

## APPENDICES

## **APPENDIX A**

### **CONSOLIDATED TABLE OF RECOMMENDATIONS**

### Appendix A Consolidated Table of Recommendations

No.	Lesson-Learned Report	Problem	App. F Item No.	Recommendations
1.0	South Texas Project	3.1.1 Program Guidance for Assessing Long-Standing Hardware Problems	F.2.2	Establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes. An effectiveness review of the change to IP 71152 (addressing longstanding hardware issues) should also be conducted.
2.0	South Texas	3.1.2 NRC Inspector/Reviewer Skills, Abilities, Experience	F.2.3	Develop and implement a process check within the CAP recommended in Section 3.1.1 to ensure recommendations from lessons learned activities are fully addressed. Revisit training provided to inspectors to ensure current training covers the recommendations from the STPLLTF.
3.0	South Texas	3.1.3 Integration of Inspection Findings	F.2.8	Since the budget process is predictive in nature, an effectiveness review should be conducted each year to verify that the inspection resources are adequate to implement the ROP.
4.0	South Texas	3.1.4 Performance Review Process	F.2.9 Inspector Guidance  Inspector Oversight	As discussed in the recommendations in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes. IIPB should ensure that the STPLLTF recommendations regarding surveillance testing are incorporated into the ROP Inspection Program. Inspection Manual Part 9900 should be assessed as to whether it should be revised.  Develop and implement a process check within the CAP recommended in Section 3.1.1 to ensure recommendations from lessons learned activities are fully addressed. (This is identical to the recommendation in Section 3.1.2).

### Appendix A Consolidated Table of Recommendations (Contd.)

No.	Lesson-Learned Report	Problem	App. F Item No.	Recommendations
5.0	Millstone	3.2.1 Closeout of Inspection Findings Before Licensee Implementation of Corrective Actions	F.2.1	Similar to the recommendation in Section 3.1.2, develop and implement a process check within the CAP recommended in Section 3.1.1 to ensure recommendations from lessons learned activities are fully addressed. Ensure the ROP clearly state management's expectation for identifying, following up, and closing open items.
6.0	Millstone	3.2.2 NRC Inspector/Reviewer Skills, Abilities, Experience	F.2.3	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes. PM training should be revisited to ensure the recommendations from the MLLTF are addressed.
7.0	Millstone	3.2.3 Performance Review Process	F.2.9	An assessment should be conducted by IIPB to verify that the current process addresses all of the MLLTF concerns regarding SMMs. As recommended in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes.
8.0	Indian Point 2	3.3.1 NRC Inspector/Reviewer Skills, Abilities, Experience	F.2.3	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes.

**Appendix A Consolidated Table of Recommendations (Contd.)**

No.	Lesson-Learned Report	Problem	App. F Item No.	Recommendations
9.0	Indian Point 2	3.3.2 Specific Review Guidance	F.2.7	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Additionally, there needs to be a basis document or some other means to explain the reasons for changes and to ensure that future changes to documents or processes will not unknowingly remove these changes.
10.0	Indian Point 2	3.3.3 Performance Review Process	F.2.9	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. In addition, more formality and accountability should be required to change and extend dates for completion of corrective actions.
11.0	Indian Point 2	3.3.4 Inadequate Industry Guidance	F.2.10	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Corrective actions should not be closed out until the final actions are completed or addressed. An effectiveness review of the actions taken should also be conducted.
12.0	Indian Point 2	3.3.5 Inadequate Requirements in Licensing Basis	F.2.11	Similar to the recommendation in Section 3.1.1, establish a CAP that has a centralized tracking system (with archive) for lessons learned recommendations and corresponding corrective actions. Corrective actions should not be closed out until the final actions are completed.

### Appendix A Consolidated Table of Recommendations (Contd.)

No.	Lesson-Learned Report	Problem	Recommendations
13.0	Tracking Systems	<p>Indian Point 2 Millstone South Texas</p> <p>Data Management</p>	<p>There needs to be a centralized, official agency tracking system and archive for corrective actions and the corresponding recommendations from lessons learned. Also, an effectiveness review and lessons learned process that focuses solely on verifying corrective actions' effectiveness and proper closeout should be established as a permanent entity within the agency. Those corrective actions that tend to linger or require a policy decision should be brought to senior management's attention in a timely manner. This process should also have (1) a separate database for the corrective actions and (2) periodic reports issued to the Office Director and all Division Directors. Additionally, line organizations should also conduct an effectiveness review of their own corrective actions.</p> <p>ADAMS has the potential to be an excellent database for storing status and closeout documents that contain dispositioned corrective actions associated with lessons learned reports. This database needs to be improved to better access information; specifically, profiling records from lessons learned task force reports need to be improved. Also, guidance should be established to require that all status and closeout documents be input into ADAMS as agency records.</p>

### Appendix A Consolidated Table of Recommendations (Contd.)

No	LLRD	Problem	Recommendation
14.0	South Texas Indian Point 2 Millstone (All)	5.2.1 Inspectors Knowledge, Training and Skills	IIPB should continue to monitor the performance of inspectors who complete the revised qualification process and those that receive training through the refresher and self study courses designed to instill the fundamentals of the inspector competency model.
15.0	All	5.2.2 Performance Review Process	NONE
16.0	All	5.3.1 Operating Experience	<p>OES should continue its efforts in making OE information more assessable to inspectors. Databases that are managed by OES should be kept current and more comprehensive to give a complete history on the subject matter.</p> <p>IIPB should continue its efforts with the electronic Web page geared towards making information (such as results of inspection reports and operating experience) more assessable to inspectors. The search capability from the inspection report and operating experience database should include the ability to perform searches on equipment failures, effected plants, system types, components, words, complete history, etc. Currently, the developmental plans for the electronic Web page do not include a search capability on inspection reports. (The STPLLTF report had an almost identical recommendation).</p>
17.0	All	5.3.2 Questioning Attitude	IIPB should continue to take measures to codify a questioning attitude and to conduct an effectiveness review on the measures taken thus far.

**APPENDIX B**

**CONTRIBUTING CAUSES**



## Appendix B - Contributing Causes

Problems	Contributing Cause
1.0 (a) CA Partially Completed/Addressed	1. Line Organizations Decided CA
(b) CA Inadequately Addressed Issue	2. No Effectiveness Review within Line Organization
(c) CA Closed out to Other Activities	
2.0 (a) CA closed, Work On-going, Not Complete	1. Line Organization Manages Commitments
(b) Due Dates Changed Frequently	2. No Accountability to Justify to an Outside Organization the Reason(s) Overdue
3.0 CA Done, then Undone (Reversed)	1. No Bases Document
4.0 Inadequate Tracking System	1. Lack of Continuity Between Tracking Systems Used to Manage Commitments
5.0 Recommendation Does Not Result in a Measurable Action (not specific enough)	1. Task force not knowledgeable about line Organization processes

**APPENDIX C**  
**NRR DATABASES**

## **Appendix C - NRR Databases**

When the task force was unable to obtain closure documents to verify that the lessons learned recommendations were completed and effective, NRR official agency tracking systems were searched for the dispositioned corrective actions. The following official agency tracking systems have been budgeted, and established by OCIO: the Time Resource Inventory Management (TRIM), the Safety Issues Management System (SIMS), and the Reactor Programs System (RPS), which includes the Inspection Follow-up System (IFS), the Performance Issues Matrix or Plant Issues Matrix (PIM), and the Master Inspection Plan System (MIPS).

### **REACTOR PROGRAMS SYSTEM (RPS)**

RPS was designed to satisfy increasing and critical requirements for improved information management and analytical capabilities associated with reactor regulatory activities. The need for a single system to collect and integrate information for both inspections and licensing in one location, which could be correlated and analyzed, was envisioned.

NRR/PMAS/PIMB sponsored the development of RPS to fulfill program requirements that evolved over several years starting in the mid 1990s. The initial problems were highlighted in 1995 by both the staff and GAO. The findings indicated a lack of NRC diagnostic and planning capabilities resulting from NRC information contained in inspection programs and activities.

Today, RPS is used as a tool utilized by approximately 1,300 NRC headquarters and regional staff to implement the policy and inspection guidance for programs assigned to the NRC regional offices and assess the effectiveness and uniformity of the region's implementation of those programs through the planning, scheduling, conducting, reporting, and analyzing of inspection activities at nuclear power reactors.

### **TIME RESOURCE INVENTORY MANAGEMENT (TRIM)**

TRIM was developed by NRR to replace the Work Information Scheduling Program (WISP) on February 11, 2002 as the electronic work planning tool for NRR. The TRIM system is a module of RPS sponsored by NRR/PMAS/POEB as a new electronic tool for all NRR employees to create new Technical Assignment Control (TAC) numbers and schedule themselves to work on existing TACs. TRIM also subsumed the NRR Work Item Tracking System (NRR WITS) as an independent module to support the tracking of the Chairman's Tracking Memo (CTM), as well as Green, and Yellow ticket types. TRIM also interfaces with the NRC's Human Resources Management System (HRMS) Time and Labor system via RPS to supply the activities to which employees can charge time.

## SAFETY ISSUE MANAGEMENT SYSTEM (SIMS)

NRR/PMAS/PIMB is the organizational sponsor for the SIMS system. SIMS allows users to modify existing Multi-Plant Action (MPA) and Safety Issue information as well as define new safety issues and concerns and MPA for nuclear power reactors and other regulatory programs directly. Specifically, SIMS tracks information regarding Three Mile Island (TMI) issues, unresolved safety issues, generic safety issues, bulletins, generic letters, and other multi-plant activities.

SIMS was identified as a module within the NRR TRIM system that was designed as the replacement for the aging WISP system. TRIM is under the cognizant responsibility of NRR/PMAS/POEB as NRR's central scheduling and reporting authority. The plan was to migrate SIMS from NIH to TRIM to facilitate a centralized commitment tracking system. Accessibility to commitments for verification was cumbersome; hence, giving no clear indication that a commitment was verified. It is believed that the NRR updates to the SIMS system ceased as a result of the extremely low volume of SIMS items and staff attrition. With the release of TRIM Version 04.04.00, the production version of SIMS will be maintained on the NRC client/server platform by NRR/PMAS/PIMB, and effective June 2004.

## Conclusion

Too often, when new tracking systems are developed, the requirements on the type of data to track and report are not appropriately considered in the initial stages; thus, the data from the old systems are lost. Weaknesses exist with the lack of integration of old data and interfacing organization. A centralized tracking system database needs to be developed. Links to narrative status and closeout documents should be consistently maintained in ADAMS.

Interviews with the OCIO revealed that there are plans for the implementation of the new EDO WITS system utilizing workflow that may be expanded to agency wide use. There were no plans to migrate the data contained in the old EDO WITS tracking system. Migration is critical to establishing continuity of commitment tracking. The proposed EDO WITS system needs to include all affected staff to ensure that the new system captures the intricacies of the program office WITS systems and the often complex dependencies that exist within and between offices in responding to WITS items.

## **APPENDIX D**

### **APPENDIX F OF THE DAVIS BESSE LESSONS LEARNED TASK FORCE REPORT**

## APPENDIX D

### APPENDIX F OF THE DAVIS BESSE LESSONS LEARNED TASK FORCE REPORT SUMMARY OF RELATED ISSUES INVOLVING PREVIOUS NRC LESSONS-LEARNED EFFORTS

#### **F.1 Scope**

The task force reviewed the following reports from previous NRC lessons-learned activities to determine whether they suggested any recurring or similar problems:

- “Indian Point 2 Steam Generator Tube Failure Lessons-Learned Report,” October 23, 2000
- “Report of the Millstone Lessons-Learned Task Group, Part 1: Review and Findings,” September 13, 1996
- SECY 97-036, “Millstone Lessons-Learned Report, Part 2: Policy Issues,” February 12, 1997 (Part 2 of this report included the recommendations from Part 1. The two reports are referred to here as the “Millstone Report”)
- “Task Force Report Concerning the Effectiveness of implementation of the NRC’s Inspection Program and Adequacy of the Licensee’s Employee Concerns Program at the South Texas Project,” March 31, 1995

Table F-1 summarized the related issues.<sup>1</sup>

#### **F.2 Review Results**

The task force identifies several areas in which previous assessments had uncovered performance or programmatic issues that are similar to some issues identified in this review. The task force did not conduct an extensive review of each of the previous lessons to determine what particular elements were common with the DBNPS event. The following is a brief description of these issues.

##### **F.2.1 Closeout of Inspection Findings Before Licensee Implementation of Corrective Actions**

The Millstone report recommended that guidance be issued for identification, follow up and closeout of inspection findings.

As noted in Section 3.3.2 of this report, an open item involving a cited violation was closed without thorough inspection follow up. The NRC inspection of the licensee's corrective action implementation was not apparent.<sup>1</sup>

## **F.2.2 Program Guidance for Assessing Long-Standing Hardware Problems**

The Indian Point 2 report recommended that the performance indicator or the inspection program be assessed to determine if revisions were needed to address trends in RCS leakage.

The South Texas Project report recommended that improvements were needed in assessing the effectiveness of long-term corrective action programs.

Sections 3.2.1, 3.2.2, 3.3.1, and 3.3.2 of this report discuss issues involving RCS leakage trends, PI&R inspection effectiveness, and long-standing or recurring hardware problems.

## **F.2.3 NRC Inspector / Reviewer Skills, Abilities, Experience**

The Indian Point 2 Report recommended that NRC inspectors receive specialized training and that staff expertise in steam generator (SG) issues be maintained with formal training programs.

The Millstone report recommended that the NRC determine if inspectors have sufficient knowledge and skills needed to independently verify the acceptability of design-related actions.

The South Texas Project report recommended that the proper mix of skills and experience should be maintained between inspectors and supervisors.

Sections 3.3.1, and 3.3.5 of this report discuss issues involving a lack of training on boric acid corrosion control and PWSCC of Alloy 600 nozzles.

## **F.2.4 Process to Verify Information**

The Millstone report had two recommendations related to development of processes to identify important aspects of plant-specific licensing actions and to verify their implementation.

The Indian Point 2 report recommended that guidance should be developed regarding NRR and Regional Office interface that might be needed to verify information submitted by licensees.

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<sup>1</sup>The recommendations related to Indian Point 2 are listed in a table in Section 9 of its report. The recommendations related to Millstone are listed in a table provided in the appendix to Part 2 of the report. The lessons-learned and recommendations related to the South Texas Project are listed in Section 5 of its report. For ease of reference, Table F-1 provides recommendations, numbers from the source documents, as applicable.

Section 3.1.2 of this report discusses issues involving the lack of independent verification of licensee provided information in connection with NRC Bulletin 2001-01 VHP nozzle inspections. Sections 3.1.2 and 3.1.5 discuss issues involving unverified assumptions pertaining to VHP nozzle cracking and its effects on the RPV head. Also, Section 3.3.7 discusses issues involving the approval of LAR related to the RCS leakage detection system in which those staff members processing the LAR were unaware of the fouling of the associated radiation monitors.

### **F.2.5 NRC Review of Routine Reports**

The Indian Point 2 report recommended that the NRC assess the need for and processes related to the review of routinely submitted (SG) inspection reports required by TS.

Section 3.3.7 of this report discusses issues involving the lack of review of licensee inservice inspection summary reports and other licensee submitted information, such as summary reports involving changes to commitments.

### **F.2.6 NRR/Regional Office Interaction During Safety Evaluation Development**

The Indian Point 2 report recommended that guidance should be developed regarding NRR and Regional Office interface that might be needed to verify information submitted by licensees.

Section 3.3.7 of this report discusses the level of awareness of RCS leakage detection system radiation monitor filter elements fouling relative to the processing of a TS amendment request involving that system.

### **F.2.7 Specific Review Guidance**

The Indian Point 2 report recommended that formal guidance be provided to staff reviewers to SG- related submittals.

Sections 3.1.2 and 3.3.7 of this report discuss issues involving the level of guidance for the review of generic communication submissions.

### **F.2.8 Integration of Inspection Findings**

The South Texas Project report recommended that the process of integrating findings be examined for areas of possible improvement.

Sections 3.3.1 through 3.3.3 of this report discuss a number of issues involving the lack of integrations and assessment of inspection findings.

### **F.2.9 Performance Review Process**

The Indian Point 2 report recommended that additional guidance be developed to support SG inspection for the baseline inspection program.



The South Texas Project report recommended that improvements were needed in inspection guidance and inspector oversight needed to be strengthened.

The Millstone report had a recommendation related to NRC processes used to assess plant performance.

Sections 3.3.1 through 3.3.4 of this report discuss issues involving inspection guidance and oversight in a number of areas, including RCS leakage.

#### **F.2.10 Inadequate Industry Guidance**

The Indian Point 2 report recommended that EPRI SG guidelines be improved.

Sections 3.1.4 and 3.3.4 discuss issues involving the technical adequacy of industry guidance involving VHP nozzle cracking and boric acid corrosion control.

#### **F.2.11 Inadequate Requirements in Licensing Basis**

The Indian Point 2 report recommended TS improvements related to PWR SG requirements.

Sections 3.2.1 and 3.3.4 of this report discuss issues involving the adequacy of various requirements including TS involving RCS leakage.

#### **F.3 Recommendation**

The NRC should conduct an effective review of the actions taken in response to past lessons-learned reviews.

**Table F-1 Summary of Issues from Previous Lessons-Learned Reviews Related to the Davis-Besse Event**

<b>Issue Related to the Davis Besse</b>	<b>DBLL Recommendation No. (see App. A)</b>	<b>Related Previous Lessons or Recommendations</b>
F.2.1 Closeout of inspection findings before licensee implementation of corrective actions	3.3.2(4)	Millstone (item 4)
F.2.2 Program guidance for assessing long-standing hardware problems	3.2.1(2), (3), 3.2.2(1), 3.3.1(1), (2), 3.3.2(1), (2)	South Texas Project Indian Point 2 (item 5e)
F.2.3 NRC inspector/reviewer skills, abilities, and experience	3.3.1(1), 3.3.5(1)	Indian Point 2 (items 5b, 5c) Millstone (item 14) South Texas Project
F.2.4 Process to verify information	3.1.2(1), 3.3.7(1)	Millstone (items 2 and 6) Indian Point 2 (item 6d)
F.2.5 NRC review of routine reports	3.3.7(5), (6)	Indian Point 2 (item 6c)
F.2.6 NRR/Regional office interaction during safety evaluation development	3.3.7(1)	Indian Point 2 (item 6d)
F.2.7 Specific review guidance	3.1.2(4), 3.3.7(2)	Indian Point 2 (item 6a)
F.2.8 Integration of inspection findings	3.3.2(3), (4), 3.3.3(2)	South Texas Project
F.2.9 Performance review process	3.3.3(1), (2)	Indian Point 2 (items 5a, 5f) South Texas Project Millstone (item 15)
F.2.10 Inadequate industry guidance	3.1.4(1) 3.3.4(8)	Indian Point 2 (item 2)
F.2.11 Inadequate requirements in licensing basis	3.2.1(1), 3.3.4(8), (9)	Indian Point 2 (item 3)

## **APPENDIX E**

### **CHARTER**

January 14, 2004

MEMORANDUM TO: Serita Sanders, Lead  
Effectiveness Review Team

FROM: Bruce A. Boger, Director */RA/*  
Division of Inspection Program Management  
Office of Nuclear Reactor Regulation

SUBJECT: CHARTER FOR AN EFFECTIVENESS REVIEW OF PAST LESSONS-  
LEARNED

The purpose of this memorandum is to direct a team to conduct a limited effectiveness review of the actions taken in response to four lessons-learned reports. In addition, for those corrective actions that were not effectively implemented, the team should identify the root and contributing causes and recommend actions to prevent recurrence. This effort addresses the Davis-Besse Lessons Learned Task Force Appendix F recommendation to determine the cause of recurring programmatic and performance problems identified by previous lessons-learned reviews.

Prior to writing the final report, the team should brief the Executive Team and Leadership Team (ET/LT) on the results such that an expanded review scope could be undertaken, if deemed necessary.

Attachments: 1. Effectiveness Review Charter  
2. Appendix A

MEMORANDUM TO: Serita Sanders, Lead  
Effectiveness Review Team

FROM: Bruce A. Boger, Director  
Division of Inspection Program Management  
Office of Nuclear Reactor Regulation

SUBJECT: CHARTER FOR AN EFFECTIVENESS REVIEW OF PAST LESSONS-  
LEARNED

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Prior to writing the final report, the team should brief the Executive Team and Leadership Team (ET/LT) on the results such that an expanded review scope could be undertaken, if deemed necessary.

Attachments: 1. Effectiveness Review Charter  
2. Appendix A

DISTRIBUTION:

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## **EFFECTIVENESS REVIEW CHARTER**

### **Objective**

The objective of this team is to conduct a limited effectiveness review of the actions taken in response to four lessons-learned reports.

### **Scope**

The Davis-Besse Lessons Learned Task Force (DBLLTF) identified several areas in which previous assessments had uncovered performance or programmatic issues that were similar to the ones identified during the DBLLTF's review. This team will review the same reports reviewed by the DBLLTF for those findings that were similar to the Davis-Besse findings. The corrective actions for these findings will be evaluated for effectiveness. The team will then determine the root cause or causes of any recurring performance or programmatic issues and make recommendations for resolution.

Those action items that are identified as similar to the ones recognized by the DBLLTF will be verified for effectiveness. The team will also examine the Office of Nuclear Reactor Regulation's (NRR's) and the regions current systems for tracking high-priority items to closure.

### **Schedule**

Received ET approval	9/03	
Form team	11/03	
Document review	11-12/03	
Assess regional implementation	12/03	
Assess effectiveness	12/1-15/03	
Perform limited root cause analysis	12/15-30/03	
Present to ET	1/04	
Write report	2/04	(provided ET does not extend review period)
Issue report	3/04	

### **Staffing**

The team will consist of the following members:

Serita Sanders, DIPM/NRR, Team Leader  
Eva Brown, DLPM/NRR  
Carl Konsman, PMAS/NRR  
TBD (NRR)  
Yamir Diaz, DE/NRR (Intern)  
Kelly Grimes, DRIP/NRR (Administrative Support)

### **Senior Management Interface**

In January, upon the completion of the 8-week review period, the Leadership Team (LT) and Executive Team (ET) will be briefed on the results. The ET, with a recommendation for the LT, will decide if the findings and recommendations are sufficient or if additional resources should be allocated to expand the scope of the review.

## **APPENDIX A**

### **List of Lessons-Learned Reports Being Reviewed**

"Indian Point 2 Steam Generator Tube Failure Lessons-Learned Report," October 23, 2000

"Report of the Millstone Lessons-Learned Task Group, Part 1: Review and Findings,"  
September 13, 1996

SECY 97-036, "Millstone Lessons-Learned Report, Part 2: Policy Issues," February 12, 1997  
(Part 2 of this report includes the recommendations from Part 1)

"Task Force Report Concerning the Effectiveness of Implementation of the NRC's Inspection  
Program and Adequacy of the Licensee's Employee Concerns Program at the South Texas  
Project," March 31, 1995

## **APPENDIX F**

### **ACRONYMS**



## Appendix F

### List of Acronyms

ADAMS	Agencywide Documents Access and Management System
ADRP	Associate Director for Reactor Projects
CAL	Confirmatory Action Letter
CONED	Consolidated Edison
DBLLTF	Davis Besse Lessons Learned Task Force reports
DBNPS	Davis Besse Nuclear Power Station
DIPM	Division Inspection Program Management
DLPM	Division of Licensing Project Management
DQSR	Director Quarterly Status Report
EDO	Executive Director of Operations
EPRI	Electric Power Research Institute
ERLLTF	Effectiveness Review Lessons Learned Task Force
HL&P	Houston Lighting & Power Company
IFS	Inspection Follow-up System
IIPB	Inspection Program Management
IP	Inspection Procedure
IP2LLTF	Indian Point 2 Lessons Learned Task Force
ISI	Inservice Inspection
MIPS	Master Inspection Plan System
MLLTF	Millstone Lessons Learned Task Force
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
NRR	Nuclear Reactor Regulation
NTOL	Near Term Operating License
NU	Northeast Utilities
OCIO	Office of Chief Information Officer
OE	Operating Experience
OIG	Office of Inspector General
PIPB	Inspection Program Management
PIP	Performance Improvement Plan
PI&R	Problem Identification and Resolution
PM	Project Manager
ROP	Reactor Oversight Process
RPS	Reactor Programs System
RPV	Reactor Pressure Vessel
RI	Resident Inspector
SG	Steam Generator
SDG	Steam Diesel Generator
SIMS	Safety Issue Management System
SMM	Senior Management Meeting
SRI	Senior Resident Inspector
STP	South Texas Project

## List of Acronyms - Cont.

STPLLTF	South Texas Project Lessons Learned Task Force
TRIM	Time Resource Inventory Management
TS	Technical Specification
TDAFW	Turbine Driven Auxiliary Feedwater Pump
VHP	Vessel Head Penetration
WITS	Work Item Tracking System

**APPENDIX G**

**REFERENCES**

## Appendix G - References

### South Texas

1. Memorandum to William T. Russell, NRR Director, "Response to Task Force Report Concerning the Effectiveness of Implementation of the NRC's Inspection Program and Adequacy of the Licensee's Employee Concerns Program at the South Texas Project," dated June 11, 1996
2. Memorandum to William T. Russell, NRR Director, "Response to Task Force Report Concerning the Effectiveness of Implementation of the NRC's Inspection Program and Adequacy of the Licensee's Employee Concerns Program at the South Texas Project," dated June 11, 1996
3. Inspection Procedure 71152, "Identification and Resolution of Problems," dated September 8, 2003
4. Inspection Procedure, 40500, "Effectiveness of Licensee Process to Identify, Resolve, and Prevent Problems," dated May 3, 1999
5. Task Force Report Concerning the Effectiveness of Implementation of the NRC's Inspection Program and Adequacy of the Licensee's Employee Concerns Program at the South Texas Project, March 31, 1995

### Millstone

1. Memorandum to L. Joseph Callan, "Staff Requirements - SECY-97-036 - Millstone Lessons Learned Report, Part 2: Policy Issues," dated May 20, 1997
2. Memorandum to Roy P. Zimmerman, "Commission Paper to Respond to Staff Requirements Memorandum on SECY-97-036, Millstone Lessons Learned Report, Part 2: Policy Issues, Dated May 20, 1997," dated July 24, 1997
3. Office Letter Transmittal 900, "Managing Commitments Made by Licensees to the NRC," dated March 24, 2000
4. SECY-98-218, "Suspension of the Systematic Assessment of Licensee Performance Program," dated September 21, 1998
5. SECY-97-294, "Response to Staff Requirements Memorandum of October 24, 1997, Regarding the Decision-Making Process at the Senior Management Meeting and the Benefits that the Process and Watch List provide in terms of Public Health and Safety," dated December 19, 1997
6. SECY-98-045, "Status of the Integrated Review of the NRC Assessment Process for Operating Commercial Nuclear Reactors," dated March 9, 1998

7. SECY-98-224, "Staff and Industry Activities Pertaining to the Management of Commitments Made by Power Reactor Licensees to the NRC," dated September 28, 1998
8. SECY-95-300, "Nuclear Energy Institute's Guidance Document, 'Guide Line for Managing NRC Commitments'," dated December 20, 1995
9. SECY-97-205, "Integration and Elevation of Results from Recent Lessons-Learned Reviews", dated September 10, 1997
10. Memorandum from Samuel J. Collins, "Interim guidance for the commitment information tracking form", dated March 16, 2000
11. Memorandum from Bruce A. Boger and Brian W. Sheron, "Interim Guidance to Manage Licensee Commitments Being Relied upon in Licensing Actions," dated April 30, 1998
12. Memorandum from John C. Hoyle, "Staff Requirements - SECY-97-122 - Integrated Review of the NRC Assessment Process Operating Commercial Nuclear Reactors", dated August 19, 1997
13. Administrative letter 98-07, ML0311101410, "Interim Suspension of the Systematic Assessment of Licensee Performance (SALP) Program," dated October 2, 1998
14. Office Instruction LIC-502, ML003771257, "Procedure for Development, Implementation, and Management of Action Plans," dated June 29, 2001
15. Office Instruction LIC-100 Revision 1, ML033530249, "Control of Licensing Bases for Operating Reactors," dated January 7, 2004
16. Office Instruction LIC-105, ML022750041, "Managing Regulatory Commitments made by Licensees to the NRC," dated May 27, 2003
17. SECY-97-072, "Staff Action Plan to Improve the Senior Management Meeting Process," dated April 2, 1997
18. SECY-98-055, "Response to Staff Requirements Memorandum of October 24, 1997, Regarding Improvements in Senior Management Assessment Process for Operating Reactors," dated March 25, 1998
19. SECY-96-093, "Guidance for Senior Management Meeting and Plant Evaluation Processes," dated May 1, 1996
20. SECY-99-086, "Recommendations Regarding the Senior Management Meeting Process and Ongoing Improvements to Existing Licensee Performance Assessment Processes," dated March 23, 1999

21. SECY-98-170, "Response to Staff Requirements Memorandum of June 30, 1997, Regarding (1) The use of Graphs or Charts at the Senior Management Meeting, (2) Improvements to Help the Public Understand the Linkages Between the Various Evaluation Mechanisms that the NRC uses, and (3) Superior Performance Recognition," dated July 9, 1998
22. SECY-97-192, "Peer review of The Arthur Andersen Methodology and Use of Trending letters," dated August 21, 1997
23. SECY-96-02, "Semiannual Status Report on the Implementation of Regulatory Review Group Recommendations," dated February 2, 1996
24. Report of the Millstone Lessons-Learned Task Group, Part 1: Review and Findings, September 23, 1996
25. SECY-97-036, "Millstone Lessons-Learned Task Group, Part 2: Policy Issues, February 12, 1997 (Part 2 of this report included the recommendations from Part 1. The two reports are treated as one report for this review)

#### Indian Point 2

1. NRC Memorandum from S. J. Collins to W. D. Travers, "Indian Point Unit 2 Steam Generator Tube Failure Lessons-Learned Task Group and Charter," dated May 24, 2000 (ADAMS Accession No. ML 013600381).
2. Indian Point 2 Steam Generator Tube Failure Lessons-Learned Report," dated October 23, 2000 (ADAMS Accession No. ML020320416).
3. Regulatory Issue Summary, "Issues Stemming from NRC Staff Review of Recent Difficulties Experienced in Maintaining Steam Generator Tube Integrity," dated November 3, 2000 (ADAMS Accession No. ML003758988).
4. NRC Memorandum from J. A. Zwolinski, J. R. Strosnider, B. A. Boger and G. M. Holahan to B. W. Sheron and R. W. Borchardt, "Steam Generator Action Plan Revision and Completion of Item Nos. 1.1, 1.2, 1.3, 1.4, 1.7, 1.8, 1.15, 2.1 and 2.2," dated March 23, 2001 (ADAMS Accession No. ML010820457).
5. NRC Memorandum from J. R. Strosnider to B. W. Sheron and R. W. Borchardt, "Steam Generator Review Guidance," dated April 30, 2001 (ADAMS Accession No. ML011220621)
6. NRC Memorandum from J. R. Strosnider to B. W. Sheron and R. W. Borchardt, "Steam Generator Action Plan Item 1.11A - Review and Revise the Baseline Inspection Program Related to Steam generator Inspections," dated April 30, 2001 (ADAMS Accession No. ML011210293).

7. NRC Memorandum from R. J. Barrett to M. R. Johnson, "Suggested Modifications to the Significance Determination Process to Address Inspection Findings Related to Steam Generator Tube Degradation," dated September 21, 2001 (ADAMS Accession No. ML012680252).
8. NRC Memorandum from J. R. Strosnider to J. A. Zwolinski, "Commitment and New Process for SG Conference Calls and Inspection Reports," dated October 25, 2001 (ADAMS Accession No. ML013020093).
9. NRC Memorandum from B. A. Boger to B. W. Sheron and R. W. Borchardt, "Steam Generator Action Plan Item 1.11C - Review and Revise the Training Program for Inspectors Related to Steam Generator Inspections," dated February 27, 2002 (ADAMS Accession No. ML020560366).
10. NRC Memorandum from B. A. Boger to B. W. Sheron and R. W. Borchardt, "Steam Generator Action Plan 1.11.B.2 - Develop and Issue Draft Revision of Risk Informed Significance Determination process to Assess Results of In-Service Inspections," dated April 8, 2002 (ADAMS Accession No. ML020730318).
11. NRC's Internal Director's Quarterly Status Report, "Action Plans, Rulemaking, Generic Communications and Compliance Activities," Office of Nuclear Reactor Regulation, dated July 2003 (ADAMS Accession No. ML031900239)
12. "Degradation of the Davis-Besse Nuclear Power Station Reactor Pressure Vessel Head Lessons-Learned Report," dated September 30, 2002 (ADAMS Accession No. ML022760172).
13. NRC Memorandum from B. A. Boger to S. Sanders, "Charter for an Effectiveness Review of Past Lessons Learned," dated January 14, 2004 (ADAMS Accession No. ML040150790).
14. NRR Office Letter 803, Revision 3, "License Amendment Review Procedures," dated December 30, 1999 (ADAMS Accession No. ML993550418).
15. NRR Office Instruction LIC-101, Revision 3, "License Amendment Review Procedures," dated February 9, 2004 (ADAMS Accession No. ML040060258).
16. "Indian Point 2 Steam Generator Tube Failure Lessons-Learned Report," October 23, 2000

#### Others

1. "Degradation of the Davis-Besse Nuclear Power Station Reactor Pressure Vessel Head Lessons-Learned Report," September 30, 2002
2. "Reactor Operating Experience Task Force Report," November 26, 2003