INSPECTION PROCEDURE 95001

SUPPLEMENTAL INSPECTION RESPONSE TO ACTION MATRIX COLUMN 2 (REGULATORY RESPONSE) INPUTS

Effective Date: 08/19/2021

PROGRAM APPLICABILITY: IMC 2515B, IMC 2201B

CORNERSTONES: ALL

INSPECTION BASIS: IMC 0308 Attachment 2

95001-01 INSPECTION OBJECTIVES

01.01 To ensure that the root- and contributing causes of *individual and collective (multiple inputs)* white performance issues are understood. [C2]

01.02 To ensure that the extent of condition and extent of cause of *individual and collective (multiple inputs)* white performance issues are identified. [C2]

01.03 To ensure that completed corrective actions to address and preclude repetition of white performance issues are prompt and effective.

01.04 To ensure that pending corrective action plans direct prompt and effective actions to address and preclude repetition of white performance issues.

95001-02 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 Supplemental Inspection (2515B-08)
- Findings, Violations, General- and Significant Weaknesses (2515B-09)
- Inspector Requirements, Reactor Oversight Process (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.

b.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. Terminology used in this procedure may be defined differently by licensees.

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).

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 white 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. *Determine whether the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture traits in NUREG-2165, "Safety Culture Common Language," referenced in IMC 0310-06.* [C1]

f. *When inspecting two white inputs in the same cornerstone, examine the common-cause analyses for potential programmatic weaknesses in performance.* [C2]

02.04 Corrective Actions

a. For each root cause of the white performance issue(s), determine whether the licensee has specified one or more appropriate Corrective Actions to Preclude Repetition (CAPR 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.* [C3]

c. For each contributing cause of the white 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).

f. Determine whether specified corrective actions to preclude repetition of the white performance issue(s) (i.e. CAPRs as defined in IMC 2515 Appendix B) are or will be prompt and effective.

g. Determine whether appropriate quantitative or qualitative measures of success have been developed for determining the effectiveness of all specified corrective actions.

h. For planned CAPRs, determine whether a completion plan has been recorded that aligns with 02.04.a through d.

i. *For planned CAPRs, ensure the capture of necessary information to efficiently and effectively schedule and conduct follow-up inspection to verify prompt effective CAPR implementation in accordance with the NRC-accepted licensee corrective action plan.* [C3]

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.* [C4]

95001-03 INSPECTION GUIDANCE

03.01 General Guidance

a. Regarding general requirements and guidance in IMC 2515 Appendix B, "Supplemental Inspection Program," no guidance is necessary.

b. Regarding the challenging of aspects of the licensee's problem identification, causal analysis, and corrective actions, inspectors are not 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. 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, 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).

03.02 Problem Identification

a. Regarding 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), evaluate the licensee's determination as to why. 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 white performance issue, 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. Regarding 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. 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 assurance oversight did not detect the error should be included in the problem identification statement and addressed in the causal evaluation.

c. Regarding significant plant-specific consequences and compliance concerns, the evaluation should address significant plant-specific consequences of the issue. The inspector's examination of the significance assessment should be coordinated with a senior reactor analyst. Due to the generic nature of the performance indicators (PIs), a plant-specific assessment may better characterize the significance associated with a white 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. With regard to the 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 prompt 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 inspection procedure (IP) 93002, "Managing Fatigue," for guidance on the requirements of Title 10 of the *Code of Federal Regulations* (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. With regard to the level of detail commensurate with the significance and complexity of the issue, the causal evaluation should be conducted to a level of detail that is adequate to be understood and verified to preclude repetition by a knowledgeable reader. 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. With regard to consideration of prior occurrences 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. With regard to the extent of condition and the extent of cause, the causal evaluation should include a proper consideration of the extent of condition and the extent of cause of the problem and of whether other systems, equipment, programs, or conditions could be affected.

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. With regard to the consideration of safety culture traits, *the causal evaluation should include a proper consideration of whether a weakness in any safety culture component was a root cause or significant contributing cause of the performance issue (PI or inspection finding), and if so, that weakness should be addressed through adequate corrective actions. Therefore, for each performance issue that prompted this inspection, consider whether the performance issue, the licensee's evaluation methodology, the results obtained using that methodology, or any related circumstance indicates that a weakness in any safety culture component could reasonably have been a root cause or significant contributing cause of the performance issue. If so, for each such weakness, determine whether the licensee's evaluation considered whether the weakness was a root cause or significant contributing cause of the deficiency and documented that consideration* [C1].

f. With regard to common-cause analysis associated with two white inputs in the same cornerstone, the evaluation should look for shared causes (e.g., Cross-Cutting Aspects as discussed in IMC 0310; shared systems, structures, and components; shared procedures, processes, or personnel) for programmatic weaknesses in performance.

03.04 Corrective Actions

a. With regard to licensee specification of one or more CAPRs for each root cause of the white performance issue(s), 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.

b. With regard to differentiating CAPRs vs. non-CAPRs and separation of CAPRs into planned vs. completed CAPRS, the goal is to ensure that each CAPR plan aligns with one or more root cause determinations, include a planned implementation date, and that the date and plan be 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. With regard to determining that 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. With regard to the prioritization of corrective actions, include consideration of the licensee's significance assessment results of the issue in prioritizing the type of corrective actions chosen. Attention should be given to solutions that involve only changing procedures or providing training because they are sometimes overused. In such cases, consider more comprehensive corrective actions such as design modifications. The corrective action plan should also include a review of the regulations to ensure that it achieves compliance, if compliance issues exist.

e. With regard to adequately addressing cited violations, in the case of an 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, corrective actions that have been taken and the achieved results, corrective actions that will be taken, and the date when full compliance was or will be achieved. The adequacy of the corrective actions should be reviewed in accordance with the guidance above to determine whether they address the violation. When applicable, the licensee response to the cited violation in accordance with 10 CFR 2.201, "Notice of Violation," should be reviewed.

f. With regard to prompt and effective CAPRs, these actions should be 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. With regard to corrective action effectiveness reviews, they should establish appropriate quantitative or qualitative measures to validate the effectiveness of completed corrective actions to address and preclude repetition of significant performance issues. Effective methods include but are not limited to assessments, audits, inspections, tests, trending of plant data, or follow-up discussions with plant staff.

h. With regard to acceptable schedules for planned corrective actions, schedules and resource allocations should align with the prioritization of planned corrective actions.

i. *With regard to the information necessary to ensure efficient and effective NRC scheduling and completion of follow-up CAPR implementation inspection:*

- *For significant performance issues subject to 10 CFR Part 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 corrective action program document number(s), and (c) the date(s) when the planned CAPRs are scheduled to be implemented.*

- *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 information in the supplemental inspection report in accordance with IMC 0611C.* [C3]

j. *With regard to the requirement to clearly communicate the outcomes to an independent reader and to explicitly address additional actions required by the inspectors, the inspectors should explicitly differentiate between CAPRs that have been satisfactorily implemented and inspected (Completed or Closed CAPRs) and those planned and acceptably inspected (Planned or Open CAPRs).* [C4]

95001-04 RESOURCE ESTIMATE

Completion of this procedure is estimated to require between 16 and 40 hours for one white issue and between 80 and 120 hours for two white issues. IMC 2515-08.04, "Completion of Inspection Procedures," discusses the intent of the inspection hours estimate.

95001-05 PROCEDURE COMPLETION

Meeting all of the inspection objectives defined in Section 95001-01, as implemented in accordance with the requirements of Section 95001-02 of this IP, constitutes 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 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."

95001-06 REFERENCES

IMC 0305, "Operating Reactor Assessment Program"

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

IMC 0609, “Significance Determination Process”

IMC 0611, “Power Reactor Inspection Reports”

IMC 0611 Appendix C, “Documenting Supplemental Inspections”

IMC 0612, “Issue Screening”

IMC 0612 Appendix B, “Issue Screening”

IMC 2515, “Light-Water Reactor Inspection Program - Operations Phase”

IMC 2515 Appendix B, “Supplemental Inspection Program”

IP 71152, “Problem Identification and Resolution”

IP 93002, “Managing Fatigue”

NUREG-2165, “Safety Culture Common Language”

END

Attachment 1 – Revision History for IP 95001

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	Incorporated minor changes to better define "extent of condition" and to reference IMC 0610 guidance for documenting the results of the inspection.	No	
N/A	01/17/02 CN 02-001	Revised to include minor editorial changes.	No	N/A
N/A	ML031570251 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
C1	ML061560516 06/22/06 CN-06-015	Incorporate safety culture initiatives described in Staff Requirements - 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	ML061570117
N/A	ML062890448 10/16/06 CN-06-027	This IMC has been revised to incorporate comments from the Commission in which the term public confidence has been change to openness	No	N/A
N/A	ML080040263 04/09/09 CN 09-011	This IP has been revised to address the following ROP feedback forms: 95001-1121, 95001-1122, 95001-1123, 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	No	ML083220122

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)
		reflect the Strategic Plan for FY 2008-2013; references IMC 0612 for documentation guidance; updates old design issue guidance; clarifies expansion of the IP; adds guidance to follow-up on NOVs; and expands the list of root cause evaluation methods.		
N/A	ML092680661 11/09/09 CN 09-026	Added reference to IP 93002, "Managing Fatigue"	No	N/A
N/A	ML102020522 02/09/11 CN 11-001	Defined procedure completion criteria and added reference section. Reworded for clarity (feedback form 95001-1534). Added guidance for issuing inspection reports for held open and parallel PI findings.	No	ML110120516
C2	ML15223B348 08/24/16 CN 16-021	Incorporated Staff Requirements Memorandum, SECY-15-0108 "Recommendation to Revise the Definition of Degraded Cornerstone as used in the Reactor Oversight Process" (ML15335A559) direction to revise IP 95001 to include additional resources [Increased from "approximately 40 hours" to "approximately 40 hours to complete for one white issue and approximately 120 hours to complete for two white issues"] and guidance to be used to review licensee common cause analyses when a licensee has a second White input in the same cornerstone in order to consider the potential for programmatic weaknesses in a licensee's performance. [C2]	No	ML16146A656 95001-1797 ML16147A119 95001-2009 ML16147A135 95002-2144 ML16147A146

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)
		Also simplified the IP title; formatted to support navigation pane; incorporated language consistent with 10 CFR 50 Appendix B Criterion XVI (e.g. “prompt” vs. “timely” and “preclude repetition” vs. “prevent recurrence”); addressed ROP Feedback Form 95001-1797 and partially addressed ROPFF 95001-2009; updated safety culture terminology to conform to IMC 0310 revision per ROPFF 95002-2144.		
C3 C4	ML19179A011 10/21/20 CN 20-054	C3 addresses agency-committed actions (ML19325C330) in response to OIG-19-A-19 Audit of the NRC Oversight of Supplemental Inspection Corrective Actions and Agency Response, dated October 10, 2019 (ML19256A776). C4 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 supplemental inspections as follows: a. Highly qualified inspectors are entrusted with the responsibility to inspect to the requirements of the procedure; b. Inspectors should document their assessment of how the licensee met the inspection’s objectives; c. The inspection report should clearly communicate the outcomes to an independent reader; and d. The inspection report’s conclusions should be explicit regarding additional actions required by the inspectors. Relocated General Requirements and Guidance common to Supplemental Inspections to IMC 2515 Appendix B	Program office-led training of IP 9500X inspectors, team leads, and managers that oversee IP 9500X inspections. Training to be completed prior to effective date of revised IP.	ML20153A380

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)
		"Supplemental Inspection Program" to reduce unnecessary replication. Adjusted resource estimates and enhanced procedure organization and clarity to promote improved implementation efficiency and consistency.		
	ML21175A172 08/19/21 CN 21-028	Correct Objective 01.02 which was erroneously over-stated during the CN 16-021 implementation of [C2]. Other minor editorial edits better-align language and formatting to that used elsewhere in supplemental inspection program, consistent with IMC 0040.	None	ML21194A445