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## INSPECTION PROCEDURE 95002

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### SUPPLEMENTAL INSPECTION RESPONSE TO ACTION MATRIX COLUMN 3 (DEGRADED PERFORMANCE) INPUTS

Effective Date: 4/1/2021

PROGRAM APPLICABILITY: IMC 2515B, IMC 2201B

CORNERSTONES: ALL

INSPECTION BASIS: See IMC 0308 Attachment 2

#### 95002-01 INSPECTION OBJECTIVES

- 01.01 To **ensure** that the root-and contributing causes of **significant** individual and collective performance issues (**multiple greater-than-green inputs**) are understood.
- 01.02 To independently assess and **ensure** that the extent-of-condition and extent-of-cause of **significant** individual and collective performance issues (**multiple greater-than-green inputs**) are identified.
- 01.03 To ensure that completed corrective actions to address and preclude repetition of performance issues are **timely** and effective.
- 01.04 To ensure that planned corrective actions to preclude repetition direct **timely** and effective actions to address and preclude repetition of significant individual and collective performance issues.
- 01.05 *To independently determine if safety culture **traits** caused or significantly contributed to the performance issues. [C1]*

#### 95002-02 INSPECTION REQUIREMENTS

##### 02.01 General Requirements

- a. Follow general requirements and guidance in Inspection Manual Chapter (IMC) 2515 Appendix B, "Supplemental Inspection Program." Among the areas addressed are:
- Enhanced Inspection, Assessment, and Successful Completion (2515B-07)
  - Initiating, Delaying, Suspending, or Expanding Inspection (2515B-08)
  - Findings, Violations, General- and Significant Weaknesses (2515B-09)
  - Inspection Requirements, ROP Expectations, and Regulatory Obligations (2515B-10)
  - Follow-up Inspection of Planned Corrective Actions (2515B-11)

- b. Sufficiently challenge aspects of the licensee's problem identification, causal analysis, and corrective actions to ensure the causes of the performance issues are correctly identified and corrective actions are adequate to promptly and effectively address and preclude repetition.
- c. Key terminology used in this and other supplemental inspection procedures has been consolidated and explicitly defined in Inspection Manual Chapter (IMC) 2515 Appendix B "Supplemental Inspection Program," Section 04, "Definitions." Employ these terms as defined. Licensee definitions may vary.

#### 02.02 Problem Identification

- a. Determine **whether** the evaluation documented who identified the **performance issue(s)** (e.g., licensee-identified, self-revealed, or NRC-identified) and under what conditions.
- b. Determine **whether** the evaluation documented **when and for** how long the **performance issue(s)** existed and prior opportunities for identification.
- c. Determine **whether** the evaluation documented **significant** plant-specific consequences and compliance concerns associated with the **performance issue(s)** both individually and collectively.

#### 02.03 Causal Analysis

- a. Determine **whether** the **performance issue(s)** was (were) evaluated using a systematic methodology to identify the root- and contributing causes.
- b. Determine **whether** the **causal** evaluation was conducted to a level of detail commensurate with the significance **and complexity** of the **performance issue(s)**.
- c. Determine **whether** the **causal** evaluation **considered** prior occurrences of the **performance issue(s)** and knowledge of prior operating experience.
- d. Determine **whether** the **causal** evaluation **identified** the extent-of-condition and the extent-of-cause of the **performance issue(s)**.
- e. When inspecting multiple significant inputs in a strategic performance area, examine the common-cause analyses for potential programmatic weaknesses in performance.

#### 02.04 Independent Assessment of Extent-of-Condition and Extent-of-Cause

The inspection team leader will develop an inspection plan using IPs listed in IMC 2515, Appendix B, Attachment 1, to facilitate an independent assessment of the validity of licensee extent-of-condition and extent-of-cause analysis and the conclusions associated with significant individual and collective performance issues. Inspectors shall independently **sample** enough of the licensee assessments to ensure they are sufficiently comprehensive in addressing the key attributes of the cornerstone(s) associated with the significant performance issue(s). This independent assessment and results will be documented in the supplemental inspection report.

## 02.05 Independent Determination of Safety Culture Contribution

*Independently determine whether the licensee root cause, extent-of-condition, and extent-of-cause evaluations appropriately considered if any safety culture component caused or significantly contributed to a significant performance issue. Refer to IMC 0305-10.02.c. if a safety culture component weakness caused or significantly contributed to a significant performance issue but was not properly recognized by the licensee evaluation. [C1].*

IMC 0305 directs use of IP 40100, "Independent Safety Culture Assessment Follow-up," when the NRC requests the licensee to perform an independent safety culture assessment. When triggered from IP 95002, the IP 40100 effort is treated as an expansion of the IP 95002 inspection and effort is charged to IP 95002.

## 02.06 Corrective Actions

- a. For each performance issue root cause<sup>1</sup>, determine whether the licensee specified one or more appropriate corrective actions to preclude repetition (CAPRs), as defined in IMC 2515 Appendix B, or has documented an adequate explanation as to why not. Licensees may, in addition, identify non-CAPR corrective actions.
- b. Differentiate CAPRs vs. non-CAPRs then separate the CAPRs into the following two groups for immediate or follow-up inspection and documentation:
  - *Planned CAPRs must be inspected during the supplemental inspection to verify that each plan aligns with one or more root causes to preclude repetition and has been assigned a planned implementation date from which NRC will schedule follow-up inspection (See IMC 2515B-11), and*
  - *Completed CAPRs which must each satisfy the plan inspection requirement described above and the implementation of each plan must be inspected to verify satisfactory plan-to-implementation alignment during the supplemental inspection. [C2]*
- c. For each contributing cause of the significant performance issue(s), determine whether the licensee has identified or implemented appropriate corrective actions.
- d. Determine **whether** corrective actions have been prioritized with consideration of significance and regulatory compliance.
- e. Determine **whether specified** corrective actions: **adequately address each supplemental inspection-related Notice of Violation (NOV).**

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<sup>1</sup> Root cause is used here as defined in IMC 2515 Appendix B, "Supplemental Inspection Program" which may differ from the licensee's definition. The absence of one or more licensee-identified root causes as defined by IMC 2515B constitutes an IMC 2515B-defined weakness or omission and warrants further inspector evaluation in accordance with IMC 2515B. Unless the licensee identifies one or more root causes, it may be difficult or impossible for inspectors to satisfy the objectives and requirements the supplemental IP without expanding or delaying completion of the inspection.

- f. Determine whether specified CAPRs of the performance issue(s) are or will be timely and effective.
- g. Determine whether appropriate quantitative or qualitative measures of success have been developed for determining the effectiveness of all CAPRs.
- h. Ensure that a completion plan has been recorded for planned CAPRs that aligns with 02.06.a through g.
- i. *For planned CAPRs, ensure the capture of information necessary to efficiently and effectively schedule and conduct follow-up inspection to verify timely and effective CAPR implementation in accordance with the NRC-accepted licensee corrective action plan. [C2]*
- j. *The inspectors must gather the information necessary so that the inspection report will clearly communicate the inspection outcomes to an independent reader and the inspection report's conclusions will be explicit. [C3]*

95002-03 INSPECTION GUIDANCE

03.01 General Guidance

- a. No guidance is necessary in connection with 02.01.
- b. In challenging of aspects of the licensee's problem identification, causal analysis, corrective actions, inspectors are not generally required to perform an independent evaluation of the performance issue(s) nor may they merely verify that an evaluation has been performed and translated into corrective plans and actions without assessing adequacy. However, as directed in Sections 02.04 and 02.05, above, and discussed in Sections 03.04 and 03.05 below, licensees subject to Action Matrix Column 3 and thus to this IP will receive greater independent review and increased inspection rigor compared to licensees subject to Column 2 and IP 95001. Otherwise, as with IP 95001, the inspection requirements relate to the minimum set of information that the NRC will generally need to ensure that the inspection objectives are satisfied. In determining which aspects of the licensee Problem Identification and Resolution (PI&R) effort to challenge beyond that required in Sections 2.04 and 2.05, inspectors may consider a variety of factors including but not limited to issue complexity, periodic NRC licensee PI&R performance assessment, and inspection team perceptions regarding strengths or weaknesses in the licensee's PI&R performance (e.g. transparency, objectivity, scrutability, documentation, and interview clarity and completeness, conformance to licensee self-imposed standards, and regulatory requirements).
- c. To promote reliability and clarity across supplemental inspection procedures, terminology shared across supplemental inspection procedures has been clarified and consolidated into IMC 2515B. As such, prior to each supplemental inspection, it is important for inspectors to familiarize themselves with IMC 2515B including the definitions therein. The purpose is not to focus the inspection on the terminology used by the licensee nor to compel the licensee to adopt the terminology defined in IMC 2515B but to promote consistency and clarity in communicating inspection objectives, requirements, guidance, and results to all stakeholders.

### 03.02 Problem Identification

- a. In determining whether the licensee evaluation documented how and by whom the performance issue(s) was (were) identified, if the licensee did not identify the performance issue, problem, or condition at a precursor level (e.g. before an actual demand following return to service), the licensee's determination as to why should be evaluated. Specifically, the licensee's failure to identify a performance issue, condition, or problem before it became more significant may indicate a more substantial problem. Examples include failure to: (1) recognize the performance issue, (2) enter the recognized performance issue into the corrective action program, (3) recognize the safety or regulatory importance of the issue, (4) raise safety concerns to management; or (5) complete corrective actions for a previously identified performance issue, condition, or problem that resulted in further degradation. If the NRC identified the significant performance issue(s), the evaluation should address why the licensee's processes, such as peer review, supervisory oversight, inspection, testing, self-assessments, or quality activities, did not identify it.
- b. In determining whether the licensee evaluation documented when and for how long the performance issue(s) existed and prior opportunities for identification, the evaluation should identify the dates when the performance issue, condition, or problem occurred, when it was identified, how long the condition(s) existed, and whether there were prior opportunities for correction. For example, if a maintenance activity resulted in an inoperable system that was not detected by post-maintenance testing or quality assurance oversight, the reasons that the testing and quality oversight did not detect the error should be included in the problem identification statement and addressed in the causal evaluation. The evaluation should state when the performance issue, condition, or problem was identified, how long the condition(s) existed, and whether there were prior opportunities for correction.
- c. In determining whether the licensee evaluation documented significant plant-specific consequences and compliance concerns, the evaluation should address significant plant-specific consequences of the issue. A Senior Risk Analyst (SRA) should perform an assessment of the individual risk associated with the team's findings. The SRA may perform a collective risk assessment by summing or qualitatively assessing the risk impacts of multiple separate or independent findings that overlap in time to gain an understanding of the aggregated or collective risk profile. When performing the collective risk assessment, it is important to clearly ascertain the time history (appropriate identification of start and end dates) of each overlapping inspection finding to reach a proper result. Assessing the collective risk from the "roll-up" of multiple related, non-overlapping independent findings or of combining all of the findings identified during the inspection would produce an artificially high risk estimate leading to incorrect conclusions. Due to the generic nature of the PIs, a plant-specific assessment may better characterize the significance associated with a greater-than-green PI. For conditions that are not easily assessed quantitatively, such as the unavailability of security equipment, a qualitative assessment should be completed. Some issues may be more appropriately assessed as hazards to plant personnel or the environment. The evaluation should also include an assessment of compliance.

### 03.03 Causal Analysis

- a. In determining whether the performance issue(s) was (were) evaluated using a systematic methodology to identify the root-and contributing causes, the licensee is expected to select an effective methodology to address the nature of the performance issue. The methodology should yield the most basic reason for the failure, problem, or deficiency which, if corrected, would preclude repetition (i.e., the root cause).
  1. The licensee-selected methodology should generally be systematic and suited to identify the root- and contributing causes. Causal evaluation methods commonly used include:
    - (a) Events and causal factors analysis – to identify the events and conditions that led up to an event;
    - (b) Fault tree analysis – to identify relationships among events and the probability of event occurrence;
    - (c) Barrier analysis – to identify the barriers that if present or strengthened would have prevented the event from occurring;
    - (d) Change analysis – to identify changes in the work environment since the activity was last performed successfully that may have caused or contributed to the event;
    - (e) Management Oversight and Risk Tree (MORT) analysis – to systematically check that all possible causes of problems have been considered;
    - (f) Critical incident techniques – to identify critical actions that if performed correctly would have prevented the event from occurring or would have significantly reduced its consequences;
    - (g) Why Staircase – to produce a linear set of causal relationships and use the experience of the problem owner to determine the root cause and corresponding solutions; and
    - (h) Pareto Analysis – a statistical approach to problem solving to determine where to start an analysis.
  2. The licensee may use other methods to perform causal evaluations. A systematic evaluation of a problem normally includes:
    - (a) A clear identification of the performance issue, condition or problem, and the assumptions made as a part of the causal evaluation. For example, the evaluation should describe the initial operating conditions of the system or component identified, staffing levels, and training requirements, as applicable.

- (b) The timely collection and verification of data, and preservation of evidence to ensure that the information and circumstances surrounding the problem are fully understood. The analysis should be documented such that the progression of the problem is clearly understood, any missing information or inconsistencies are identified, and the problem can be easily understood by others.
  - (c) A determination of cause and effect relationships resulting in an identification of root- and contributing causes that consider potential hardware, process, and human performance issues. For example:
    - (1) Hardware issues could include design, materials, systems aging, and environmental conditions;
    - (2) Process issues could include procedures, work practices, operational policies, supervision and oversight, preventive and corrective maintenance programs, and quality control methods; and
    - (3) Human performance issues could include training, communications, human-system interface, and fitness for duty (which includes managing fatigue). See IP 93002, "Managing Fatigue," for guidance on the requirements of 10 CFR Part 26, Subpart I – Managing Fatigue.
3. A successful root cause analysis should yield a root cause that satisfies the following criteria:
- (a) The problem would not have occurred had the root cause not been present;
  - (b) The problem will not recur if the root cause is corrected or eliminated;
  - (c) Correction or elimination of the root cause will preclude repetition of similar conditions;
  - (d) The root cause can realistically be corrected by the licensee.
4. Common root cause analysis problems:
- (a) Narrowly defining the scope.
  - (b) Calling something a root cause that is actually an intermediate cause.
  - (c) Calling something a root cause that is merely a category of causes.
  - (d) Leaving out other causation chains.
  - (e) Calling something a cause that is only a renaming of the effect.
  - (f) Leaving out important negative causes.
  - (g) Calling the violation of a requirement a cause.

- b. In determining whether the licensee causal evaluation was conducted to a level of detail commensurate with the significance and complexity of the issue, consider whether the causal evaluation was conducted and documented to a level of detail that is adequate to be understood and verified by a knowledgeable reader to preclude repetition.

Different causal evaluation methods provide different perspectives of the problem. In some instances, using a combination of methods helps ensure the analysis is thorough. Therefore, the causal evaluation should consider evaluating complex problems, which could result in significant consequences, using multi-disciplinary teams and/or different and complimentary methods appropriate to the circumstances. For example, problems that involve hardware issues may be evaluated using barrier analysis, change analysis, or fault trees.

The depth of a causal evaluation is normally achieved by completely and systematically applying the methods of analysis such as but not necessarily limited to those described in Section 03.03.a and by repeatedly asking the question "Why?" about the occurrences and circumstances that caused or contributed to the problem. Once the analysis has developed all the causes for the problem (i.e., root, contributing, and programmatic), the evaluation should also look for any relationships among the different causes. The depth of the causal evaluation may be assessed by:

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

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

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

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

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

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

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

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

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

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

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

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

2. Determine **whether** previous **causal** evaluations, corrective actions, **or both**, missed or inappropriately characterized the issues. Determine those aspects of **the** corrective actions that did not **preclude repetition** of the problem.

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

3. Determine **whether** the **causal** evaluation for the current **performance deficiency** specifically addresses those aspects of the prior **causal evaluations** or corrective actions that were not successfully **resolved**.

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

4. Include a review of prior documentation of problems and their associated corrective actions to determine **whether** similar incidents occurred in the past.

For example, the licensee **staff's** review of prior operating experience **should consider** internal self-assessments, maintenance history, adverse problem reports, and external **databases** developed to identify and track operating experience issues. Examples of external **databases** may include Information Notices, Generic Letters, and vendor **or** industry generic communications. The inspectors should discuss the problem and associated root causes with other resident, regional, or headquarters personnel to assess whether previous similar problems or root causes should have been considered.

- d. **In determining whether the licensee causal evaluation identified the extent-of-condition and the extent-of-cause of the performance issue(s):**

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

For example, **a** licensee's fire protection staff considered that the root causes identified for the misalignment **associated with** the safety injection system could potentially affect fire suppression systems **because** the systems shared a common tagging and alignment method. As a result, feedback was provided to the incident review committee to **modify** the fire suppression system control procedure and provide formal training to all fire protection personnel. **The extent-of-condition review differs from the extent-of-cause review in that the extent-of-condition review focuses on the actual condition and its existence in other places. The extent-of-cause review focuses more on the actual root causes of the condition and on the degree to which these root causes may have resulted in additional weaknesses.**

- e. **In examining the licensee common-cause analyses for potential programmatic weaknesses in performance, the evaluation should look for shared causes (e.g., cross-cutting areas as discussed in IMC 0310; shared systems, structures, and components; shared procedures, processes, or personnel) for programmatic weaknesses in performance.**

#### 03.04 Independent Assessment of Extent-of-Condition and Extent-of-Cause

**In independently assessing the validity of the licensee of extent-of-condition and extent-of-cause analysis and conclusions associated with significant individual and collective performance issues:**

- a. The **goal** of the independent extent-of-condition review is to ensure that the **licensee's** evaluation was of sufficient breadth **and depth** to identify additional issues similar to those for which the supplemental inspection was performed. For example, if the issue was an inoperable valve actuator due to inadequate motor torque, the inspectors should

sample other valve actuators to ensure that their motor torque is adequate. If the issue was due to an inadequate procedure, the inspectors should sample other procedures to determine their adequacy.

- b. The **goal** of the independent extent-of-cause review is to ensure that the **licensee's** evaluation was of sufficient breadth and depth to identify other plant equipment, processes, or human performance issues that may have been impacted by the root causes of the performance issue. For example, if in the above example the inadequate valve actuator motor torque was due to an inadequate engineering design guide for performing motor torque calculations, the inspectors should review other engineering design guides to assess their adequacy.
- c. The depth of the extent-of-**condition** and **extent-of-cause** **reviews** should be commensurate with the nature and complexity of the original performance issue(s). For those instances where multiple issues have been documented, the inspectors should consider performing a broad-based inspection(s) to assess performance across the associated strategic performance area. If this IP is being performed due to a single yellow **performance** issue, a more focused inspection would likely be appropriate.
- d. Consideration should be given to the comprehensiveness of the **licensee's** evaluations. In those cases where weaknesses are identified in the **licensee's** evaluations during implementation of Sections 95002-02.02, 02.03, or 02.06 of this procedure, consideration should be given to performing a more in-depth programmatic review of the **licensee's** corrective action program.

#### 03.05 Independent Determination of Safety Culture Contribution

*In independently determining whether the licensee root cause, extent-of-condition, and extent-of-cause evaluations appropriately considered if any safety culture component caused or significantly contributed to a significant performance issue:*

- a. *The licensee evaluation should be reviewed to determine and/or discuss with appropriate personnel if the root cause methodology considered whether a possible weakness in a safety culture trait could have been a root cause or a significant contributing cause of the deficiency. If so, inspectors should also verify whether the consideration included at least those traits that the inspectors determined could reasonably have been a root cause or a significant contributing cause of the deficiency.*
- b. *If the licensee did not consider whether a possible weakness in a particular safety culture component could have been a root cause or a significant contributing cause of the deficiency, and if the inspectors determined that a weakness in the same component could reasonably have been a root cause or a significant contributing cause of the deficiency, then an independent NRC evaluation should be performed. The evaluation should be extensive enough to (1) determine whether a weakness in that component actually was a root cause or a significant contributing cause of the deficiency and (2) establish the relationship between the weakness and the deficiency. If the inspectors' evaluation shows that a weakness in a safety culture component actually was the root cause or a significant contributing cause of the deficiency, and the licensee's evaluation did not recognize that cause or contribution, and then refer to IMC 0305. [C1]*

### 03.06 Corrective Actions

- a. In determining whether the licensee specified one or more CAPRs for each performance issue root cause, inspectors should examine for gaps between root causes and corrective actions including weakness associated with aligning corrective actions to preclude repetition with the extent-of-condition and extent-of-cause. The corrective actions should be clearly defined. Examples of corrective actions may include but are not limited to modifications, inspections, testing, process or procedure changes, and training. The proposed corrective actions should be reasonably achievable and should not create new or different problems. If the licensee determines that no corrective actions are necessary, then the basis for this decision should be documented in the evaluation and, likewise, examined.
- b. In differentiating CAPRs vs. non-CAPRs and separating CAPRs into planned vs. completed CAPRs, the goal is to ensure that each CAPR plan aligns with one or more root cause determinations, includes a planned implementation date, and that the date and plan are documented and integrated into the ROP follow-up inspection planning. Those planned CAPRs that the licensee implements and are satisfactorily inspected prior to completion of the supplemental inspection should be documented as completed CAPRs.
- c. In determining whether the licensee has identified or implemented appropriate corrective actions for contributing causes, those non-CAPR corrective actions whose implementation could not be inspected during the supplemental inspection should be sampled during follow-up inspection of planned CAPR implementation.
- d. In determining whether licensee corrective actions have been prioritized with consideration of significance and regulatory compliance, attention should be given to solutions that involve only changing procedures or providing training as these actions are sometimes overused. In such cases, corrective action plans should consider more comprehensive corrective actions such as design modifications. Where compliance issues exist, the corrective action plan should also include a review of the regulations to ensure that it achieves compliance.
- e. In determining whether specified corrective actions adequately address each supplemental inspection-related NOV, for each NOV that directly corresponds with the performance issue that was the basis for or otherwise directly related to the supplemental inspection, the licensee should address the reason for the violation, and either (i) corrective actions that have been taken and the achieved results or (ii) corrective actions that will be taken and the date when full compliance will be achieved. When possible, the licensee response to the cited violation in accordance with 10 CFR 2.201, "Notice of Violation," should be reviewed.
- f. In determining whether specified CAPRs of the performance issue(s) are or will be **timely** and effective, the inspection should consider whether the actions were assigned to appropriate individuals or organizations to ensure that they are promptly planned and implemented. The licensee should also establish a formal tracking mechanism for each of the specific corrective actions.

- g. In determining whether appropriate quantitative or qualitative measures of success have been developed for determining the effectiveness of all CAPRs, consider that effective methods could include but need not be limited to assessments, audits, inspections, tests, trending of plant data, and follow-up discussions with plant staff.
- h. In ensuring that an acceptable completion plan has been recorded for planned CAPRS, the plan should address all CAPRs not yet completed and satisfactorily inspected, address inspection requirements 02.06.a through g., allocate necessary resources, and incorporate a timely and realistic completion schedule.
- i. *In ensuring the capture of information necessary to ensure efficient and effective NRC scheduling and completion of follow-up CAPR implementation inspection to verify prompt effective CAPR implementation in accordance with the NRC-accepted licensee corrective action plan:*
  - 1. *For significant performance issues subject to 10 CFR 50 Appendix B Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants, it may be sufficient to succinctly document in accordance with IMC 0611C: (a) the specific planned CAPRs, (b) the associated CAP document number(s), and (c) the date(s) when the Planned CAPRs are scheduled to be implemented.*
  - 2. *However, for significant performance issues that are not subject to Appendix B or a comparable regulatory obligation, licensees might not record or retain sufficient information to support efficient follow-up inspection of implemented CAPRs. Absent reasonable assurance that the licensee will record and retain sufficient information, inspectors should capture the necessary additional information in the supplemental inspection report in accordance with IMC 0611C. [C2]*
- j. *In gathering the information necessary so that the inspection report will clearly communicate the inspection outcomes including explicit conclusions to an independent reader and to address additional actions required by the inspectors during follow-up inspection, the inspectors should explicitly differentiate between CAPRs that have been satisfactorily implemented and inspected (Completed or Closed CAPRs) and those acceptably planned but not yet implemented and acceptably inspected (Planned or Open CAPRs). [C3]*

#### 95002-04 RESOURCE ESTIMATE

Completion of this procedure is estimated to require 200 hours but may vary greatly depending the complexity of the issue(s), the effectiveness of the licensee corrective action program, the specific procedure(s) chosen to independently assess the extent-of-condition and extent-of-cause, and whether additional independent safety culture assessment follow-up activities were required. When documenting effort expended in completing IP 95002, include hours expended while referencing IMC 2515, Appendix B, Attachment 1 procedures and IP 40100.

#### 95002-05 PROCEDURE COMPLETION

Meeting all of the inspection objectives defined in Section 95002-01, as implemented in accordance with the requirements in Section 95002-02 of this IP, constitute procedure

completion. Failure to satisfy any inspection objective precludes completion of this procedure and will normally result in a continued or a follow-up inspection under this IP. See IMC 0305 for similar criteria regarding the removal or retention of Action Matrix inputs. IMC 2515, Appendix B, provides additional information.

Document supplemental inspection results using the governance contained in IMC 0611 Appendix C, "Documenting Supplemental Inspections" and IMC 0611, "Power Reactor Inspection Reports."

#### 95002-06 REFERENCES

IMC 0305, "Operating Reactor Assessment Program"

IMC 0310, "Aspects within the Cross-Cutting Areas"

IMC 0611, "Power Reactor Inspection Reports"

IMC 0611, Appendix C, "Documenting Supplemental Inspections"

IMC 0612, "Issue Screening"

IMC 0612, Appendix B, "Additional Issue Screening Guidance"

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

IMC 2515, Appendix B, "Supplemental Inspection Program"

IP 40100, "Independent Safety Culture Assessment Follow-Up"

IP 71152, "Problem Identification and Resolution"

IP 93002, "Managing Fatigue"

IP 95001, "Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs"

NUREG-2165, "Safety Culture Common Language"

END

Attachment 1 – Revision History for IP 95002

Commitment Tracking Number	Accession Number Issue Date Change Notice	Description of Change	Description of Training Required and Completion Date	Comment Resolution and Closed Feedback Form Accession Number (Pre-Decisional, Non-Public Information)
N/A	04/03/00 CN 00-003	Initial Issue.	Yes	
N/A	03/06/01 CN 01-006	Revised to provide additional guidance regarding the scope of the inspection when multiple issues are identified within the affected cornerstone(s). It also provides additional guidance concerning the inspection requirement to perform an independent extent-of-condition review.	No	
N/A	ML020400011 01/17/02 CN 02-001	Revised to include minor editorial changes.	No N/A	N/A
N/A	ML031570328 05/23/03 CN 03-016	Clarified guidance on extent-of-condition review and add guidance for evaluating whether credit should be given for "old design issues."	No N/A	N/A
C1	ML061560517 06/22/06 CN-06-015	Incorporated safety culture initiatives described in Staff Requirements Memorandum, SECY-04-0111, "Recommended Staff Actions Regarding Agency Guidance in the Areas of Safety Conscious Work Environment and Safety Culture" dated August 30, 2004.	Yes 07/01/06	<a href="#">ML061570127</a>
N/A	ML062890451 10/16/06 CN-06-027	This IP has been revised to incorporate comments from the Commission in which the term "public confidence" has been changed to "openness."	No N/A	N/A

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N/A	ML083470431 04/09/09 CN 09-011	This IP has been revised to address the following ROP feedback forms: 95001-1121, 95001-1126, 95001-1127, 95001-1133, and 95001-1243. This revision: clarifies that all safety culture components should be considered; removes discussion pertaining to PI fault hours and NEI 99-02; updates the NRC's goals to reflect the Strategic Plan for FY 2008-2013; references IMC 0612 for documentation guidance; updates old design issue guidance; clarifies intent of a collective risk assessment; clarifies expansion of the IP; adds guidance to follow-up on NOVs; and expands the list of root cause evaluation methods.	No N/A	<a href="#">ML083470429</a>
N/A	ML092680674 11/09/09 CN 09-026	Added reference to IP 93002, "Managing Fatigue"	No N/A	N/A
N/A	ML102020532 02/09/11 CN 11-001	Defined procedure completion criteria and add reference section.	No N/A	<a href="#">ML110120516</a>
C2  C3	ML20238C055 03/19/21 CN 21-014	C2 addresses agency-committed actions ( <a href="#">ML19325C330</a> ) in response to OIG-19-A-19 Audit of the NRC Oversight of Supplemental Inspection Corrective Actions and Agency Response, dated October 10, 2019 ( <a href="#">ML19256A776</a> ). C3 is established in response to the EXECUTIVE DIRECTOR FOR OPERATIONS ASSESSMENT AND DECISION on Pages 8 and 9 of DPO-2018-001 Case File [OUO – Sensitive Internal Information] (ADAMS ML19214A199) to enhance direction regarding	Program office-led training of IP 9500X inspectors, team leads, and managers that oversee IP 9500X	<a href="#">ML21004A134</a>

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		<p>supplemental inspections as follows:</p> <ul style="list-style-type: none"> <li>a. Highly qualified inspectors are entrusted with the responsibility to inspect to the requirements of the procedure;</li> <li>b. Inspectors should document their assessment of how the licensee met the inspection's objectives;</li> <li>c. The inspection report should clearly communicate the outcomes to an independent reader; and</li> <li>d. The inspection report's conclusions should be explicit regarding additional actions required by the inspectors.</li> </ul> <p>Relocated General Requirements and Guidance common to Supplemental Inspections to IMC 2515 Appendix B "Supplemental Inspection Program" to reduce unnecessary replication.</p> <p>Governance regarding treatment of old design issues has been deleted as fully redundant with IMC 0305 which contains ample governance addressing old design issues in connection with IPs 95001 and 95002.</p> <p>Addresses and closes ROP FBFs 95002-1713, -1776, -1798, -1969, -1975, -1985, -2019, -2111, -2112, -2144, and -2335</p>	<p>Supplemental Inspection Training was completed on November 12, 2020, following issuance of IP 95001</p>	<p>95002-1713 ML21015A306 95002-1776 ML21015A307 95002-1798 ML21015A308 95002-1969 ML21015A309 95002-1975 ML21015A310 95002-1985 ML21015A311 95002-2019 ML21015A312 95002-2111 ML21015A313 95002-2112 ML21015A314 95002-2144 ML21015A316 95002-2335 ML21015A317</p>