EXAMPLES OF LESS THAN SATISFACTORY FINDINGS OF A PROGRAM PERFORMANCE FOR INCIDENT AND ALLEGATIONS

The effectiveness of a program is assessed through the evaluation of the criteria listed in Section III, Evaluation Criteria, of MD 5.6. These criteria are NOT intended to be exhaustive but provide a starting point for the IMPEP review team to evaluate this indicator. The review team should also take into consideration other relevant mitigating factors that may have an impact on the program's performance under this performance indicator. The review team should consider a less than satisfactory finding when the identified performance issue(s) is/are programmatic in nature, and not isolated to one aspect, case, individual, etc. as applicable.

This list is not all inclusive and will be maintained and updated in the IMPEP Toolbox on the state communications portal Web site.

The following are examples of review findings that resulted (or could result) in a program being found "**satisfactory, but needs improvement**" for this indicator:

1. In more than a few cases, incidents received by the Program were not reported to the NRC's Headquarters Operations Center in accordance with the time frames established in SA-300, "Reporting Material Events" of the overall incidents reviewed.

2. The review team's evaluation of selected incident case files and interviews with inspectors found that the Program's responses to reported incidents were not well coordinated, not consistent, and in some cases, not thorough. In more than a few cases, the Program lacked a systematic approach to determine what type of response was warranted for reported events. There was no determination as to whether an onsite response was warranted regarding the safety or security significance of an event, and if so, the time frame and scope of the response.

3. The review team found that the Program did not perform an onsite response to a potential overexposure of a radiation worker that resulted in deterministic radiation effects. The failure to perform an onsite inspection resulted, among other things, in no evaluation of other workers and members of the public in the vicinity of the event.

4. In more than a few cases, the Program failed to follow-up on allegations reported to them. The review team determined that the cases where no follow-up was conducted, included the failure to file reciprocity on the part of a licensee working in multiple jurisdictions and use of a worker not deemed trustworthy and reliability.

5. In more than a few cases, the Program did not close out the allegations including providing allegation follow-up results to the allegers.

The following are examples of review findings that resulted (or could result) in a program being found "**unsatisfactory**" for this indicator:

1. In most cases, incidents received by the Program were not reported to the NRC's Headquarters Operations Center in accordance with the time frames established in SA-300, "Reporting Material Events" of the overall incidents reviewed.

2. The review team's evaluation of incident case files found that the Program's responses to reported incidents were not well coordinated, not consistent, and not thorough. In most cases, the Program lacked a systematic approach to determine what type of response was warranted for reported events. There was no a determination as to whether an onsite response was warranted regarding the safety or security significance of an event, and if so, the time frame and scope of the response.

3. The review team found that the Program did not perform onsite responses to multiple events involving potential overexposure cases of radiation workers that resulted in deterministic radiation effects. The failure to perform onsite inspections resulted in no evaluation of other workers and members of the public in the vicinity of the event and no independent determinations of the root cause of the events.

4. In most cases, the Program failed to follow-up on allegations reported to them. The review team determined that the cases where no follow-up was conducted, included safety and security related activities for licensees who possess category 1 and category 2 materials, failure to file reciprocity on the part of a licensee working in multiple jurisdictions, and use of a worker not deemed trustworthy and reliability.

5. In most cases, the Program did not close out the allegations and did not provide allegation follow-up results to the alleger.