOMMITOR NOTICE DESCRIBING DESIGN PROPILEM WITH ASEA BROWN REALRY (AUB) K-LINE CIRCUIT BREAKTRS DELIVERD TO CUSTOMERS PEFORE JALY 1974 MHICH COALD CAUSE BREAKER FAILURES DIRING A SEISNIC EVENT.

IN OPARTION NUTICE ISSUED AS A RESULT OF VINCOR REPORT TO NOC REGULAD BY 10 OFR PART 21.

### INFORMATION NUTICE 87-28

INFORMATION NOTICE ON COMPLETION OF AN AEOD LONG TERM STUDY OF AIR SYSTEM PROBLEMS INCLUDING DISCUSSION OF SEVERAL SPECIFIC EVENTS.

INFORMATION NOTICE ISSUED AS A RESULT OF AN IN-DEPTH SYSTEMATIC REVIEW OF PROPLEMS OCCURRING OVER SEVERAL YEARS WITH AIR SYSTEMS.

INFORMATION NOTICE WAS FOLLOWED BY GEMERIC LETTER REQUESTING SPECIFIC UTILITY ACTIONS TO ADDRESS AIR SYSTEM PROBLEMS, GEMERIC LETTER REQUIRED RESPONSE FROM EACH UTILITY.

# PACKFIT CONSIDERATIONS PECARDING BILLETINS AND GENERIC LETTERS

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BACKFIT FALE MUST BY CONSIDERED OF GENERIC COMMICATION IMPOURS DINNE IN NPPLICABLE REGLATERY STAFF POSITION.

EVERY BIALETIN OR GENERIC LETTER IS PRESENTED TO CPOR, GENERALLY ACCORTINIED BY A PACKAGE THAT INCLUES RESPONSES TO THE REQUIRED CUESTIONS IN 10 CFR 50,109.

MAINER OF CHOR REVIEW OF SOME OCHERIC LETTERS MAY BE CEIZINED RECAUSE NO CHANGE IN STRFF POSITION OR NEW REQUIREMENT IS IMPRIME.

CRGR METTING MINUTES AND MATERIAL SUBMITTED FOR CROCK REVIEW ARE MADE FOR TOTAL OF

AVAILABLE.



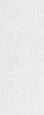


### BULETIN RP. NO

DISTRIBUTIONS MILCH MOLD RESULT IN IPPOCEPTABLE THEPPAL STRESSES AND (2) TAKE ACTION DALETIN ISSUED TO REGRET THAT UTILITIES (1) REVIEW THERE MACTOR COOLANT SYSTEMS TO TO ENSIDE THAT SUCH PIPING WILL NIT RE SIRVECTED TO UNACCEPTARE THERMAL STREETS. IDENTIFY ANY CONNECTED, UNISCIPALE PIPING THAT COLD RE SIRVECTED TO TEMPERATIRE

PALETIN ISSUED AS A RESULT OF A SPECIFIC EVENT IMPLYING LOSS OF INTEGRITY OF REACTOR COOLANT SYSTEM PRESSING BOATTARY THO BILLET IN SUPPLEMENTS ISSUED TO PRIVITE IN OPHITICN (N OTHER SIMILAR EVENTS AT FOR THAT REACTORS. ONE SIPPLEMENT ISSUED TO EMPHASIZE MEDI FOR FRAMEDI DE TRASINIC TESTING AND EXPRIMEND PLISOMALL TO RETECT CRACKS IN STAIMESS STEEL PIPING.

BRIETIN ISSED UNDER COMPLIANE JUSTIFICATION IN THE BACKFIT RALE - GUIRAL INSIGN CRITERION 14. 10 GR PART 30, APPENDIX A, "HEACTOR CONAMI PRESSIRE RUMMARY"



BULLTIN PR-07

ALCUARE OPPATOR TRAINING TO PREVENT OCCURRENCE OF UNCONTRALED FOMER OCCULUTIONS RELETIR ISSUED TO REGEST THAT UTILITIES WITH POILING WATER REACTORS DATHER THE AVAILABILITY OF AUX CUATE OF HATTING, PROCEMENTS AND INSTRUMENTATION. AND FRONTIA DRING ALL MIRES OF NAMAL AND NAMANIL OFFICIAN.

THE ANY LITTLE OF THE POWER MAY GREATER THAN PREVIDED Y EXPERIENCED FOR IN-PHASE WILL BE STARLE LINER ALL OPERATING CORDITIONS TARING A FIEL CYCLE. FURTHERMAN RALETIN ISSUED AS A RESULT OF A SPECIFIC APARAMIC CATARING EVENT INDICATING THAT PAST LICENSING CALOULATIONS WHE NUT RULIARE IN MITHAINING THAT A COM-LIMIT CYCLE COCILLATIONS CARING U.S. SPECIAL STARILITY TESTS, AND FOR KNOWN FUELICH CREATING REACTOR EVENTS AND TESTS.

BALLETIN SIRPLEMENT ISSUED TO FRAVIDE APAITTIONAL INCOMMUTION (CONCERNING POWER OSCILLATIONS IN BARS AND REGEST ACTIONS TO ENSURE THAT THE SAFETY LIMIT FOR MINIMEN CRITICAL PONCE PATTO IS NOT VIOLATED.

DESIGN CRITERICN 12, 10 CFR PART 50, APTENDIX A, "SUPPRESSION OF REACTOR PARTY MALETIN ISSUED UNDER COPPLIANCE ABJIFICATION IN THE PACKETI PARE - GENERAL OSCILLATIONS."

### BULLETIN 89-03

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ELETIN ISSUED TO RECENT ACTIONS BY UTILITIES WITH PRESSIRIZED WATER REACTORS TO PREVENT POTENTIAL VIOLATIONS OF REQUIRED SHITTOOMN MARGIN AND, IN EXTREME CASES, INNEWERTENT CRITICALITY DARING REFUELING (MTRATICAS.

POTENTIAL LOSS OF STRITCHIN MARGIN DURING PETIALING OPERATIONS AT CALVERT QUIEFS BALLETIN ISSULU AS A RESULT OF A 10 CFR PART 21 REPORT TO THE NRC READING THE NUCLEAR POWER PLANT, UNITS I AND 2.

BIALLETIN ISSUED ON THE RASIS OF THE WEED TO PRIVIDE ADRIGUATE PROTECTION TO THE HEALTH AND SAFETY OF THE PURILY CONSISTENT WITH THE PRINTISIONS OF 10 CFR 50.109A(4)(11).

### BULLETIN 90-01

BULLETIN ISSUED TO REQUEST THAT ADDRESSEES PROMPTLY IDENTIFY AND TAKE APPROPRIATE CORRECTIVE ACTIONS FOR MODEL 1153 SERIES B. MODEL 1153 SERIES D. AND MODEL 1154 PRESSURE AND DIFFERENTIAL PRESSURE TRANSMITTERS MANUFACTURED BY ROSEMOUNT THAT MAY BE LEAKUS FILL-OIL.

BULLETIN ISSUED AS RESULT OF SERIES OF REPORTED FAILURES OF MODELS 1153 MMD 1154 TRANSMITTERS AND AFTER EXTENSIVE DISCUSSIONS WITH ROSEMOUNT AND NUCLEAR UTILITIES CONCERNING THE CAUSE OF THE FAILURES, DETECTION OF THE FAILURES, AND CORPECTIVE ACTIONS. TRANSMITTER FAILURES CAUSED BY LEAKING FILL-OIL ARE NOT READILY DETECTED AND INCREASE THE POTENTIAL FOR COMMON MODE FAILURES WHICH MAY RESULT IN THE AFTECTED SAFETY SYSTEM NOT PERFORMING ITS INTENDED SAFETY FUNCTION.

BULLETIN ISSUED UNDER COMPLIANCE JUSTIFICATION IN THE BACKFIT RULE -- GENERAL DESIGN CRITERION 21, 10 CFR PART 50, APPENDIX A, "PROTECTION SYSTEM RELIABILITY NAT TESTABILITY," AND 10 CFR 50.55A(H) (REQ.IRING THAT PROTECTION SYSTEMS MEET IFFE-279).

### GENERIC LETTER 88-14

GENERIC LETTER ISSUED TO REQUES, THAT LICENSEES ENSURE THEIR OPERATIONAL PROCRAM INCLUDES TESTING TO VERIFY INSTRUMENT AIR QUALITY, AIR ACCUMULATOR CAPACITY, VALVE FAILURE POSITIONS ON LOSS OF INSTRUMENT AIR, AND ADEQUACY OF MAINTENANCE PRACTICES, EMERGENCY PROCEDURES AND TRAINING.

GENERIC LETTER ISSUED AS RESULT OF AEOD STUDY INDICATING PERSISTENT AIR SYSTEM PROPLEMS.

GENERIC LETTER IMPLEMENTED EXISTING REQUIREMENTS BASED ON FSAR COMMITMENTS ON THE DESIGN BASIS (COMPLIANCE EXCEPTION).

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### GENERIC LETTER 89-10

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GENERIC LETTER REQUESTED THAT LICENSEES DEVELOP AND IMPLEMENT PROGRAM TO ASSURE THAT MOTOR OPERATED VALVES WILL PERFORM THEIR INTENDED SAFETY FUNCTIONS UNDER CONDITIONS ASSOCIATED WITH DESIGN BASIS ACCIDENTS. GENERIC LETTER WAS SECUEL TO BULLETIN 85-03 IN EXTENDING THE REQUESTED ACTIONS TO ALL SAFETY RELATED MINS.

GENERIC LETTER ISSUED TO COMPLEMENT THE REQUIREMENTS OF ASME SECTION XI TESTING, RESOLVE GENERIC ISSUES 87 AND II.E.G.I. AND MAINTAIN FAILURE RATES OF MON'S WITHIN ACCEPTABLE LIMITS.

GENERIC LETTER JUSTIFIED ON BASIS OF COMPLIANCE WITH 10 CFR PART 50, APPENDIX A (GDCS 1, 4, 18 & 21) AND APPENDIX B.

## GENERIC LETTER 89-13

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CERTAIN FLATURES TO ASSUME ADECLARY OF THE SERVICE WATER SYSTEM. 3001 FLATURES CAPABILITY: PROTECTION AGAINST CORPOSION, EAGSION AND PLOFOREING; CONFIRMATION INCLUED MASTRES TO PRECLUE FLOW RECORDE ; TESTING TO VERIFY HEAT TRANSFER GENERIC LETTER REGESTED THAT LICENSES ESTATUES PROGRAM THAT WORD INCLAR. OF FEACTIONALITY WITH RESPECT TO DESIGN BASIS.

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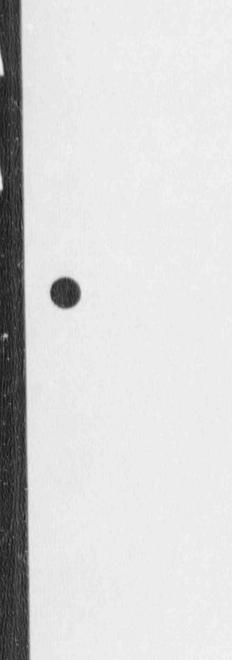
GENERIC LETTER ISSUED IN RESPONSE TO A LANT NIMER OF OPERATIONAL EVENTS. GENERIC LETTER RESOLVED GENERIC ISSUE 51, RESTONED TO NOD CASE STUDY, RESPONDED TO REGIONAL RECOMMENDATION FOR PURFIC ACTION. GENERIC LETTER JUSTIFIED ON PASIS OF CONVIANCE WITH TO GEN PART 50, APPENDIX A (GACS 444, 45 & 46 RELATED TO HEAT REMOVAL) NOT APPENDIX E.





# NAC GENERIC RESPONSE TO EVENTS AND OTHER SAFETY 1551ES

- · INFORMATION NOTICES
- · BULLETING
- · GENERIC LETTERS



## INFORMITICH NOTICES

NOTIFY UTILITIES OF PROBLEMS THAT CORD METCT THESE PLANTS

MAY RELINEAT CORRECTIVE ACTIONS TAKEN BY ONE OR WHIF UTILITIES

TO NUT PRESCRIPE ANY SPECIFIC ACTIONS

DO NUT REQUIRE RESURCE

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TO NOT COMMENT ANY CHANGES TO STAFF POSITIONS

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REGLEST ACTIONS IN RESPONSE TO MULTURIN OR PHYLLEM OR SEMERAL RELATED EVANIS AND PROPERTY

MAY RECRESS UPILITIES TO DETERMINE ANYOGRAPHATE PRENDUED CORPECTIVE ACTIONS WITHIN CONFILM CUITED IN'S AND SIGNIT PROPOSED ACTIONS FOR NEC APPROVAL MAY CONTAIN SPECIFIC CORRECTIVE ACTIONS AND ASK UTILITIES TO CONFIRM TO THE NAC THAT THE ACTIONS HAVE REEN OR WILL DE TAKEN

MAY CONVEY A CHANGE IN STAFF POSITION

PEQUIPE MPITTEN RESPONSE



REQUEST ACTIONS IN RESPONSE TO PROCRAMMATIC PROBLEMS OR ISSUES

ACTIONS REQUESTED GENERALLY OF A CONTINUING NATURE

MAY COMMEY A CHANGE IN STAFF POSITION

MRITTEN RESTRICE GENERALLY REQUIRED

-/

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### INFORMATION NOTICE 89-07

INFORMATION NOTICE DESCRIBING FAILUPES IN TUBING OF INSTRUMENTATION AND CONTROL AIR SYSTEMS AS WELL AS IN FUEL OIL AND LURE OIL SYSTEMS APPARENTLY CAUSED BY VIBRATION WHICH CAN RENDER EMERGENCY DIESEL GENERATORS INOPERABLE

INFORMATION NOTICE ISSUED AS A RESULT OF SEVERAL RELATED EVENTS AND PROBLEMS





### INFORMATION NOTICE 89-15

INFORMATION NOTICE DESCRIBING APPAPENT DECOUPLING OF A REACTOR COOLANT PUMP SIMET AND IMPELLER AT THE CRYSTAL RIVER UNIT 3 PLANT IN JANUARY 1989.

INFORMATION NOTICE ISSUED AS A RESULT OF ONE SPECIFIC EVENT. OTHER INFORMATION NOTICES HAD BEEN ISSUED DISCUSSING PREVIOUS REACTOR COOLANT PUMP SHAFT FAILUPES.



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### INFORMATION MOTICE 89-20

INFORMATION NOTICE DESCRIBING WELD FAILURES IN PRIMAPY LOOP RECIRCULATION PUMPS OF BYRON-JACKSON DESIGN EXPERIENCED BY OWNERS OF POILING WATER PEACTORS IM A FOREIGN COUNTRY.

INFORMATION NOTICE ISSUED AS A RESULT OF SEVERAL RELATED PROBLEMS OCCURRING IN A FOREIGN COUNTRY.

### INFORMATION NOTICE 89-21

INFORMATION NOTICE DESCRIBING VENDOR PRACTICES IN WHICH CHANGES TO MOLDED CASE CIRCUIT BREAKER TIME-CURRENT CHARACTERISTIC CURVES PERTAINING TO PARTICULAR BREAKER TYPES WERE MADE WITHOUT CHANGING THE PART NUMBER OF THE BREAKERS AND WITHOUT ANY SPECIFIC NOTIFICATION TO THE CUSTOMERS.

INFORMATION NOTICE ISSUED AS A RESULT OF FINDINGS FROM NRC INSPECTIONS OF EQUIPMENT VENDORS.





### INFORMATION NOTICE 89-22

INFORMATION NOTICE DESCRIBING PROFLEMS WITH THE CERTIFICATION OF BOLTS, MITS, AND STUDS FURNISHED BY HARDWARE SPECIALTY COMPANY, INCORPORATED OF LONG ISLAND CITY, NEW YORK.

INFORMATION NOTICE ISSUED AS A RESULT OF FINITINGS FROM NRC INSPECTIONS AT THE WATEPFORD SITE AND HARDWARE SPECIALTY COMPANY.

### INFORMATION MOTICE 89-26

INFORMATION NOTICE DESCRIBING PROBLEMS FOUND BY UTILITIES WHEN PERFORMING ACTIONS REDUESTED BY NRC IN A GENERIC LETTER ENTITLED "INSTRUMENT AIR SUPPLY SYSTEM PROBLEMS AFFECTING SAFETY-RELATED EQUIPMENT."

INFORMATION NOTICE ISSUED AS A RESULT OF SEVERAL RELATED PROPLEMS. CONSIDERAPLE DETAILS FOR THE INFORMATION NOTICE PROVIDED BY REGIONAL OFFICES.

### INFORMATION NOTICE 89-29

INFORMATION NOTICE DESCRIBING DESIGN PROBLEM WITH ASEA BROWN BOMERI (ABB) K-LINE CIRCUIT BREAKERS DELIVERED TO CUSTOMEPS REFORE JULY 1974 WHICH COULD CAUSE BREAKER FAILURES DURING A SEISMIC EVENT.

INFORMATION NOTICE ISSUED AS A RESULT OF VENDOR REPORT TO NRC REQUIRED BY 10 CFR PART 21.

### INFORMATION NOTICE 87-28

INFORMATION NOTICE ON COMPLETION OF AN AEOD LONG TERM STUDY OF AIR SYSTEM PROBLEMS INCLUDING DISCUSSION OF SEVERAL SPECIFIC EVENTS.

INFORMATION NOTICE ISSUED AS A RESULT OF AN IN-DEPTH SYSTEMATIC REVIEW OF PROPLEMS OCCURRING OVER SEVERAL YEARS WITH AIR SYSTEMS.

INFORMATION NOTICE WAS FOLLOMED BY GEMERIC LETTER REQUESTING SPECIFIC UTILITY ACTIONS TO ADDRESS AIR SYSTEM PROBLEMS. GENERIC LETTER REQUIRED RESPONSE FROM EACH UTILITY.

### PACKFIT CONSIDERATIONS REGARDING BULLETINS AND GENERIC LETTERS

.

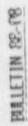
BACKFIT RULE MUST BE CONSIDERED IF GENERIC COMMINICATION INVOLVES CHAMPE IN APPLICABLE REGULATORY STAFF POSITION.

EVERY BULLETIN OR GENERIC LETTER IS PRESENTED TO CPCR. GENERALLY ACCOMPANIED BY A PACKAGE THAT INCLUDES RESPONSES TO THE REQUIRED QUESTIONS IN 10 CFR 50, 109.

WAIVER OF ORGR REVIEW OF SOME GENERIC LETTERS MAY BE OBTAINED RECAUSE NO CHANGE IN STAFF POSITION OR NEW REQUIREMENT IS INVOLVED.

CRGR MEETING MINUTES AND MATERIAL SUBMITTED FOR CRGR REVIEW ARE MADE PUPLICLY AVAILABLE.





DISTRIBUTIONS MHICH MORE RESILT IN INVOCED ABLE THEPMAL STRESSES AND (2) TAKE ACTION DALLETIN ISSUED TO RECLEST THAT UTILITIES (1) REVIEW THE P. P. ACTOR COOLANT SYSTEMS TO TO ENGINE THAT SICH PIPING WILL NIT BE STRUCTED TO UNACCEPTARLE THERMAL STRUCCES. IDENTIFY ANY CONNECTED, UNISOLARIE PIPING THAT COULD BE SIRRECTED TO TUMERATIRY

RALETIN ISSUED AS A RESULT OF A SPECIFIC EVENT IMMUVING LOCS OF INTEGRITY OF REACTOR COLLANT SYSTEM PRESSIRE RULFTARY. THO BALETIN SUPPLEMENTS ISSUED TO PROVINE IN OPPORTION ON OTHER SIMILAR EVENTS AT FOREIGN REACTORS. ONE SUPPLIEDENT ISSUED TO EMPLASIZE MED FOR FRANKED IL IRASTNIC TESTING AND EXTRIBUTED PERSIMMEL TO FATECT CRACKS IN STAINLESS STEFT PIPING.

BALETIN ISSUED UNCER COMPLIANCE JISTIFICATION IN THE PACKFIT MALE - GUMPAL RESIGN CRITERION 14. 10 CFR PART 50, MPENDIX A, "PEACTOR COOLANT PRESSIRE ROUMARY"



BULLETIM ISSUED TO REQUEST THAT UTILITIES WITH DOILING WATER REACTORS ENGINE THE AVAILABILITY OF ADEQUATE OPERATING PROCEDURES AND INSTRUMENTATION, AND PROVIDE ADEQUATE OPERATOR TRAINING TO PREVENT OCCURRENCE OF UNCONTROLLED POWER OSCILLATIONS DURING ALL MODES OF NORMAL AND ADDERMAL OPERATION.

RULLETIN ISSUED AS A RESULT OF A SPECIFIC APNORMAL OPERATING EVENT INDICATING THAT PAST LICENSING CALCULATIONS WERE NOT RELIABLE IN DETERMINING THAT A CORE WILL BE STABLE UNDER ALL OPERATING CONDITIONS DURING A FUEL CYCLE. FURTHERMORE, THE AMPLITUDE OF THE POMER WAS GREATER THAN PREVIOUSLY EXPERIENCED FOR IN-PHASE LIMIT CYCLE OSCILLATIONS DURING U.S. SPECIAL STABILITY TESTS, AND FOR KNOWN FOREIGN OPERATING REACTOR EVENTS AND TESTS.

BULLETIN SUPPLEMENT ISSUED TO PROVIDE ADDITIONAL INFORMATION CONCERNING POWER OSCILLATIONS IN BURS AND REQUEST ACTIONS TO ENSURE THAT THE SAFETY LIMIT FOR MINIMUM CRITICAL POWER RATIO IS NOT VIOLATED.

DULLETIN ISSUED UNDER COMPLIANCE JUSTIFICATION IN THE PACKFIT RULE -- GENERAL DESIGN CRITERION 12, 10 CFR PART 50, APPENDIX A, "SUPPRESSION OF REACTOR FUM R OSCILLATIONS."



## BIALETIN 20-05

BALLETIN ISSUED TO RECIEST ACTIONS BY UTILITIES WITH PRESSURIZED WATER REACTORS TO PREVENT POTENTIAL VIOLATIONS OF REQUIRED SHIFTIONN MARGIN MAD, IN EXTRIME CASES, INAMERIENT CRITICALITY DRING REHELING OPERATIONS.

POTENTIAL LOSS OF STATEJAM MARGIN DIRING, PETIRELING OFFINITIONS AT CALMERT CLIFFS RALLETIN ISSUED AS A RESULT OF A 10 CFR PART 21 REPORT TO THE NRC REGARDING THE NUCLEAR POWER PLANT, UNITS 1 AND 2.

BALLETIN ISSUED ON THE PASIS OF THE MED TO PRIVITE ALEQUATE PROTECTION TO THE HEALTH AND SAFETY OF THE PARILY CONSISTENT WITH THE PRIVISIONS OF 10 CFR 50.109A(4)(11).

### RULLETIN 90-01

BULLETIN ISSUED TO REQUEST THAT ADDRESSEES PROMPTLY IDENTIFY AND TAKE APPROPRIATE CORRECTIVE ACTIONS FOR MODEL 1153 SERIES B. MODEL 1153 SERIES D. AND MODEL 1154 PRESSURE AND DIFFERENTIAL PRESSURE TRANSMITTERS MANUFACTURED BY ROSEMOUNT THAT MAY BE LEAKING FILL-OIL.

BULLETIN ISSUED AS RESULT OF SERIES OF REPORTED FAILURES OF MODELS 1153 MD 1154 TRANSMITTERS AND AFTER EXTENSIVE DISCUSSIONS WITH ROSEMOUNT AND NUCLEAR UTILITIES CONCERNING THE CAUSE OF THE FAILURES, DETECTION OF THE FAILURES, AND COPPECTIVE ACTIONS. TRANSMITTER FAILURES CAUSED BY LEAKING FILL-OIL ARE NOT READILY DETECTED AND INCREASE THE POTENTIAL FOR COMMON MODE FAILURES WHICH MAY RESULT IN THE AFFECTED SAFETY SYSTEM NOT PERFORMING ITS INTENDED SAFETY FUNCTION.

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BULLETIN ISSUED UNDER COMPLIANCE ANSTIFICATION IN THE BACKFIT RULE - GENERAL DESIGN CRITERION 21, 10 OFR PART 50, APPENDIX A, "PROTECTION SYSTEM RELIABILITY AND TESTABILITY," AND 10 OFR 50.55A(H) (""QUIRING THAT PROTECTION SYSTEMS MEET IEEE-279).

### GENERIC LETTER 88-14

GENERIC LETTER ISSUED TO REQUEST THAT LICENSEES ENSURE THEIR OPERATIONAL PROGRAM INCLUDES TESTING TO VERIFY INSTRUMENT AIR QUALITY, AIR ACCUMULATOR CAPACITY, VALVE FAILURE POSITIONS ON LOSS OF INSTRUMENT AIR, AND ADEQUACY OF MAINTENANCE PRACTICES, EMERGENCY PROCEEDURES AND TRAINING.

GENERIC LETTER ISSUED AS PESULT OF AEOD STUDY INDICATING PERSISTENT AIR SYSTEM PROFILEMS.

GENERIC LETTER IMPLEMENTED EXISTING REQUIREMENTS BASED ON FSAR COMMITMENTS ON THE DESIGN BASIS (COMPLIANCE EXCEPTION).

## GINERIC LETTER 89-10

Å

ASSOCIATED WITH DESIGN BASIS ACCIDENTS. GENERIC LETTER MAS STORE TO BULLETIN 85-07 GARRIC LETTER ROLESTED THAT LICENCES DEVELOP AND IMPEDITING PROCRAM TO ASSIRE THAT MOTOR OPERATED VALVES WILL PERFORM THETR INTERALE SALETY FUNCTIONS UNLER CONDITIONE IN EXTENDING THE RECEIPTINGS TO ALL SWELLY RELATED MVS.

RESOLVE GENERIC ISSUES 87 ME 11.E.6.1, AND MAINTAIN FAILURE RATES OF MOVS WITHIN GENERIC LETTER ISSUED TO COMPENSITI THE REGULARMENTS OF ASPE SECTION XI TESTING. ACCEPTABLE LIMITS.

GENERIC LETTER JUSTIFIED ON BASIS OF COMPLANTE WITH IN CER PART 50, APPENDIX A (GDCS 1, 4, 18 & 21) AND APPONDIX B.

0



# GENERIC LETTER 89-13

SUCH FEATINES CAPABILITY; PROTECTION AGAINST CORRECTOR, EROSION AND PLOFORLING; CORFIRMATION INJUED RASPES TO PRECIDE FLOW RICKARE: TESTING TO VERIFY HEAT TRANSFER GOVERIC LETTER REQUESTED THAT LICENCEES ESTATE ISH PRICAM THAT WALD INCLURE CERTAIN FLATIBLES TO ASSURE AREQUARY OF THE SERVICE WATCH SYSTEM. OF RENCTIONALITY WITH RESPECT TO DESIGN BASIS.

GENERIC LETTER ISSUED IN RESPONSE TO A LARFE NIMBER OF OPERATIONAL EVENTS. CONFILC LETTER RESEARD CONFILC ISSUE 51, RESTONED TO ACOD CASE STUDY. RESPONDED TO REGIONAL RECOMPONENTION FOR (EDURIC ACTION. GPACRIC LETTER JUSTIFIED ON PASIS OF COMPLIANCE WITH TO OFR PART 50, APPENDIX A (COCS 44, 45 & 46 RELATED TO HEAT REMOVAL) NO APPENDIX E.

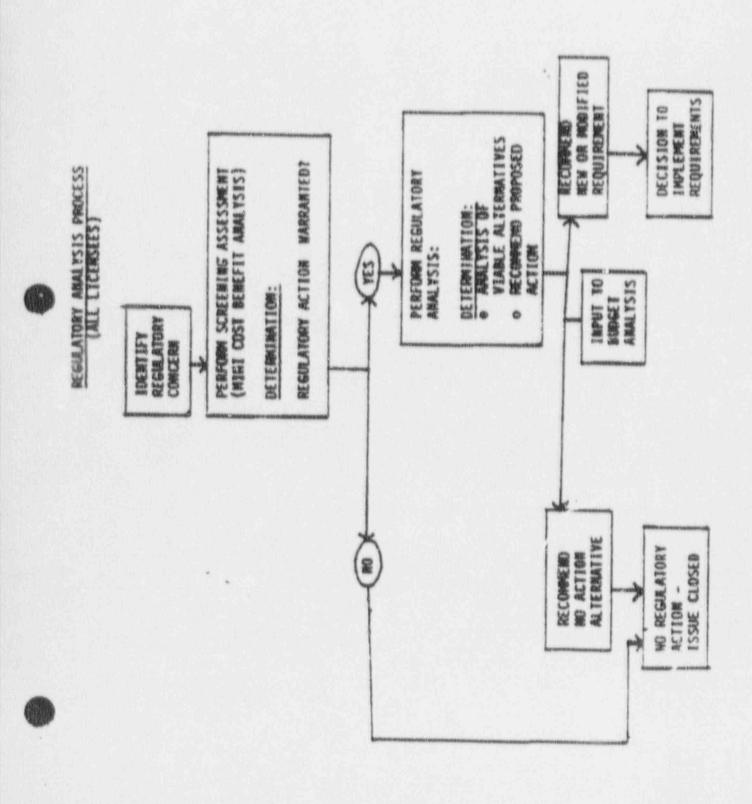


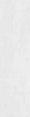


RESEARCH PERSPECTIVE

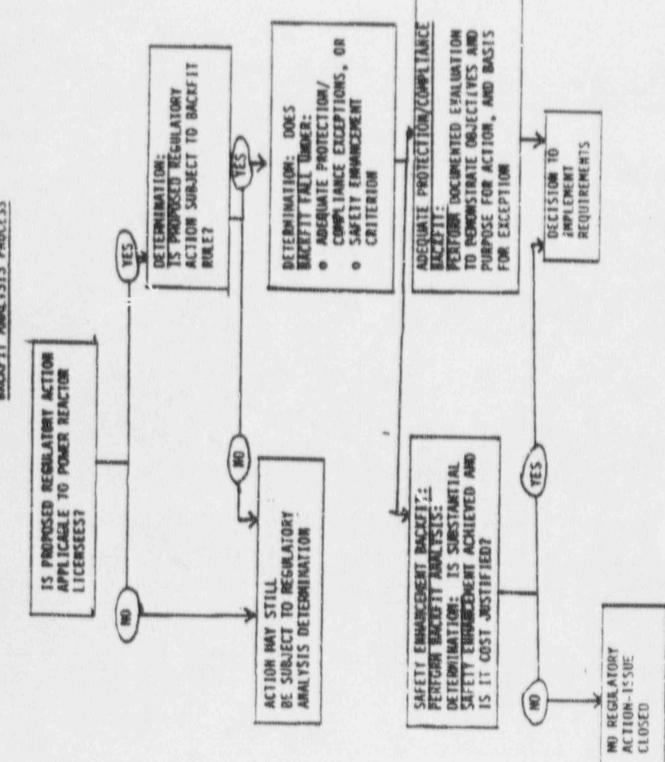
C. J. HELTEMES, JR. DEPUTY DIRECTOR FOR GENERIC ISSUES AND RULEMAKING OFFICE OF NUCLEAR REGULATORY RESEARCH U. S. NUCLEAR REGULATORY COMMISSION

SEPTEMBER/OCTOBER 1990





BACKFIT ANAL TSIS PROCESS



#### THE NATURE OF THE DIFFERENT TYPES OF ANALYSES

- O THE REGULATORY ANALYSIS ASSESSES COSTS AND BENEFITS OF VIABLE ALTERNATIVES AND RECOMMENDS A PROPOSED ACTION. A PROPOSED BACKFIT. IF IT IS A SAFETY ENHANCEMENT. REGULARES A BACKFIT ANALYSIS WHICH ASSESSES COSTS AND BENEFITS ASSOCIATED WITH THE PROPOSED ACTION. OTHER BACKFITS, ADEQUATE PROTECTION AND COMPLIANCE, REQUIRE A DOCIMENTED EVALUATION WHICH STATES THE OBJECTIVES AND PURPOSE OF THE BACKFIT AND THE BASIS FOR INVOKING THE EXCEPTION.
- 0 IN MANY RESPECTS, THE REGULATORY ANALYSIS, AND BACKFIT ANALYSIS FOR SAFETY ENHANCEMENT BACKFITS, ARE SIMILAR.
- O THEY BOTH REQUIRE AN ANALYSIS IN WHICH THE VALUE IMPACT OR COST BENEFIT ASSESSMENT IS THE CENTRAL ELEMENT.
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- O THE BACKFIT ANALYSIS FOR SAFETY ENHANCEMENT BACKFITS IS MORE DEMANDING OF THE STAFF AS ONE IS FORCED TO MAKE A DETERMINATION THAT:
  - SUBSTANTIAL IMPROVEMENT TO PUBLIC HEALTH AND SAFETY IS ACHIEVED; AND
  - COSTS OF IMPLEMENTATION ARE JUSTIFIED.





# REGILATORY ANALYSIS

- TO DEVILOP AND DOCUMENT INFORMATION ON THE NEED FOR AND CONSECRENCES OF A FROPOSED RESULATORY ACTION AND ITS ALTERNATIVES. PUR 20.4: 0
- 0 ELEMENTS OF REGULATORY ANALYSES:
- STATE THE PROBLEM AND DEFINE OBJECTIVES
  - BEFIRE ALTERNATIVES
- SELECTION OF ATTRIBUTES (VALUES, IMPACTS) TO BE INCLUDED
  - IN VALUE IMPACT ANALYSIS
- EVALUATE CONSEGUENCES (VALUE IMPACT ANALYSIS)
- DEVELOP DECISION RATIONALE
- DESCRIPT IMPLEMENTATION



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PURPOSE :

SYSTEMATIC, DOCUMENTED ANALYSIS OF PROPOSED BACKE'S TOTALON TO DETERMINE WHETHER

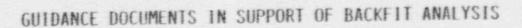
- PUBLIC REALTH AND SAFETY OF COMMON DEFENSE AND SECURITY
  - AR' SUBSTANTIALLY INCOM
- JUSTS OF IMPLEMENTATION ARE JUSTIFIED

ELEMENTS:

- SPECIFIC OBJECTIVES OF BACKFIT
- ACTIVITY REG. NED OF LICENSEE
- CHANGE IN ACCIDENTAL OFFSITE RADIOLOGICAL RISK TO PUBLIC
- POTENTIAL IMPACT ON RADIOLOGICAL EXPOSURE OF ON-SITE WORKERS
- INSTALLATION AND CONTINUING LICENSEE COSTS
- IMPACT ON OPERATIONAL COMPLEXITY/RELATIONSHIP TO REGULATORY REQUIREMENTS
- IMPACT ON NRC RESULTS
- IMPACT OF DIFFERENCES IN FACILITY TYPES
  - WHETHER INTERIM OR FINAL ACTION
- OTHER GERMANE FACTORS

#### GHIDANCE DOCUMENTS IN SUPPORT OF REGULATORY ANALYSIS

- 0 FEGULATORY ANALYSIS GUIDELIMES, NUREG/BR-0058, REV. 1, MAY 1984
- 0 HANDDOOK FOR VALUE-IMPACT ASSESSMENT, NUREG/CR-3568, DECEMBER 1983
- 0 I-ANDBOOK FOR COST ESTIMATING, NUREG/CR-3971, OCTOBER 1984
- 0 GENERIC COST ESTIMATES ... ABSTRACTS FROM GENERIC STUDIES FOR USE IN PREPARING FEGULATORY IMPACT ANALYSES, NUREG/CR-4627, REV. 1, JANUARY 1988.
- 0 OFFICE LETTERS
  - -- NRR OFFICE LETTER 16, REV. 3, "REGULATORY ANALYSIS GUIDFLINES," MAY 16, 1986
  - -- NRR OFFICE LETTER 503, DRAFT, "REGULATORY AMALYSIS GUIDEL!NES," SEPTEMBER 29, 1989
  - -- RES OFFICE LETTER 2, "PROCEDURES FOR OBTAINING REGULATORY IMPACT ANALYSIS REVIEW AND SUPPORT," NOVEMBER 18, 1988



0 1988 BACKFIT RULE (10 CFR 50.109)

2

- 0 BACKFITTING GUIDELINES, NUREG-1409, JULY 1990
- 0 MANAGEMENT OF PLANT-SPECIFIC BACKFITTING OF NUCLEAR POWER PLANTS (MANUAL CHAPTER 0514)

O CRGR CHARTER (GENERIC BACKFIT)

CURRENT ACTIVITIES TO IMPROVE REGULATORY/BACKFIT ANALYSIS PROCESS

0 ISSUES ARE BEING ADDRESSED BY THE STAFF FOR COMMISSION CONSIDERATION.

- 0 ISSUES CONCERNING THE REGULATORY/BACKFIT ANALYSIS PROCESS WILL BE ADDRESSED IN PLANNED UPDATES TO THE FOLLOWING DOCUMENTS.
  - REGULATORY ANALYSIS GUIDELINES (NUREG/BR-0058, REV. 1). THIS DOCUMENT SETS FORTH THE GENERAL STRUCTURE, FRAMEWORK, AND INSTRUCTIONS FOR COMPLETING TASKS NECESSARY FOR A SOUND REGULATORY ANALYSIS.

A HANDBOOK FOR VALUE-IMPACT ASSESSMENT (NUREG/CR-3568). THIS DOCUMENT PRESENTS A SET OF SYSTEMATIC PROCEDURES FOR PROVIDING INFORMATION THAT CAN BE USED IN PERFORMING VALUE-IMPACT ASSESSMENTS IN SUPPORT OF NRC REGULATORY ANALYSES.

- BACKFITTING GUIDELINES (NUREG-1409). THIS DOCUMENT SETS FORTH THE PROCEDURES AND GUIDANCE ON THE BACKFITTING PROCESS.
- 0 A PLANNED 2-DAY REGULATORY ANALYSIS TRAINING COURSE.

CUPRENT ACTIVITIES TO IMPROVE REGULATORY ANALYSIS PROCESS

0 UPD11 OF REGULATORY ANALYSIS GUIDELINES (NUREG/BR-0058, REV. 1)

ISTING OF FIPES OF REGULATORY ACTIONS REQUIRING REGULATORY ANALYSIS

- ADDITIONAL GUIDANCE ON APPROPRIATE SCOPE AND LEVEL OF DETAIL
- EXPAND GUIDANCE ON ALTERNATIVES AND ALTERNATIVE REGULATORY VEHICLES
- STRUCTURE GUIDELINES TO BETTER INTEGRATE BACKFIT AND CLOR REQUIREMENTS
- NCORPORATE SAFETY GOAL CONSIDERATIONS

0 UPDATE OF A HANDBOOK FOR VALUE-IMPACT ASSESSMENT (NUREG/CR-3568)

- RESTRUCTURE TO PROVIDE METHODS AND SUPPORTING INFORMATION FOR ALL STEPS IN REGULATORY ANALYSIS
- UPDATE METHODS AND INFORMATION BASES ORIGINALLY PROVIDED. THESE INCLUDE:
  - -- OFF-SITE PROPERTY DAMAGE
  - -- UNCERTAINTY ANALYSIS
  - -- CONTAL MENT RESPONSE
  - -- DISCOUNT RATES

-

- -- IMPACT OF LICENSE RENEWAL
- -- USE OF INDUSTRY COST/RISK ESTIMATES
- -- TREATMENT OF SUPPLEMENTAL CONSIDERATIONS
- CUMULATIVE ACCOUNTING OF PAST AND ONGOING SAFETY IMPROVEMENTS
- -- TREATMENT OF SAFETY GOAL CONSIDERATIONS
- ADDITION OF APPENDIX ON NON-REACTOR REGULATORY ISSUES

ADDITION OF APPENDIX ON HUMAN FACTORS REGULATORY ISSUES





REVISION OF REGULATORY GUIDANCE

- O PRINCIP, Dr UMENTS BEING REVISED
  - REGULATORY ANALYSIS GUIDELINES, NUREG/BR-0058, REV. 1
  - LANDBOOK FOR VALUE-IMPACT ASSESSMENT, NUREG/CR-3568
- 0 ESTIM-TED SCHEDULE

NORK IN PROGRESS AT PNL
 REVISED GUIDANCE ISSUED FOR INTERNAL REVIEWS
 REGULATORY GUIDELINES - 1ST Q 1991
 VALUE IMPACT HANDBOOK - 2ND Q 1991
 INTICIPATED PUBLIC COMMENT PERIOD - 4TH Q 1991
 TARGET DATE FOR COMPLETION - 1ST Q 1992





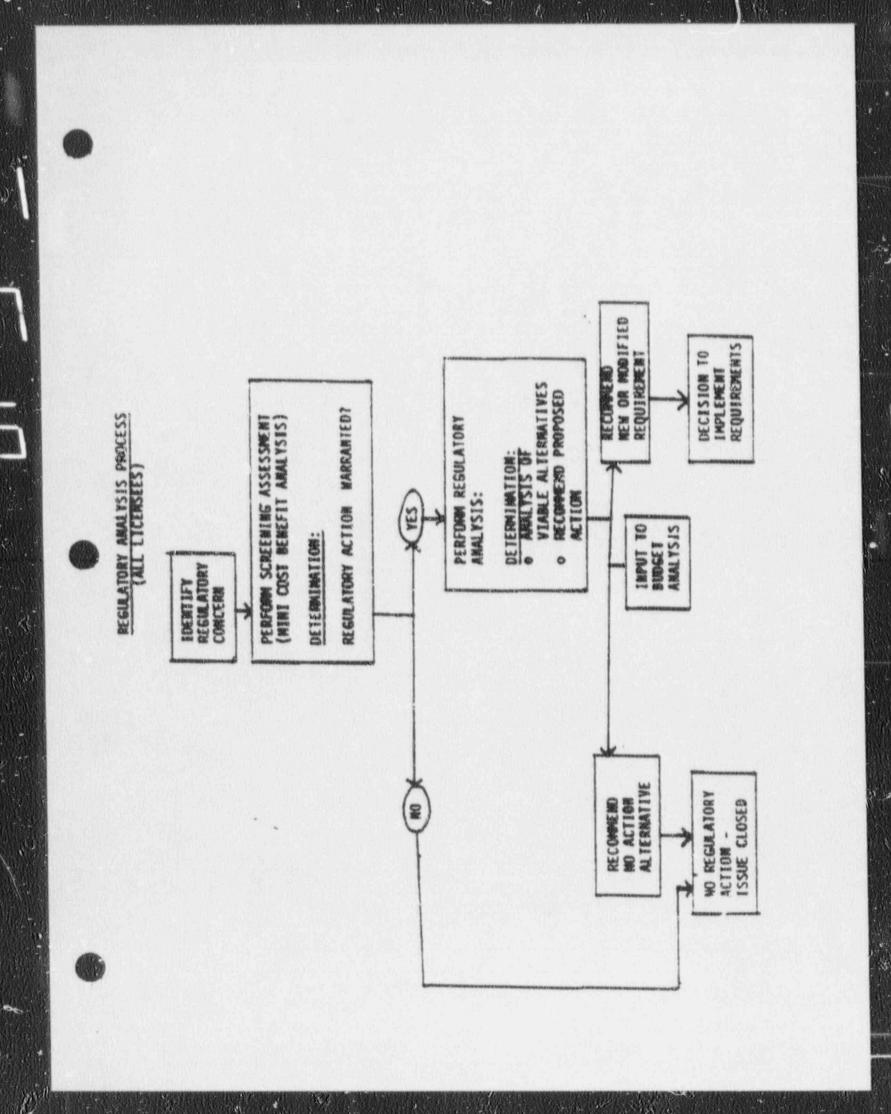


#### BACKFIT ANALYSIS WORKSHOP

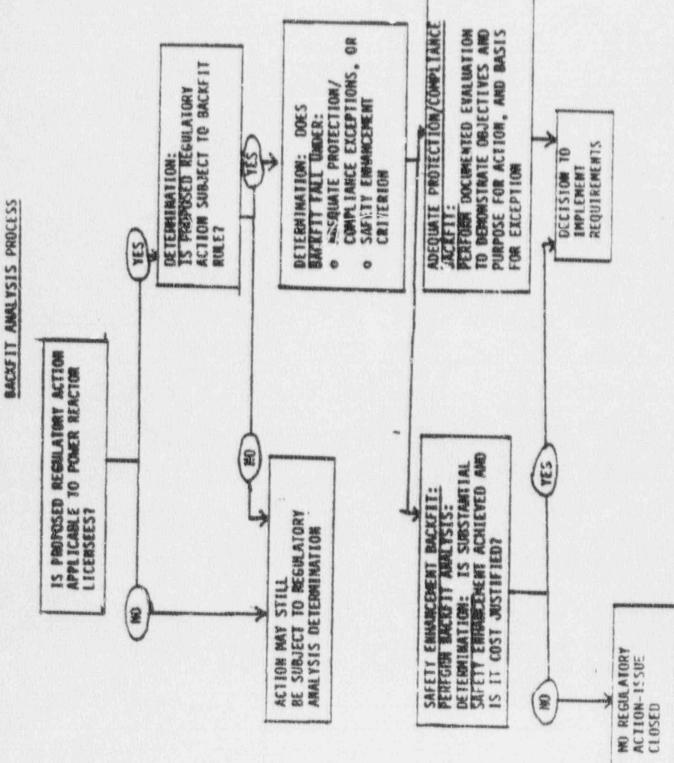
RESEARCH PERSPECTIVE

C. J. HELTEMES, JR. DEPUTY DIRECTOR FOR GENERIC ISSUES AND RULEMAKING OFFICE OF NUCLEAR REGULATORY RESEARCH U. S. NUCLEAR REGULATORY COMMISSION

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#### THE NATURE OF THE DIFFERENT TYPES OF ANALYSES

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#### REGULATORY ANALYSIS

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#### 0 ELEMENTS OF REGULATORY ANALYSIS:

- STATE THE PROBLEM AND DEFINE OBJECTIVES
- DEFINE ALTERNATIVES
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- EVALUATE CONSEQUENCES (VALUE IMPACT ANALYSIS)
- DEVELOP DECISION RATIONALE
- DESCRIBE IMPLEMENTATION



#### SAFETY ENHANCEMENT BACKFIT ANALYSIS

**PURPOSE:** 

SYSTEMATIC, DOCUMENTED ANALYSIS OF PROPOSED BACKFIT MODIFICATION TO DETERMINE WHETHER

- PUBLIC HEALTH AND SAFETY OR COMMON DEFENSE AND SECURITY
  - ARE SUBSTANTIALLY IMPROVED
- COSTS OF IMPLEMENTATION ARE JUSTIFIED

ELEMENTS:

- SPECIFIC OBJECTIVES OF BACKFIT
- ACTIVITY REQUIRED OF LICENSEE
- CHANGE IN ACCIDENTAL OFFSITE RADIGLOGICAL RISK TO PUBLIC
- POTENTIAL IMPACT ON RADIOLOGICAL EXPOSURE OF ON-SITE WORKERS
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- IMPACT ON OPERATIONAL COMPLEXITY/RELATIONSHIP TO REGULATORY REQUIREMENTS
- IMPACT ON NRC RESULTS
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#### GUIDANCE DOCHMENTS IN SUPPORT OF REGULATORY ANALYSIS

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- 0 HANDBOOK FOR VALUE-IMPACT ASSESSMENT, NUREG/CR-3568, DECEMBER 1983
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#### GUIDANCE DOCUMENTS IN SUPPORT OF BACKFIT ANALYSIS

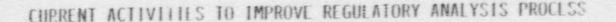
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- 0 1988 BACKFIT RULE (10 CFR 50.109)
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U UPDAT OF REGULATORY ANALYSIS GUIDELINES (NUREG/BR-0058, REV. 1)

ISTING OF TYPES OF REGULATORY ACTIONS REQUIRING REGULATORY ANALYSIS

ADDITIONAL GUIDANCE ON APPROPRIATE SCOPE AND LEVEL OF DETAIL

EXPAND GUIDANCE ON ALTERNATIVES AND ALTERNATIVE REGULATORY VEHICLES

STRUCTURE GUIDELINES TO BETTER INTEGRATE BACKFIT AND CRGR REQUIREMENTS

NCORPORATE SAFETY GOAL CONSIDERATIONS

G JPDATE OF A HANDBOOK FOR VALUE-IMPACT ASSESSMENT (NUREG/CR-3568)

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-- UNCERTAINTY ANALYSIS

-- CONTAINMENT RESPONSE

-- DISCOUNT RATES

-- IMPACT OF LICENSE RENEWAL

-- USE OF INDUSIGY COST/RISK ESTIMATES

-- TREATMENT OF SUPPLEMENTAL CONSIDERATIONS

- CUMULATIVE ACCOUNTING OF PAST AND ONGOING SAFETY IMPROVEMENTS

-

- - TREATMENT OF SAFETY GOAL CONSIDERATIONS

ADDITION OF APPENDIX ON NON-REACTOR REGULATORY ISSUES

ADDITION OF APPENDIX ON HUMAN FACTORS REGULATORY ISSUES





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**REVISION OF REGULATORY GUIDANCE** 

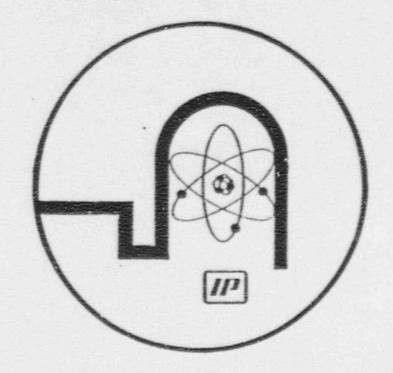
#### 0 PRINCIPAL DOCUMENTS BEING REVISED

- REGULATORY ANALYSIS GUIDELINES, NUREG/BR-0058, REV. 1
- I.ANDBOOK FOR VALUE-IMPACT ASSESSMENT, NUREG/CR-3568

#### 0 ESTIM. TED SCHEDULE

- HORK IN PROGRESS AT PNL
- REVISED GUIDANCE ISSUED FOR INTERNAL REVIEWS
  - -- REGULATORY GUIDELINES 1ST Q 1991
  - -- VALUE IMPACT HANDBOOK 2ND Q 1991
- INTICIPATED PUBLIC COMMENT PERIOD 4TH Q 1991
- TARGET DATE FOR COMPLETION 1ST Q 1992

# ILLINOIS POWER COMPANY CLINTON POWER STATION



# NRC REGION III BACKFITTING WORKSHOP OCTOBER 15, 1990

- **o** IP TOOK VIGOROUS CORRECTIVE ACTION
- **o** NO IMMEDIATE IMPACT ON SAFE OPERATION OF THE PLANT
- **o** NO METAL CONTACT IN FIELD
- WIRE CAPS HAD BEEN TESTED BY LIMITORQUE
- **o** PERFORMED TWO TESTS ON AGED WIRE CAPS
- o REWORKED VALVES
- **o** ENGINEERING ANALYSIS
- o IMMEDIATE TEST
- LIMITORQUE INSTALLED NYLON WIRE CAPS

# LIMITORQUE VALVE MOTORS



# **ELECTRICAL BUTT SPLICES**

#### ISSUE

**o** TESTING OF KYNAR AMP BUTT SPLICES

### **CORRECTIVE ACTION**

- **o** IMMEDIATE TEST
- **o** ENGINEERING ANALYSIS
- **o** TEST OF AGED SPLICES
- **O MANAGEMENT DIRECTED PLANT TO REMAIN SHUTDOWN**
- ALL BUTT SPLICES WERE REPAIRED, REWORKED OR REPLACED

#### MITIGATING FACTORS

- **QUALIFICATION CONSISTENT WITH INDUSTRY PRACTICES**
- **o** NO METAL CONTACT IN FIELD
- **o** IP TOOK VIGOROUS CORRECTIVE ACTION



## Potential Backfit of NUREG 1021 Rev. 6

- Clinton Power Station is committed to the following in Updated Analysis Report (USAR)
  - Reg Guide 1.8 Revision 1
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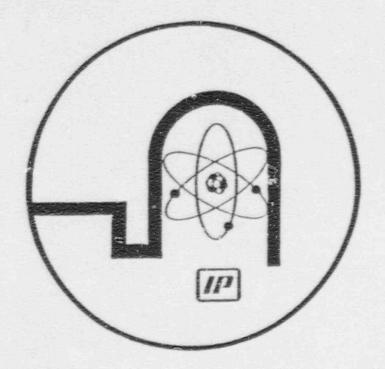


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- o However, the NRC is reviewing Clinton Power Station's License application to the requirements of NUREG 1021 Rev. 6.





# ILLINOIS POWER COMPANY CLINTON POWER STATION



# NRC REGION III BACKFITTING WORKSHOP OCTOBER 15, 1990



- o ENVIRONMENTAL QUALIFICATION JUNCTION BOX ISSUE 1987-88
- **o** OPERATOR LICENSING

9



NRC IDENTIFIED ISSUES DURING EQUIPMENT QUALIFICATION (EQ). AUDIT OF AUGUST 1987 WHICH REQUIRED FOLLOW-UP IPC ACTION.

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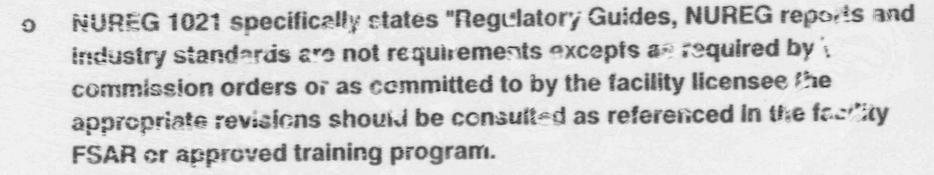
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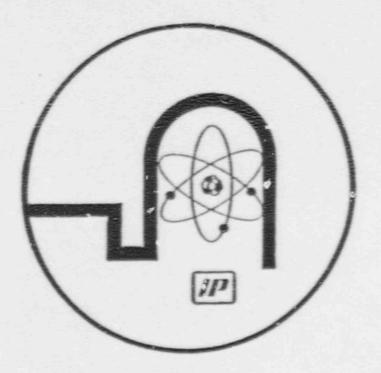
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**OCTOBER 15, 1990** 



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## 50.72 REPORTING

## NRC USE AND EXPERIENCE



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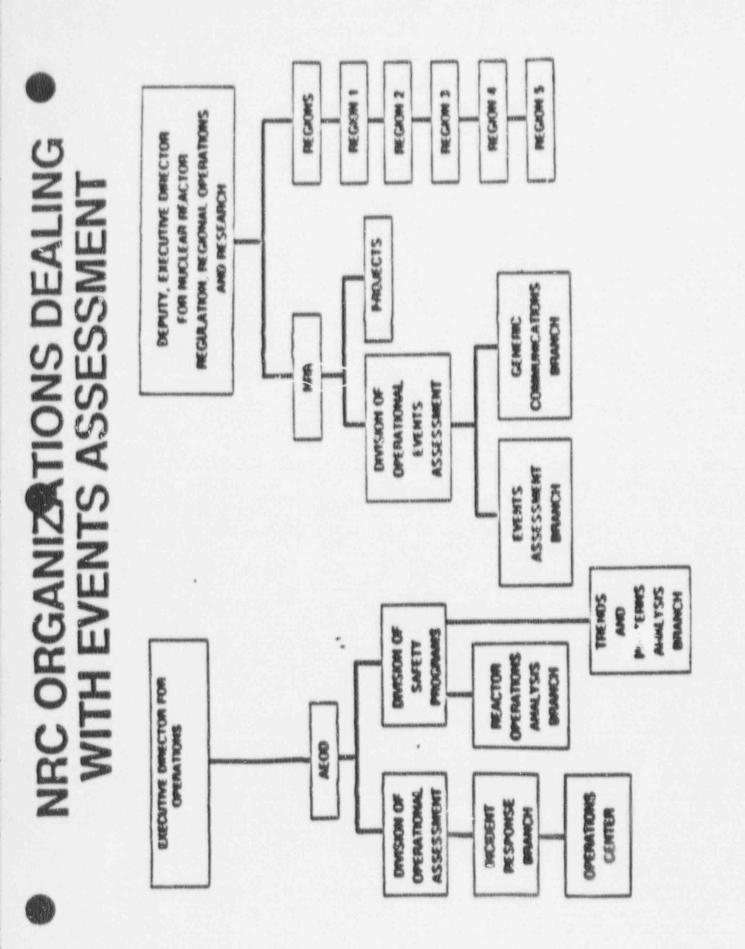
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10 CFR 50.72

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- TELEPHONE NOTIFICATION TO NRC OPERATIONS CENTER
- 1 HOUR OR 4 HOUR REPORTS
- REVIEWED BY EVENTS ASSESSMENT BRANCH, NRR

10 CFR 50.73

- APPLIES TO HOLDERS OF OPERATING LICENSES
- WRITTEN REPORT ON EVENT
- MUST BE SUBMITTED TO NRC WITHIN 30 DAYS
- REVIEWED BY AEOD



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### **REACTOR EVENTS EVALUATION**

• **REPORTING** 

- PROMPT RESPONSE, WHEN NECESSARY
- CAREFUL EVALUATION FOR GENERIC AND PLANT SPECIFIC SAFETY CONCERNS
- ISSUANCE OF GENERIC COMMUNICATIONS, WHEN APPROPRIATE

### DETAILS OF 10 CFR 50.72 REPORTING REQUIREMENTS

### EVENTS REGUIRING DECLARATION OF AN EMERCENCY CLASSIFICATION (1 HR)

ACN-EMERGENCY EVENTS (1 HR) TECH SPEC REQUIRED SHUTDOWN LEVIATIONS FROM THE PLANTS TECH SPECS (50.54(x)) SERIOUS DEGRADATION OF PLANT/SAFETY BARRIERS

- UNANALYZED CONDITION
- CLISIDE THE DESIGN BASIS

- NOT COVERED BY PLANTS OPERATING & EMERGENCY PROCEDURES NATURAL PHENOMENA OR EXTERNAL CONDITIONS THAT THREATEN PLANT SAFETY ECCS ACTUATION AND DISCHARGE TO VESSEL FROM VALID SIGNAL MAJOR LOSS OF EMERGENCY RESPUNSE CAPABILITY ACTUAL THREAT TO PLANT SAFETY FROM FIRES, TOXIC GAS RELEASE, RADIDACTIVITY

NON-EMERGENCY EVENTS (4 HR)

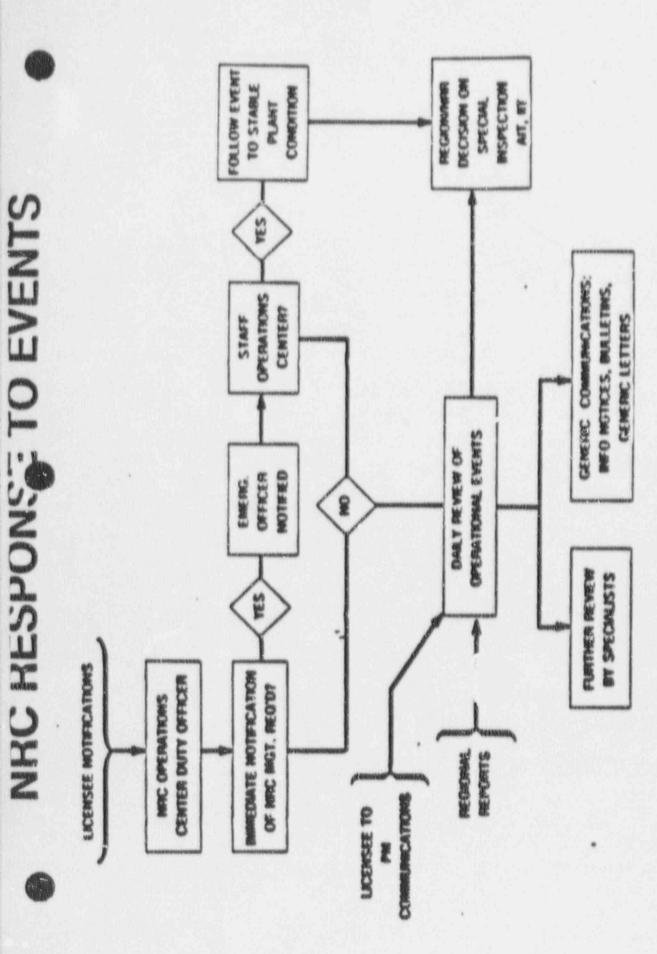
SERIOUS DEGRADATION TO PLANT SAFETY SYSTEMS FOUND WHILE SHUTDOWN

MANUAL OR AUTOMATIC ACTUATION OF ESF INCLUDING RPS-NOT PREPLANNED EVENT OR CONDITION WHICH COULD PREVENT FULFILLMENT OF SAFETY FUNCTION

- REACTOR SHUTDOWN; MAINTAIN SAFE SHUTDOWN CONDITION
- REMOVE RESIDUAL HEAT -
- CONTROL RELEASE OF RADIOACTIVE MATERIAL
- MITIGATE CONSEQUENCES OF AN ACCIDENT

RADIOACTIVE RELEASES IN EXCESS OF PART 20 TRANSPORT OF CONTAMINATED INDIVIDUAL TO OFFSITE MEDICAL FACILITY







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- · SISTEMATIC, RED WAILE IN LAWES ACCUSENT PRAVIL
- 50,72 REPORT MAITLES FACH OFFICIENS (CINIER
- REGIN GALLY REPARTS AND PART IN MARY MUT IF ICAT IONS.
- INTERNIC POST REGIONS AND PROFESS PANALTES
- MAR DIVISION DIPECTORS AND/AR REPRESENTATIVES BRIFFED BY TELEPHONE AT 8:15 A.N. ON SIGNIFICANT EVENTS, INCLIDING ALL REACTOR TRIPS
- · MAN STRICK MANAGERI INCLUED OF HIGH'S SIGNIFICANT EVENTS
- EWARS ASSESTED BANCH TELETHONE CONFIRME CALL TO DISCISS SIGNIFICANT ENGINS AT 8:50 A.M. .
- INCLUES REPRESENTATIVES OF ENG. GCB. ACID. RVIB. RP
- ATTICHS ASSIGNED TO COTAIN ADDITIONAL INFORMATION
- DISCUSSIONS ON NEED FOR ALTERNED INSPECTION TEAM OR INCLODENT INVESTIGATION TEAM





### DETERMINING BASIC FACTUAL INFORMATION

- Information from Utility Telephone Notification Supplemented by Information Obtained by Telephone from Regional Office/ Resident Inspector
- Confirmation and Augmentation from Written Report
- Formal Program for Fact Finding for Complicated Events or Events Causing Significant Degradation in Plant Safety
- Incident Investigation Team
- Augmented Inspection Team

### WEEKLY BRIEFINGS/DISCUSSIONS

- O 1:15 P.M. EVENTS MEETING ON TUESDAY

  - NEED FOR LONG TERM FOLLOW OF EVENTS
  - ASSIGNMENTS FOR LONG TERM FOLLOW
  - JRY RUN AND CRITIQUE OF WEDNESDAY MORNING EVENTS BRIEFING
- O 11:00 A.H. EVENTS BRIEFING ON WEDNESDAY
  - PRIMARILY DIVISION DIRECTORS AND ABOVE AND COMMISSIONER ASSISTANTS
  - ALL NRC PARTICIPATION REGIONS PARTICIPATE BY PHONE
  - DURATION OF 1/2 HOUR TO 1 HOUR TYPICALLY
  - BRIEFING VUGRAPHS/ATTENDANCE LIST PLACED IN PDR



RULE RECOURSES REPORTS ON SOME EVENTS OF MINOR SAFETY SIGNIFICANCE

D'SFFERENT DEFINITIONS OF SYSTEMS THAT ARE ESF SYSTEMS

DIFFERENCES OF INTERPRETATION OF RULE

- ESF "ACTUATION"

1

- "SERIOUS" DEGRADATION OF PLANT SAFETY SYSTEMS
- UNAWALYZED CONDITION, OUTSIDE DESIGN BASIS

SENSITIVITY TO EVENTS OR CONDITIONS WHICH COULD PREVENT FULFILLMENT OF A SAFETY FUNCTION

1.

- EQUIPPENT PROBLEPS THAT COULD LEAD TO COMMON MODE FAILURE 1
- DEGRADATIONS IN EQUIPMENT WHICH BY CHANCE ALLOW FULFILLMENT OF SAFETY FUNCTION 1

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## CRITERIA FOR EVENT FOLLOWUP

- SAFETY-SIGNIFICANT EVENT
- POTENTIALLY SIGNIFICANT EVENT
- EVENT NOT UNDERSTOOD
- NO FOLLOWUP NECESSARY



### EVENT FOLOWUP CRITERIA

### SIGNIFICANT EVENTS

- DEGRADATION/LOSS OF IMPORTANT SAFETY EQUIPMENT (MULTIPLE/COMMON MODE FAILURE)
- DEGRADATION OF FUEL INTEGRITY, PRIMARY COOLANT PRESSURE BOUNDARY, CONTAINMENT, AND IMPORTANT SAFETY-RELATED STRUCTURES
- UNEXPECTED PLANT RESPONSE TO A TRANSIENT
- MAJOR TRANSIENT
- SCRAM WITH COMPLICATIONS
- UNPLANNED RELEASE OF RADIOACTIVITY
- OPERATION OUTSIDE THE LIMITS OF TECH SPEC
- OTHER (RECURRING INCIDENTS, PLANT MANAGEMENT OR PROGRAMMATIC BREAKDOWNS)

## EVENT FOLLOWUP CRITERIA

## POTENTIALLY SIGNIFICANT EVENTS

- SOME BUT NOT ALL ELEMENTS OF SIGNIFICANT EVENT
- NEW OR UNIQUE EVENT (FAILURE MODE, CAUSE, **OR SEQUENCE PROGRESSION**
- EVENT WITH POTENTIAL GENERIC IMPLICATIONS (USUALLY INVOLVING A SPECIFIC PIECE OF EQUIPMENT OR PROCEDURE)
- AN EVENT WHICH DOES NOT CONFORM TO KNOWN **DESIGN/OPERATION FEATURES**
- **OTHER (SUPERVISOR'S JUDGMENT, MANAGEMENT** INQUIRY, RECURRING SYMPTOMATIC EVENTS)

-



## EVENT FOLLOWUP CRITERIA

### EVENT NOT UNDERSTOOD

- MISSING INFORMATION COULD RESULT IN SIGNIFICANT CLASSIFICATION
- DIFFERENCES IN DESIGN, TECHNICAL SPECIFICATIONS, ETC.





**Operations Officer Section** 

Incident Response Branch

Office for Analysis and Evaluation

of Operational Data

U.S. Nuclear Regulatory Commission

Phone (301) 492-9005

### NOT CONSISTENTLY REPORTED

- Anticipated Emergencies
- Large Spills
- Inadvertent Criticalities
- Small Water Hammers, Small Fires
- Overpressurization
- Potentially Generic Events
- ESF Actuations



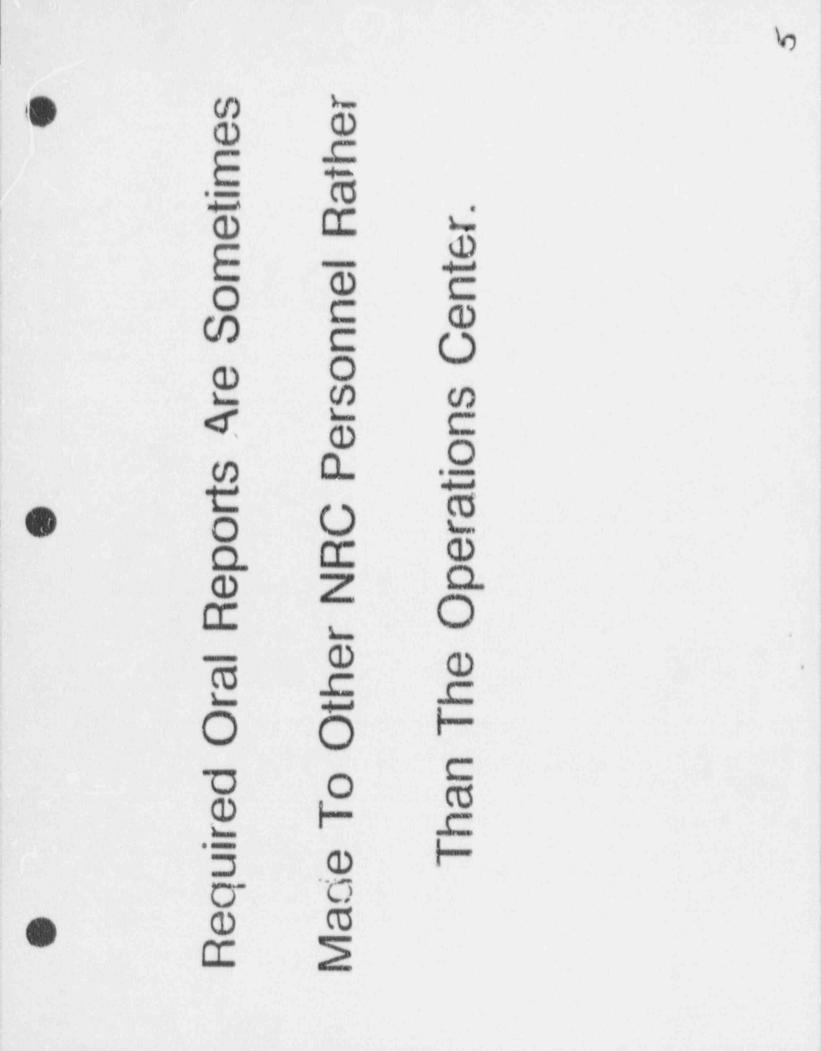
### Notifications For NRC Response To Media/Public

- Often Untimely
  - Threshold



## Deficiencies Not Always Reported

## When Found by NRC Personnel.







# The Potentially Generic Problems Are Not

Consistently Reported Because The

Not Understood. The Words Intent of 50.72 (b)(2)iii Is

"Alone Could Have Prevented"

Need To Be Explained.

### 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

### 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

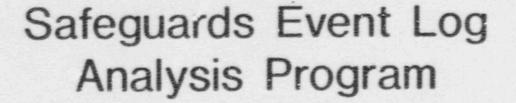
- NUREG-1304
- Incorporate Lessons Learned/ 2 Year's Experience

Generic Letter

- Policy Revision
- Eliminate Unnecessary Reporting

Responsive to Impact Survey

 Impact Survey Considered in Revision to RG 5.62 and Generic Letter



### 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

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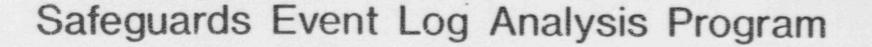


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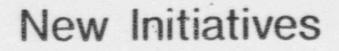
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## NRC USE AND EXPERIENCE



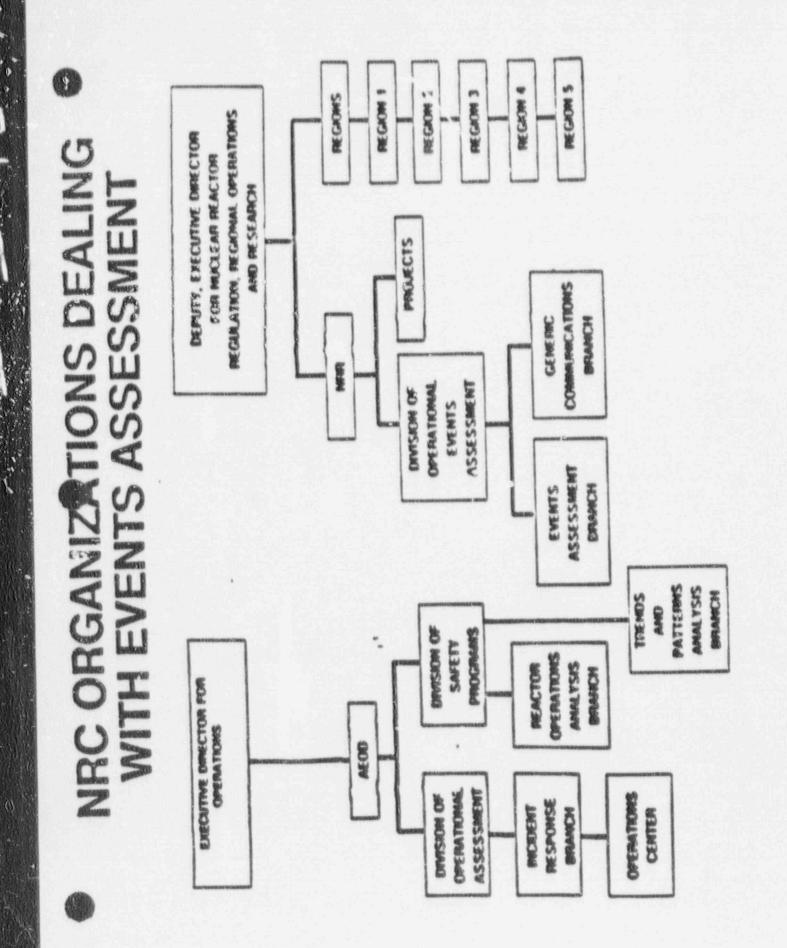
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## **REACTOR EVENTS EVALUATION**

## . REPORTING

- PROMPT RESPONSE, WHEN NECESSARY
- CAREFUL EVALUATION FOR GENERIC AND PLANT SPECIFIC SAFETY CONCERNS
- ISSUANCE OF GENERIC COMMUNICATIONS, WHEN APPROPRIATE

### DETAILS OF 10 CFR 50,72 REPORTING REQUIREMENIS

EVENTS REGULARING DECLARATION OF AN EMERCENCY CLASSIFICATION (1 HR)

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SERIOUS DEGRADATION TO PLANT SAFETY SYSTEMS FOUND WHILE SHUTDOWN

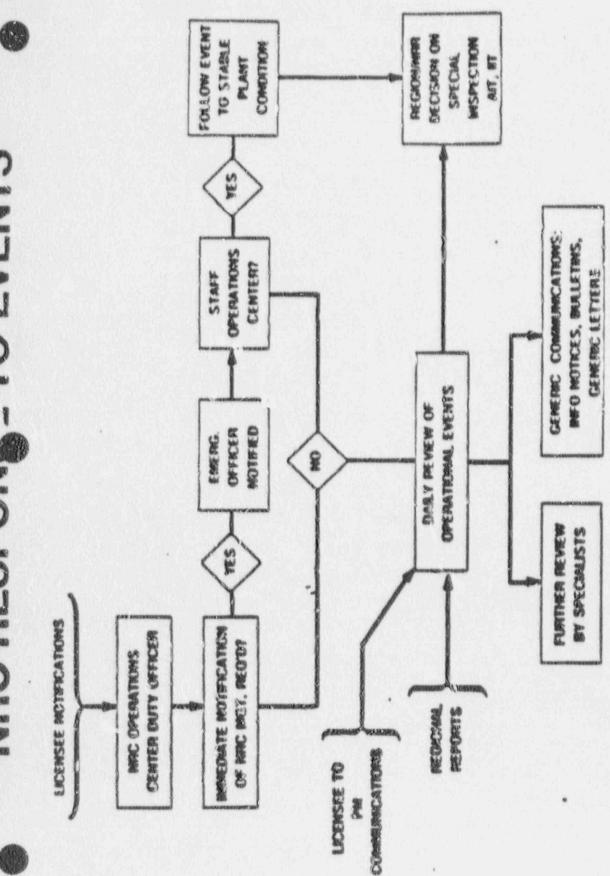
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- REACTOR SHUTDOWN; MAINTAIN SAFE SHUTDOWN CONDITION
- REMOVE RESIDUAL HEAT -
- CONTROL RELEASE OF RADIOACTIVE MATERIAL
- MITIGATE CONSEQUENCES OF AN ACCIDENT

RADIOACTIVE RELEASES IN EXCESS OF PART 20 TRANSPORT OF CONTAMINATED INDIVIDUAL TO OFFSITE MEDICAL FACILITY



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- O 1:15 P.M. EVENTS MEETING ON TUESDAY
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- NEED FOR LONG TERM FOLLOW OF EVENTS
- ASSIGNMENTS FOR LONG TERM FOLLOW
- DRY RUM AND CRITILATE OF WEDNESDAY MORNING EVENTS BRIEFING
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## PROBLEMS EXPERIENCED WITH 50.72 REPORTING

RULE RECUIRES REPORTS ON SOME EVENTS OF MINOR SAFETY SIGNIFICANCE

DIFFERENT DEFINITIONS OF SYSTEMS THAT ARE ESF SYSTEMS

DIFFERENCES OF INTERPRETATION OF RULE

- ESF "ACTUATION"

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- "SERIOUS" DEGRADATION OF PLANT SAFETY SYSTEMS
- UNARALYZED CONDITION, OUTSIDE DESIGN BASIS

SENSITIVITY TO EVENTS OR CONDITIONS WHICH COULD PREVENT FULFILLMENT OF A SAFETY FUNCTION

- EQUIPMENT PROBLEMS THAT COULD LEAD TO COMMON MODE FAILURE 1
- DEGRADATIONS IN EQUIPMENT WHICH BY CHANCE ALLOW FULFILLMENT OF SAFETY FUNCTION 1



## EVENT ASSESSMENT

# CLATERIA FOR EVENT FOLLOWUP

- SAFETY-SIGNIFICANT EVENT
- **POTENTIALLY SIGNIFICANT EVENT**
- EVENT NOT UNDERSTOOD

## NO FOLLOWUP NECESSARY

# EVENT FOLOOWUP CRITERIA

## SIGNIFICANT EVENTS

- DEGRADATION/LOSS OF IMPORTANT SAFETY EQUIPMENT (MULTIPLE/COMMON MODE FAILURE)
- PRESSURE BOUNDARY, CONTAINMENT, AND IMPORTANT DEGRADATION OF FUEL INTEGRITY, PRIMARY COOLANT SAFETY-RELATED STRUCTURES
- UNEXPECTED PLANT RESPONSE TO A TRANSIENT
- . MAJOR TRANSIENT
- SCRAM WITH COMPLICATIONS
- UNPLANNED RELEASE OF RADIOACTIVITY
- **OPERATION OUTSIDE THE LIMITS OF TECH SPEC**
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- AN EVENT WHICH DOES NOT CONFORM TO KNOWN DESIGN/OPERATION FEATURES
- OTHER (SUPERVISOR'S JUDGMENT, MANAGEMENT INQUIRY, RECURRING SYMPTOMATIC EVENTS)



## EVENT FOLLOWUP CRITERIA

## EVENT NOT UNDERSTOOD

- MISSING INFORMATION COULD RESULT IN SIGNIFICANT CLASSIFICATION
- DIFFERENCES IN DESIGN, TECHNICAL SPECIFICATIONS, ETC.

## 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



## 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 Plan'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 Jse 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



## 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





- 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 1
  - Results of licensee self-assessment
    - Identifies factors impacting licensee reporting 1



## 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

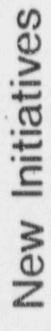
· Compare facility data against industry



## **Program Results**

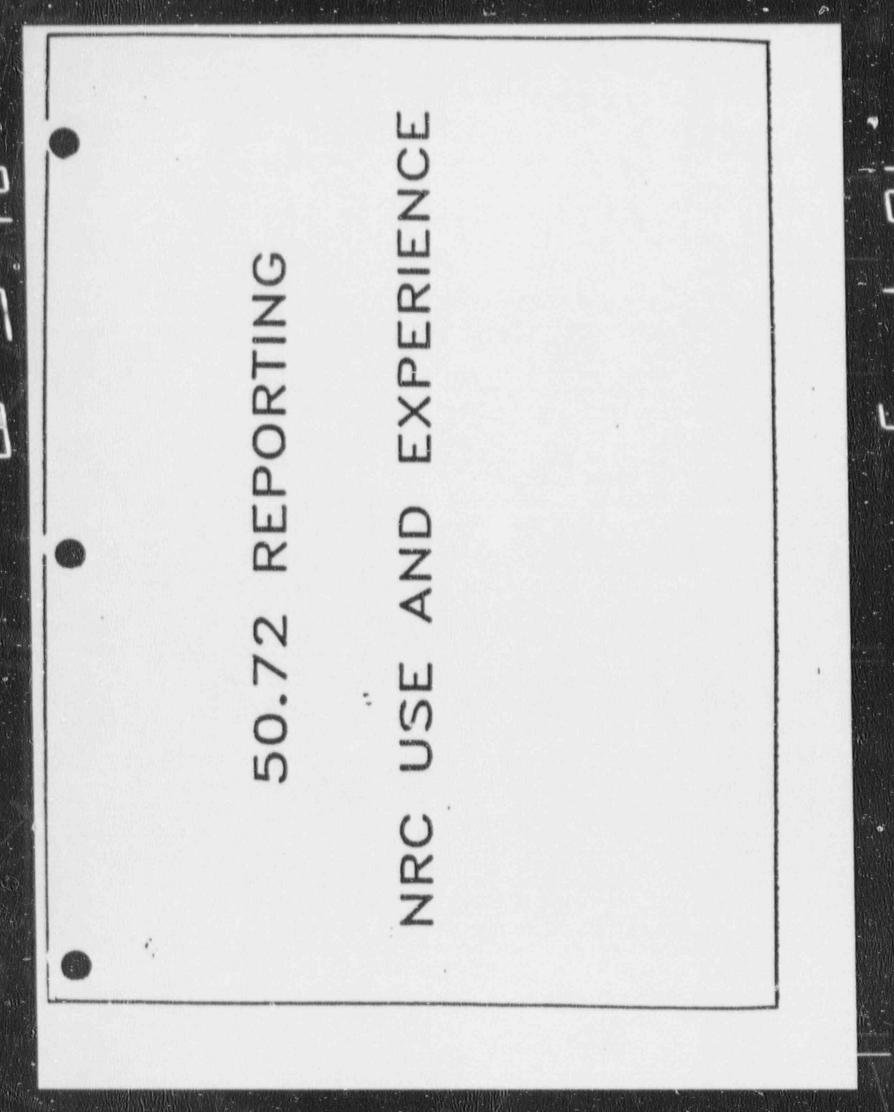
Event logs and feedback data bases for root cause analysis performed by licensee and NRC which resulted in:

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



<u>k</u> at Analysis to determine correlations between event data and facility design, equipment and special circumstances

- Normalization of data
- Root cause analysis



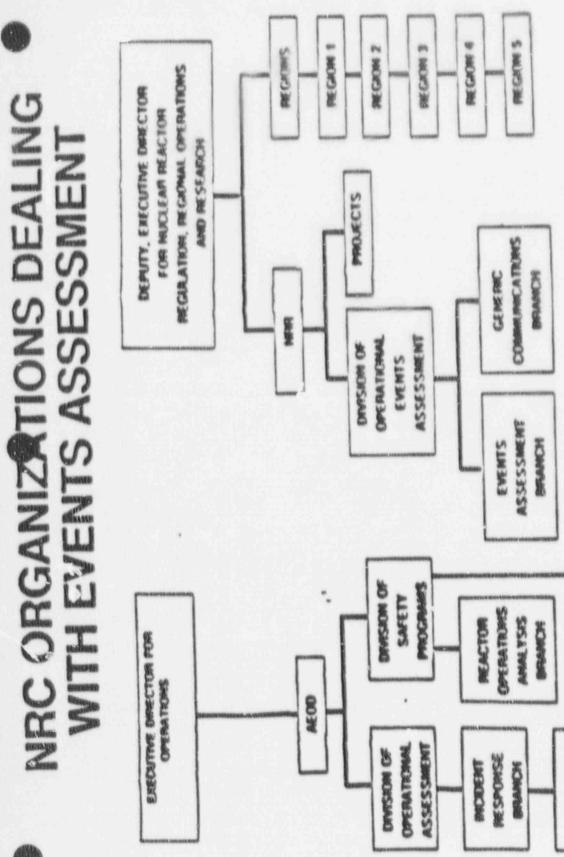
## REGULATORY REPORTING REQUIREMENTS

## 10 CFR 50.72

- APPLIES TO HOLDERS OF OPERATING LICENSES
- TELEPHONE NOTIFICATION TO NRC OPERATIONS CENTER
  - 1 HOUR OR 4 HOUR REPORTS
- REVIEWED BY EVENTS ASSESSMENT BRANCH, NRR

## 10 CFR 50.73

- APPLIES TO HOLDERS OF OPERATING LICENSES
- WRITTEN REPORT ON EVENT
- MUST BE SUBMITTED TO NRC WITHIN 30 DAYS
- REVIEWED BY AEOD



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OPERATIONS

CENTER

## **REACTOR EVENTS EVALUATION**

• **REPORTING** 

- PROMPT RESPONSE, WHEN NECESSARY
- CAREFUL EVALUATION FOR GENERIC AND PLANT SPECIFIC SAFETY CONCERNS
- ISSUANCE OF GENERIC COMMUNICATIONS, WHEN APPROPRIATE

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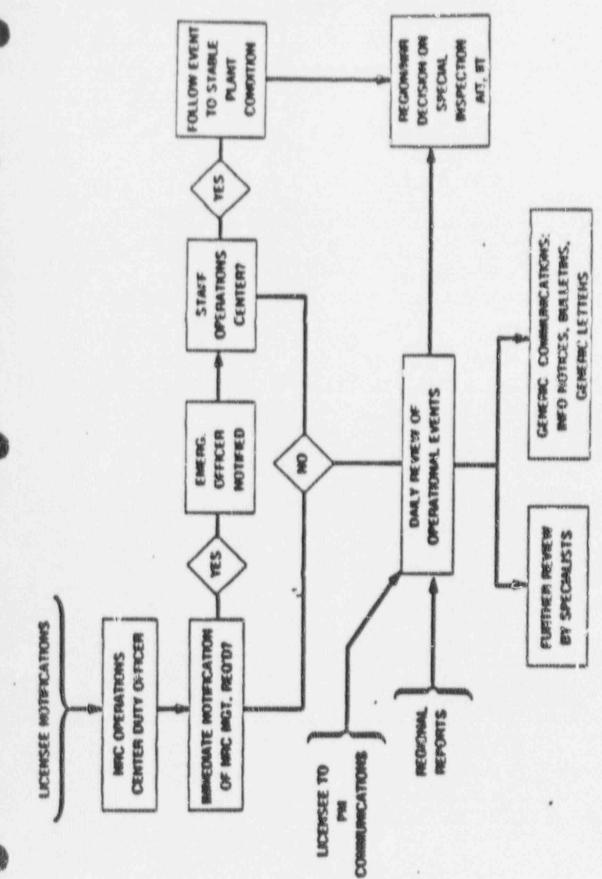
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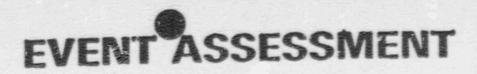
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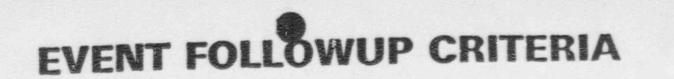
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Eric W. Weiss, Chief **Operations Officer Section Incident Response Branch** Office for Analysis and Evaluation of Operational Data **U.S. Nuclear Regulatory Commission** Phone (301) 492-9005

### NOT CONSISTENTLY REPORTED

in.

- Anticipated Emergencies
- Large Spills
- Inadvertent Criticalities
- Small Water Hammers, Small Fires
- Overpressurization
- Potentially Generic Events
- ESF Actuations

## Notifications For NRC Response To Media/Public

- Often Untimely
  - Threshold



## Deficiencies Not Always Reported

## When Found by NRC Personnel.



Mage To Other NRC Personnel Rather

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# The Potentially Generic Problems Are Not

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Need To Be Explained.





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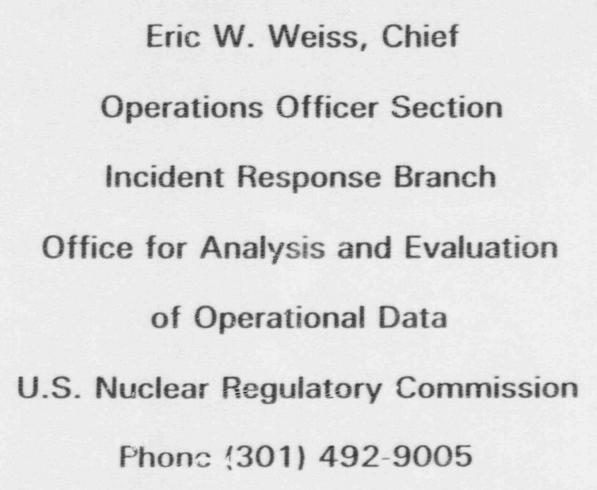
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NRC EVENT . PORTING WORKSHOP October 16, 1990 REGISTRATION

Address Affiliation Name 2650 MCCORMICK DR. CLEARWATER FL 34619 19. PATTY DAV NUS Byron Nuclear Plant CECO 20. Marseyne Show Byrn Nuclear Plant 21. Bill Pirnat CECO DN #5/RE#1 MORRIS IL. 60450 22. BARRY M. SAUNDERS CE CO (NUCL. SECURITY) 300 MADIJON AVE TOLEDO, OH, 43522 TOLEDO EDISON 23. PETER W. SMITH 101 Shiloh Blud Zion IL 60099 24. Van Geoldes CECO 101 SHILOLOH BLID ZIN, Alborro 25. Good BEALE CECO LASolle County RE1 Box 220 Marselles 161341 CALLAWAY DLANT BOX 620, FULTON, MO 65251 26. Jom Hammeeich CECO UNION ELECTRIC CO. 27. T.P. Sharkey 2650 MECORMICK DR. CLEARWATER, I-L 34619 28. PETER JORDAN NUS CORP. LASAUS COUNTY STATION, RRI BO-220 MANSAUET 12 29. DAVID REIF CECO 1035 OUTER PARK DR. SMUNGFIELD, 12 52702 IDNS CHARLES GALLINA 30 W. MONROEST CHICAGO SARGENT & LUNDY 31. JOHN GOUVAS 7101 Wisconsin Ave, Bethosola, MD 2081 32. Jamis Roberts TENERA QUAD. CITIES CECO 33. MIKE BROWN Clinton Power Station BOX678 Clinton 34. Bob GoroBERT SIL 35. Joe Siper Illinois Powel 36. TOM PLOSKI 799 ROUSE VEIT, GLEN ELYN NRC R3

799 Evenerity 21 6013 2807 W HWY 75 Montrulls Ma 400 COUS PLACE, DOWNERS GROVE, IL 4400 P. Carner Ch. R.J. Byran 14 70. Boyle 78 Cluston IL 6 1727 COVERT Mi 49038 1035 OUR PARK SPECIAL 10101 Colorial Dr Ellight City Ha Vashington, D.C. 20555 Same Address NRC EVENT REPORTING WORKSHOP MONTICELLO October 16, 1990 REGISTRATION NEC - REGION TIL Whith has hove CEC - - 1505 CEC. Byro. NRC - MEL Affiliation NE CPCO IDUS NSP NRC NRC dt. CECO. 38. MORGAN CLARITY 40. Julany Lockwood 41. JOAN Higdon 47. ED GICENNAN 48. J. R. CREED 39. MIKE PARKER 31. DON BRINDIG 42. Jim Browneld 10. C SHOZUP N. ERVEN A. E. Challe 43. GA DENENBERG Name 49. 46. 54. 51. 52. 53. 50.



NRC EVENT REPORTING WORKSHOP October 16, 1990 REGISTRATION

Address Affiliation Name Graidwood Station RRI Bax 84 Braconlle Commanmealth Edison la 1. Mark J Andraws Glead Cities Station Cordove, IL Commonwealth Editor Co 2. Keith L. Leech DAK HARBOR, OHIO TALEOU EDISON 3. JACK C DILLICH DOWNERS GROVE, 12. COMMONWEATH EDISON CO. 4. RITA RADTKE Perry Nuclear PP, FUBor 97, Perry Ohio Clausfund Electric 5. Robert Newkirk GREEN BAY SOL WISC PUBLIC SERVICE GAP 6. RICK PULES 1400 L street NW Wook DC Winston & Strawn 7. Cavid Repka 788 Lowers & Ry Cla Uly Flores NRC ByinaII 8. Bruce Buger 2650 M Cornet Dr Clearwetter 9. Davil Perkey NUS 71760 Columbia River Hory Reinier, OR Partland General Electric 10. Scott Bauer macwill fill BRAIDWOOD NPS 11. PERM SANDOVAL Detroit Estison 6400 N Dixe Hay New : 40/ 48/66 12. Lynne bardon R | Box 84 BRAG CECO - BRAINWOOD STATION 13. DAVID J. MILLER 220Bo The Stan Higher, Innot MT. 14. William L. Kogents Consumi's Rome Co. P.O. Box 678 CTudon Ruiz 15. TRACIS. ARNOLD Illidois tower Ub 11 11 11 11 16. Frank Spannpubolg Lusalle Goody Station 17. John Mcherman (e(0 799 Roasewelt Rd, Glendlyn, IL 18. Bruce L. Jorgansen NRC Region III



### LICENSEE EVENT REPORTING WORKSHOP

### MORNING SESSION



LER SYSTEM 10 CFR 50.73



### LER - 10CFR 50.73

. PRIMARY SOURCE FOR EVENTS DATA

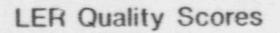
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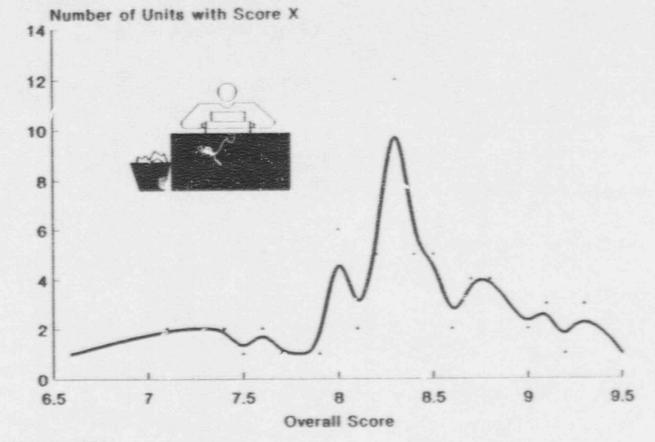
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'70 Units 1987









AEOD OPERATING EXPERIENCE FEEDBACK PROGRAM

. GOAL - FEEDBACK OF OPERATING EXPERIENCE

- . EVENTS' SCREENING AND O.E. DATABASE MAINTENANCE
- . EVENTS' ANALYSIS
- · FEEDBACK
- · SAFETY ETHIC
  - . SHARING OF OPERATING EXPERIENCE PROGRAM ORIGIN









### CURRENT ISSUES

### . MISSING REPORTS

### . REPORTS OF LOW SAFETY SIGNIFICANCE

### . IMPROVEMENT APPROACH









### INCOMING LERS (CY 1989)

### . NATURE OF REPORTS - CATEGORIES

. ESF ACTUATIONS AREA OF INTEREST FOR IMPROVEMENT

. T.S. VIOLATIONS









### LICENSEE EVENT REPORTING WORKSHOP

### MORNING SESSION



LER SYSTEM 10 CFR 50.73

### BACKGROUND

0

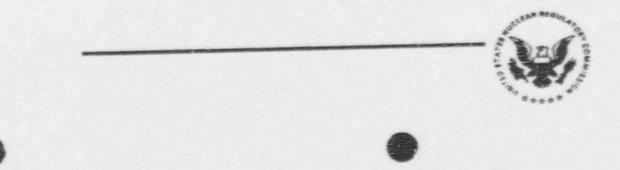
. TMI ACTION PLAN - MAY 1980

. PRE-1984 REPORTS

. IOERS (1980 ANPRM)

. INPO MANAGEMENT OF NPRDS

. 10 CFR 50.73 - EVENT LEVEL REPORTING





### LER - 10CFR 50.73

- . PRIMARY SOURCE FOR EVENTS DATA
- . NATIONAL AND INTERNATIONAL USE
- . INDIVIDUAL & COMBINED EVENT'S ANALYSIS SYSTEMATIC
- . LICENSEE PERSPECTIVE



### REPORTING GUIDANCE & EVALUATIONS

### GUIDANCE

- . NUREG 1022 & SUPPLEMENT 1
- . RESIDENT INSPECTOR AND REGIONAL FEEDBACK
- . CASE-BY-CASE AEOD OR NRR VERBAL FEEDBACK
- . AEOD OR NRR WRITTEN GUIDANCE

### EVALUATIONS

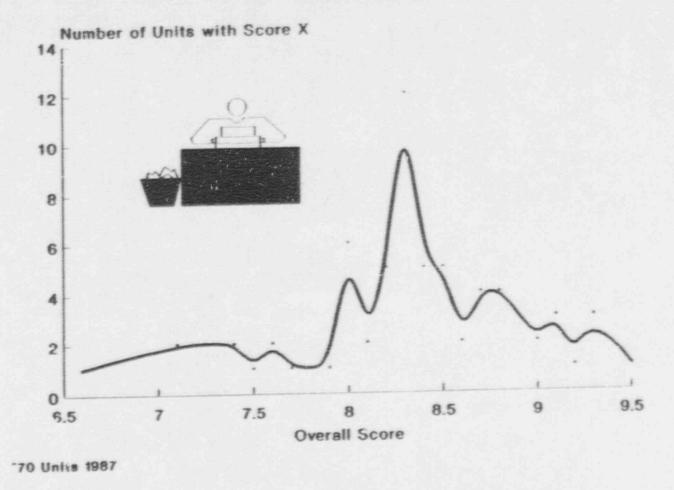
- . LER QUALITY EVALUATION PROGRAM (1985-EOFY 1987)
- . NRC OR CONTRACTOR QUESTIONS







### LER Quality Scores





### NRC USE OF LERS

- . GENERIC ISSUE EVALUATION (RES)
- . GENERIC COMMUNICATIONS (NRR)
- . OPERATING EXPERIENCE FEEDBACK (AEOD)
- · PERFORMANCE ASSESSMENT AND MONITORING (NRR/REGIONS/AEOD)







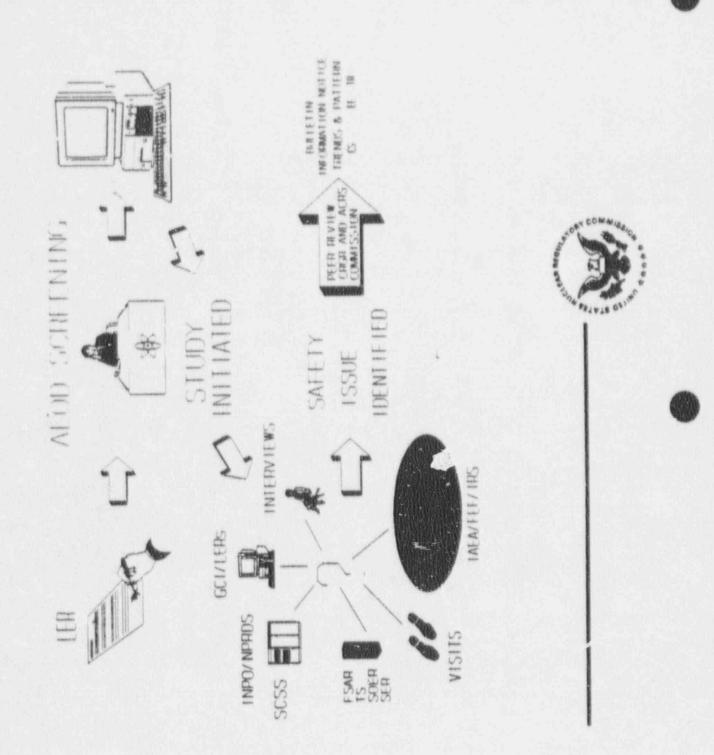


AEOD OPERATING EXPERIENCE FEEDBACK PROGRAM

. GOAL - FEEDBACK OF OPERATING EXPERIENCE

- . EVENTS' SCREENING AND O.E. DATABASE MAINTENANCE
- . EVENTS' ANALYSIS
- . FEEDBACK
- . SAFETY ETHIC
  - . SHARING OF OPERATING EXPERIENCE PROGRAM ORIGIN











### CURRENT ISSUES

### . MISSING REPORTS

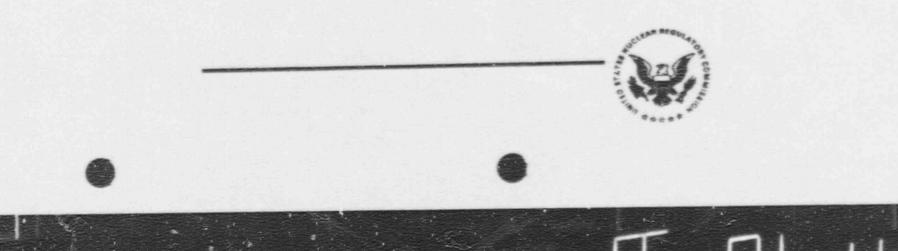
### . REPORTS OF LOW SAFETY SIGNIFICANCE

### . IMPROVEMENT APPROACH



### AFTERNOON SESSION

"RULEMAKING/GUIDANCE REVISION"





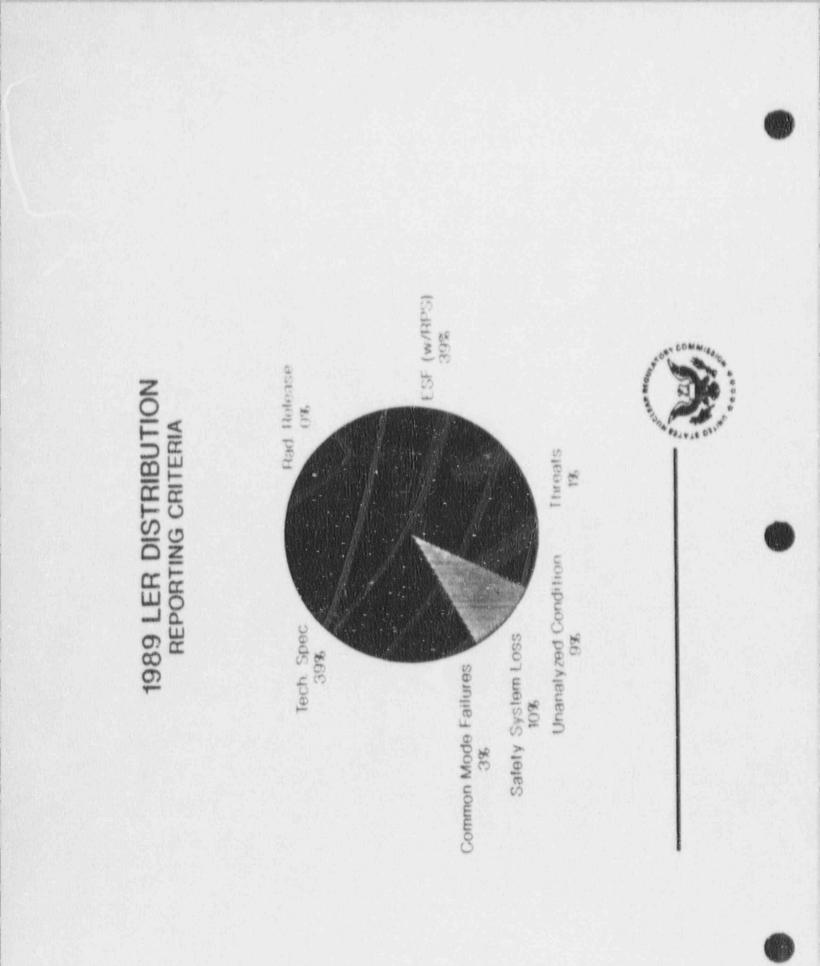


. NATURE OF REPORTS - CATEGORIES

AREA OF INTEREST FOR IMPROVEMENT

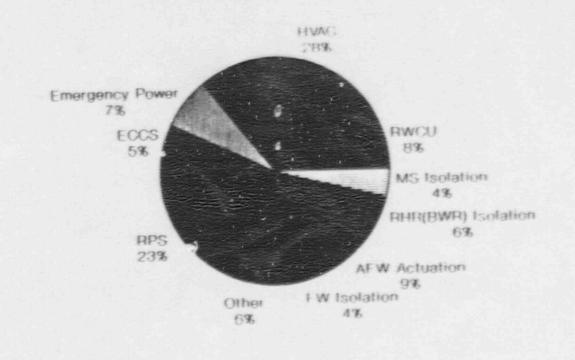
. T.S. VIOLATIONS











Besed on Total Number of Systems Actuated, Not LERs!



### 1989 ESF LERS (WITHOUT RPS)

. TOTAL LERS: 609 [1358 ACTUATIONS/ISOLATIONS]

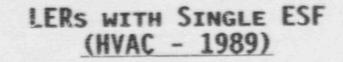
	TOTAL	INVALID*
. LERS WITH SINGLE ESF	432	325
HVAC SYSTEMS:	158	132
RWCU SYSTEM:	48	34

\* MEASURED PARAMETER DID NOT REACH SETPOINT BAND.









SYSTEM/AREA	No. LERS	INVALID
CONTROL ROOM GE WE CE BW	77 22 42 7 6	66 16 37 7 6
REACTOR BUILDING	34 5 28 1 0	29 4 24 1 0
OTHER HVAC	47	37
TOTAL	158	132



### 1989 TECHNICAL SPECIFICATION LERS VIOLATIONS



1 & C Systems + 43% of LCOs and 47% of Serveillances









### PAST STAFF INITIATIVES

. NUREG-1022 W/SUPPLEMENTS 1 & 2

. STAFF CONSIDERATION - TRAIN LEVEL REPORTING (1988)

- . SAFETY SYSTEMS TRAIN UNAVAILABILITY
  - . TABULAR MONTHLY REPORT FORMAT
- . EXCLUDE LER REPORTING FOR SELECTED ESF EVENTS



### CURRENT STAFF INITIATIVES

### NEAR-TERM

- . ELIMINATION OF SELECTED ESFS
  - . UNNEEDED' RWCU ISOLATION OR CONTROL ROOM HVAC ACTUATIONS
- . ISSUANCE OF ADDITIONAL GUIDANCE (Nureg 1022 Supp. 3)

### LONG-TERM

18

- . SYSTEMATIC RE-EVALUATION OF REQUIREMENTS
- . PROBABLE RULE CHANGE

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

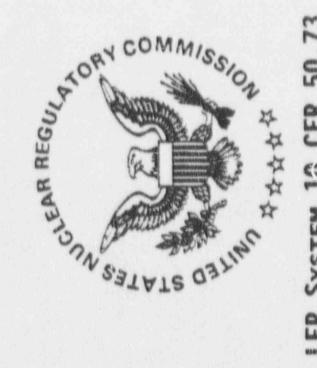








### MORNING SESSION



LER SYSTEM 10 CFR 50.73

### BACKGROUND

. TMI ACTION PLAN - MAY 1980

. PRE-1984 REPORTS

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. INPO MANAGEMENT OF NPRDS

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### REPORTING GUIDANCE & EVALUATIONS

GUIDANCE

. NUREG 1022 & SUPPLEMENT 1

. RESIDENT INSPECTOR AND REGIONAL FEEDBACK

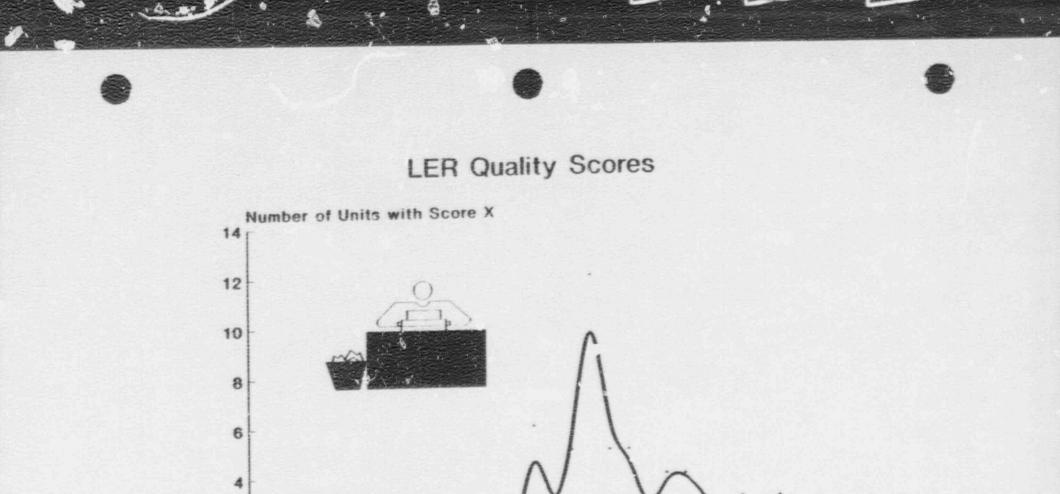
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### EVALUATIONS

- LER QUALITY EVALUATION PROGRAM (1985-EOFY 1987) . NRC or Contractor Questions





8

-

0 6.5 7.5 7 **Overall Score** 70 Unite 1987

2

10



8.5

\$.5

9

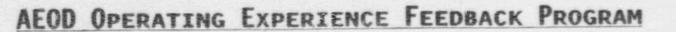
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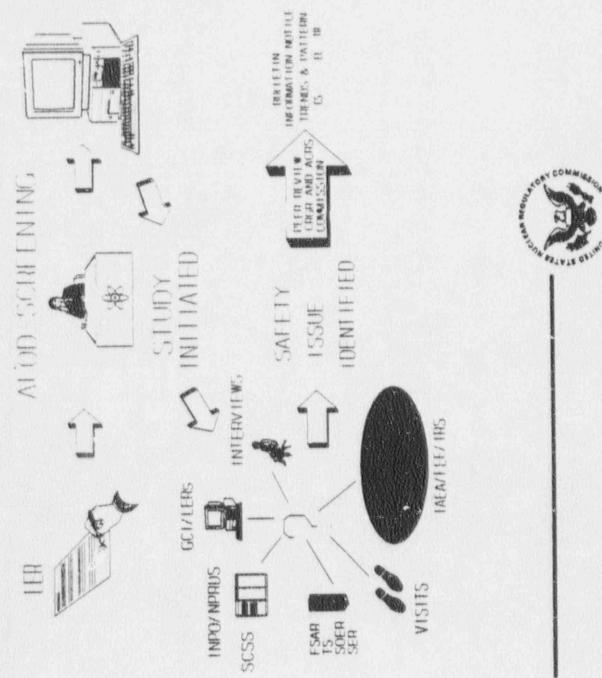




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### CURRENT ISSUES

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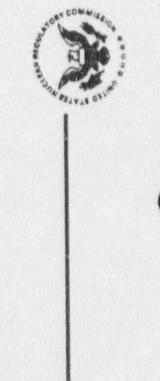
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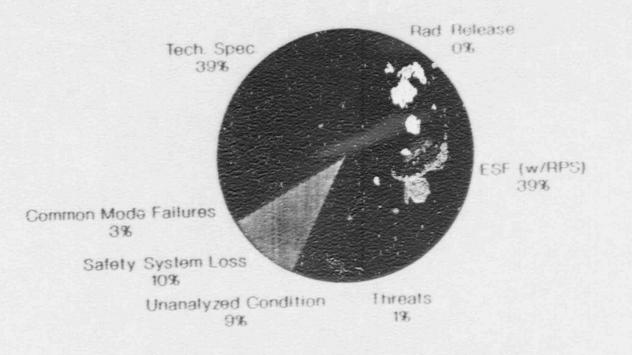
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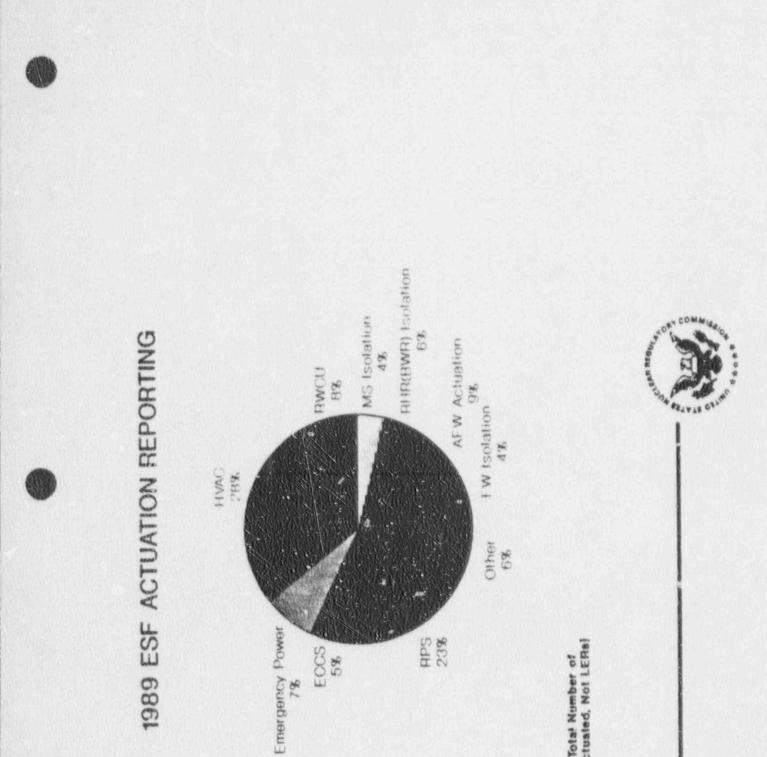


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Based on Total Number of Systems Actuated, Not LENs!

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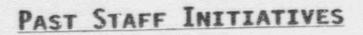
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